Audit and Assurance Committee - 28 May 2020

28 May 2020, 09:00 to 12:30

Agenda

1
Welcome and Introductions

John Union

2
Apologies for Absence

John Union

3
Declarations of Interest

John Union

4
Minutes of the Committee meeting held on 21 April 2020

John Union

4 - Public Audit Mins - April 2020.pdf (7 pages)

5
Action log following meeting held on 21 April 2020

John Union

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

6
Any Other Urgent Business: To agree any additional items of urgent business that may need to be considered during the meeting.

John Union

7
Items for Review and Assurance

7.1
Internal Audit Progress and Tracking Reports

Ian Virgill

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

7.1.1 CV AC A&A Progress Report May 20.pdf (22 pages)

8
Items for Approval / Ratification

8.1
Report of the Losses and Special Payments Panel

Robert Chadwick

8.1 - Report of the Losses and Special Payments Panel May 2020.pdf (2 pages)

8.1.1 - Appendix 1- Minutes of the May 2020 Losses Special Payments Panel.pdf (8 pages)

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9. Items for Information

9.1

1. UHW Neonatal Development Project

Ian Virgill

9.1.1 - CVU_Neonatal Development_1920_Final Report (002).pdf (20 pages)

9.2

2. Service Improvement Programme Team

Ian Virgill

9.1.2 - CUHB1920.42 SIP Team Final Report.pdf (10 pages)

9.3

3. Rookwood Re-location Project

Ian Virgill

9.1.3 - CVU_Rookwood Relocation_1920_Final Report.pdf (19 pages)

9.4

4. Surgery CB – Enhanced Supervision

Ian Virgill

9.1.4 - CUHB1920.31 Surgery CB Enhanced Supervision Final Report.pdf (20 pages)

9.5

5. Infection Prevention & Control

Ian Virgill

9.1.5 - CUHB1920.21 IP&C Final report.pdf (24 pages)

9.6

6. Management of Health Board Policies

Ian Virgill

9.1.6 - CUHB1920.04 Management of Policies Final Report.pdf (18 pages)

9.7

7. Pre-Employment Checks (Draft)

Ian Virgill

9.1.7 - CUHB1929.40 Pre-Employment Checks Draft Report v3.pdf (22 pages)

9.8

8. Strategic Planning / IMTP (Draft)

Ian Virgill

9.1.8 - CVUHB 1920.08 Strategic Planning IMTP Draft report v3.pdf (16 pages)

9.9

Good Governance During COVID-19

Nicola Foreman

9.2 - Governance during COVID 19.pdf (5 pages)

9.9.1

Appendices

9.2.1 Appendix 1UHB Governance and Delivery Arrangements COVID-19 - 30.03.20 Draft 10.pdf (1 pages)

9.2.2 - Appendix 2 Committee Meeting Schedule (002).pdf (2 pages)

9.2.3 Appendix 3 Standing Order amendment.pdf (2 pages)

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Review and Final Closure

John Union

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Items to be deferred to Board / Committee

John Union

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

Special Audit Committee - Monday, 29 June 2020 – 10.00am Executive Meeting Room, Woodlands House

John Union

Unconfirmed Minutes of the Public Audit & Assurance Committee
Held on Tuesday, 21st April 2020
Executive Meeting Room, 2nd Floor, Woodland House

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth	EB	Independent Member – ICT
Dawn Ward	DW	Independent Member – Trade Union
In Attendance:		
Bob Chadwick	BC	Executive Director of Finance *(via Skype)*
Nicola Foreman	NF	Director of Corporate Governance
Mike Jones	MJ	Wales Audit Office *(via Skype)*
Mike Usher	MU	Sector Lead – Health & Central Government *(via Skype)*
Ian Virgil	IV	Head of Internal Audit
Secretariat		
Laura Tolley	LT	Corporate Governance Officer
Apologies:		
Martin Driscoll	MD	Deputy Chief Executive Officer / Executive Director of Workforce & Organisational Development
Craig Greenstock	CG	Countefraud Manager
Stuart Walker	SW	Executive Medical Director

AAC 20/04/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 20/04/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/04/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/04/004	**Minutes of the Committee Meeting held on 3rd March 2020** The Committee reviewed the minutes of the meetings held on 3rd March 2020. **Resolved that:** (a) the minutes of the meeting held on 3rd March 2020 be	

	approved as a true and accurate record.	
AAC 20/04/005	**Action Log following the Committee Meeting held on 3rd March 2020** The Committee reviewed the action log and noted the following updates: **AC 20/03/008** – It was confirmed an internal audit would be carried out at an appropriate time agreed with the Executive Medical Director (EMD) **AC 19/05/007** – It was confirmed that Performance Reporting Data Quality –RTT had moved to the 2020-21 plan. **Resolved that:** (a) the Committee noted the action log and the verbal updates provided.	
AAC 20/04/006	**Chairs Action taken since the last Committee Meeting held on 18th February 2020** There had been no Chairs Action taken. The CC advised the Committee that a weekly Board Governance meeting had been arranged with the Chair and Vice Chair and minutes from that meeting would be shared with all Independent Members as appropriate. The Director of Corporate Governance (DCG) confirmed that all questions raised were recorded to keep an audit trail.	
AAC 20/04/007	**Internal Audit Progress and Tracking Report** The Head of Internal Audit (HIA) introduced the report and explained the current pandemic had a significant impact to complete work outlined in the work plan, however, the audit reports that were in draft were anticipated to be completed. The HIA further explained that the Committee usually discussed audits that had been fully completed, however, given the current circumstances, asked if the Committee could view the audit reports in draft during the May for information, and the final report would be brought to a future meeting when possible. After Committee discussion, the CC confirmed he was comfortable with proposed approach. The HIA confirmed the following audit reports were included in the report for information: • CD&T Laboratory Turnarounds – Substantial • UHB Core Financial Systems - Substantial • Risk Management – Reasonable The DCG confirmed the UHB was pleased with the report and in particular, the substantial reports.	**IV**

	The HIA confirmed that work was being undertaken to complete the audit plan and subsequently deliver the Head of Internal Audit Opinion. The Committee were advised that seven reports were unable to be undertaken due to COVID-19. The HIA advised the Committee that enough audits had taken place to provide sufficient coverage across the eight domains to complete the Head of Internal Audit Opinion, which would be a reasonable assurance rating. The Independent Member – ICT (IM-ICT) queried why the Health Care Standards had not been completed. In response, the HIA confirmed it was due to adjustments to the annual plan, which meant the timing had changed. The HIA commented that the draft audit plan for 2020-21 had been shared with the DCG and other appropriate Executive Directors for approval, and it was agreed that the audits that had not been completed would be reviewed on a risk based approach before including them on the plan. The CC explained he was pleased to hear that the outstanding audits would take a risk based approach and thanked the HIA for all the work undertaken over the past year. **Resolved that:** (a) the Committee considered the Internal Audit Progress and Tracking Report; (b) the Committee approved the proposed changes outlined within the report.	
AAC 20/04/008	**Declarations of Interests, Gifts and Hospitality Tracking Report** The DCG introduced the report and advised the Committee that the back log of forms had been added to the register, so the report was fully up to date which was positive. The DCG added that due to the current pandemic, all communications regarding declarations of interest had stopped, however the team were still monitoring declarations that were being received, and to date, nothing had been received that raised concern. The Independent Member – Trade Union (IM-TU) congratulated the team for the excellent progress made within Standards of Behaviour and asked how the Committee would be sighted on any Declarations of Interest taken on board at Ysbyty Calon Y Ddraig. In response, the DCG confirmed she would discuss with the Executive Director of Workforce & Organisational Development and a report would be brought back at a future meeting. The IM-ICT asked where individuals are known to the Health Board to have interests, would there be any proactive steps to ensure people declare. In response, the DCG encouraged members to inform the Corporate Governance team of any known interests and this would be followed up accordingly.	**NF**

	Resolved that: (a) the Committee noted the ongoing work in Standards of Behaviour and the progress made to date; (b) the Committee noted the Declarations of Interest Register.	
AAC 20/04/009	**Regulatory Compliance Tracking Report** The DCG introduced the report and confirmed that all trackers were up to date until COVID-19 and advised the Committee that there were no visits ongoing currently, there were planned visits for June / July, however it was anticipated these would not take place. The CC asked if there were appropriate visits and sign off for Ysbyty Calon Y Ddriag. In response, the DCG confirmed that a report outlining all visits would be produced at a future meeting to provide the Committee with assurance. **Resolved that:** (a) the Committee noted the continuing development within the Regulatory Compliance Tracking Report.	**NF**
AAC 20/04/010	**Internal Audit Tracking Report** The DCG introduced the report and confirmed activity had slowed due to COVID-19, however the number of recommendations had been reduced which was positive. The DCG advised the Committee that the UHB Chair had queried what action would be taken for significantly overdue recommendations. In response, the DCG confirmed that after COVID-19 it was expected these would be picked up and escalated as appropriate. The HIA added that the Internal Audit team would review the recommendations to ensure they were still relevant and had not been superseded. The IM-ICT asked that work be undertaken with the Director of Digital & Health Intelligence to ensure that responses received are transparent and more detailed. In response, the DCG confirmed with the new capacity, it was hoped this area would be improved significantly. **Resolved that:** (a) the Committee noted the Internal Audit Tracking Report.	**NF**
AAC 20/04/011	**Wales Audit Office Tracking Report** The DCG explained that work was still being undertaken in this area, however, it had slowed due to COVID-19. The DCG confirmed there had been a decrease from 90 outstanding recommendations to 48 which were over a course of three years.	

	Resolved that: (a) the Committee noted the Wales Audit Office Tracking Report.	
AAC 20/04/012	**Review the Risk Management System** The DCG advised the Committee that significant progress had been made within Risk Management and there was now a strategy and agreed risk appetite, along with systems in place to manage risks. The DCG explained that consistent scoring was the next phase of work to be undertaken, however this had been paused due to COVID-19. The DCG further explained that there was an expectation that risk registers would be maintained, however scoring would not be reviewed. The DCG advised that for COVID-19, a risk management register had been put in place and risk registers for the four hubs had been developed, the risk registers would be presented at the Board Governance Group and at the Board Meeting at the end of May 2020. Within the six key risks, one had been slightly amended from 'planning recovery' to 'risks to Cardiff & Vale IMTP'. **Resolved that:** (a) the Committee reviewed and noted the Risk Management System.	
AAC 20/04/013	**Annual Internal Audit Plan** The HIA advised the Committee that unfortunately, the Full Audit Plan and Charter was not included in the papers, therefore it would be circulated after the meeting. The HIA explained the audit plan had been produced following discussions with all Executives, UHB Chair and Chief Executive Officer. The HIA further explained that the Committee were being asked to approve the annual plan, but with the acknowledgement that it would need further adjustment and amendment to reflect the emerging risks coming from COVID-19. The HIA added that work was being undertaken with shared services to access potential additional support through agencies to catch up with work required after COVID-19. The IM-ICT requested an update be provided at the next Committee meeting, detailing any changes made to the plan. In response, the HIA confirmed he would update the Committee as part of the progress report. **Resolved that:** Subject to the caveats discussed;	**IV**

	(a) the Committee approved the Annual Internal Audit Plan.	
AAC 20/04/014	**Internal Audit Reports** • CD&T Laboratory Turnarounds — Substantial • UHB Core Financial Systems — Substantial • Risk Management — Reasonable **Resolved that:** (a) the Committee noted the Internal Audit Reports and Ratings.	
AAC 20/04/015	**Annual Audit Plan – Impact of COVID-19** The Sector Lead – Health & Central Government (SL-HCG) advised the Committee that all audit work had been suspended for the time being due to COVID-19, however work was being undertaken to capture learning from the pandemic on an All Wales Level. Wales Audit Office confirmed that in terms of accounts, the timetable had been altered to 22nd May – 30th June and the performance report had also been delayed to 31st August which allowed key staff to focus on current challenges. It was also explained that an Audit Committee and Board Meeting would be required either on 26th or 29th June to reflect the time table change. Wales Audit Office also explained that FRS 16 –Leases, Change in Accounting Standards had been deferred for one year, into 2021-22 which was very helpful as that would be a significant amount of work for all Health Boards. The IM-TU asked when the UHB would be sighted on the piece of work in relation to Learning from COVID-19. In response, the SL-HCG advised this was an evolving piece of work and would be shared on an All Wales Level when appropriate. **Resolved that:** (a) the Committee noted the Annual Audit Plan – Impact of COVID-19.	**MU**
AAC 20/04/016	**Items to bring to the attention of the Board/Committees.** There were no items to be brought the attention of the Board/Committees.	
AAC 20/04/017	**Review of the Meeting** The CC facilitated a review of the meeting. Members confirmed that given the current circumstances, all aspects of the meeting worked well and ran smoothly.	

AAC 20/04/019	**Date & Time of next Meeting** *(to be confirmed)* Tuesday, 19 May 2020 9.00am – 12:30pm Coed y Bwl Room, Ground Floor, Woodland House	

Action Log
Following Audit & Assurance Committee Meeting
3 March 2020

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	|STATUS/COMMENTS
Completed Actions					
AAC 20/04/013	Annual Internal Audit Plan	The full audit plan and charter be circulated after the meeting	Nicola Foreman	21.04.20	**Completed.**
Actions in Progress					
AC: 20/03/008 **AAC 20/04/005**	Consultant Job Planning Follow-up: Limited Assurance Report	For an update to be presented to the Committee in February 2021. It was agreed an Internal Audit Report would be carried out at an appropriate time agreed with Stuart Walker	Ian Virgil	9.02.21 TBC	Update to be provided at February 2021 meeting. To be confirmed
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
AAC 20/04/007	Internal Audit Progress & Tracking Report	Draft audits would be presented at the May 2020 Meeting for information	Ian Virgil	May 2020	To be included on the May Agenda
AAC 20/04/008	Declarations of Interest	A report detailing Declarations of Interest in relation to Ysbyty Calon Y Drraig be brought to a future meeting	Nicola Foreman	TBC	To be confirmed
AAC 20/04/009	Regulatory Compliance	A report detailing all visits and sign off	Nicola Foreman	TBC	To be confirmed

	Tracking Report	for Ysbyty Calon Y Ddraig be brought to a future meeting			
AAC 20/04/010	Internal Audit Tracking Report	Work be carried out with the Director of Digital & Health Intelligence to improve transparency and detailed responses	Nicola Foreman	TBC	To be confirmed
AAC 20/04/013	Annual Internal Audit Plan	Changes made to the plan be included in the Internal Audit Progress Report at the May meeting	Ian Virgil	May 2020	To be included in the Internal Audit Progress Report in May 2020
AAC 20/04/015	Annual Audit Plan – Impact of COVID-19	Work undertaken on an All Wales Level relating to learning from the pandemic be shared with the UHB	Mike Usher	To be confirmed	To be confirmed
Actions referred to other Committees/Board					

REPORT TITLE:	Internal Audit Progress Report							
MEETING:	Audit & Assurance Committee					**MEETING DATE:**	28.05.20	
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 completed 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 and issued in draft since the previous meeting of the committee and amendments to the plan.

The progress report highlights the conclusion and assurance ratings for audits finalised or issued in draft 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.

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 and draft individual audit reports.

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 May 2020

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

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

Disclaimer notice - Please note:

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

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

1. INTRODUCTION

1.1. This progress report provides the Audit & Assurance Committee with the current position regarding the work 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 during the year 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. OUTCOMES FROM COMPLETED AUDIT REVIEWS

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

2.2. Due to the effects of the COVID-19 outbreak, the Health Board has not been in a position to agree management responses for a number of draft reports. At its meeting in April the Audit Committee therefore agreed that it would receive any remaining draft reports at the May meeting so that it would have a chance to review them prior to inclusion of the outcomes within the Annual Report. These reports are therefore also highlighted within the table below.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
UHW Neonatal Development Project	Substantial	
Service Improvement Programme Team		
Rookwood Relocation Project	Reasonable	
Surgery CB – Enhanced Supervision		
Infection Prevention & Control		
Management of Health Board Policies		
Pre-Employment Checks (Draft)		
Strategic Planning / IMTP (Draft)		

3. DELIVERY OF THE 2019/20 INTERNAL AUDIT PLAN

3.1. After adjustments to the original audit plan that were agreed at previous meetings of the Audit Committee, it had been anticipated that we would produce 46 outputs at the year end. However, due to the impact of COVID-19 the final position is that 37 final and 2 Draft reports have been issued. However there were 7 audits where insufficient work could be completed to provide a report.

We have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The overall opinion is Reasonable Assurance and is detailed in full within the draft Head of Internal Audit Opinion and Annual Report.

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

3.2. Appendix C highlights the times for responding to Internal Audit reports and Appendix D shows the Audit & Assurance Key Performance Indicators.

The actual performance against all the indicators is showing as green with the exception of the Report Turnaround indicator which is amber. Only 64% of management responses were provided within the required 15 working day timescale. It is however acknowledged that this performance has been negatively impacted by delays resulting from the COVID-19 outbreak. Prior to this the Health Board had been making progress towards improving compliance with this target.

4. FINAL / DRAFT REPORT SUMMARIES

4.1. UHW Neonatal Development Project

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

The following positive aspects were noted at the project:

- Appropriate business case and funding approvals were in place;
- The project was delivered within project budget generating gain share for the UHB and Supply Chain Partner;
- Robust cost control and monitoring systems were in place;
- A full post project evaluation is planned to be undertaken [albeit timing not confirmed]; and
- A benefits realisation exercise was undertaken by service-users.

Certain enhancements, noting that they will be applicable for future projects, have been recommended in respect of:

- Performance management submissions to be completed as per Framework guidance; and
- Assurances from the Cost Adviser regarding routine review of source documentation to confirm calculations attributed to projects.

Noting the positive delivery arrangements at the highly complex project, the effectiveness of the system of internal control in place to manage the risks associated with the delivery of the individual phases of the Neonatal Development has been assessed as providing Substantial Assurance subject to the completion of the benefits realisation/PPE as scheduled.

4.2. Service Improvement Programme Team

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

The review of the Capital, Estates and Facilities Service Improvement Programme Team found that overall the controls and process in place were of a high standard.

The setting up of the team was outlined in a Project Brief which detailed clearly the remit of the team and its objectives.

The processes in place for recording all ideas and ongoing management of those 'projects' going forward were found to be appropriate.

The conclusion we have reached for the audit is based on only completing work related to two of the three objectives detailed in the Scope and Objectives. We were unable to undertake any fieldwork regarding objective 3 'The SIP team is effectively delivering against its objectives and is adding value to the Service Board by enabling the delivery of service improvements' as in order to determine this we needed to select a sample of ideas proposed and test that objectives have been met. At the time that this information was requested audit were informed that the SIP team had been suspended as a result of the Covid 19 situation and all staff have been drafted into the main CEF team to support the Health Board with COVID 19 issues, so it was unlikely that they would be able to provide the necessary information.

If in the future management determine that they still require assurance around the third objective, then Internal Audit will assess the possibility of re-visiting the SIP team and completing the outstanding testing.

4.3. Rookwood Relocation Project

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.

At the date of the review, issues regarding the cost and programme at UHL had been highlighted:

- Unforeseen works associated with relocating staff, leading to a funding shortfall [£288k as per November 2019 cost report]; and
- Potential delay to programme arising from the resolution of the requirements for fire protection to steelwork, for which no definitive cost had yet been provided.

Furthermore, whilst outside the scope of the contractors work, the UHB are experiencing issues with the PFI provider regarding acceptance of the instruction of works issued for St David's Hospital: affecting the timing of repatriation of the elderly care services within the wider Rookwood relocation programme.

Whilst being cognisant of the above issues, general compliance was noted with the established control frameworks in each of the objective areas sampled, particularly in relation to change management, budgetary /cost management and valuation.

The audit identified the following control weakness:

- the accuracy of the project risk register including the need for risk mitigation arrangements and potential costs etc.

In addition, certain enhancements have been recommended in respect of:

- the need to formally approve the plan to manage the identified funding shortfall for the remaining 11 months of the programme;
- the timeliness of payments to the main contractor; and
- the need to reconcile the Welsh Government dashboard reports to the cost reports prepared.

Accordingly, against this context, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the re-provision of Specialist Neuro and Spinal Rehabilitation and Elderly Care Services from Rookwood Rehabilitation Hospital is Reasonable Assurance.

4.4. Surgery CB – Enhanced Supervision

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

Overall there are processes in place in each of the four sampled Wards that enable nursing staff to; assess risk, appraise need and request, approve and record patients that are undergoing enhanced supervision.

There are also efficient processes in place at both Ward and Senior Nurse Management level for monitoring and reporting the use and cost of enhanced supervision to Clinical Board and Executive Board level.

However, testing identified that these processes undertaken at Ward level are not always documented in a complete and consistent manner, and in a small number of instances supporting documentation could not be located on patient's notes.

There is also currently an absence of any formal Surgery Clinical Board overarching procedure/guidance provided to Ward Managers in respect of the management and oversight of enhanced supervision.

A number of key findings were identified that require management attention in order to reinforce the current processes that are in place and are generally working well;

Additionally, it is noted that there is no section within patient's files specifically for enhanced supervision documentation which would act as a central repository and aid ease of access.

Currently, nursing notes were found to be out of date order and obtaining a sequential 'story' of enhanced supervision documented by all clinical participants was time consuming.

4.5. Infection Prevention and Control

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 Infection Prevention and Control Team has a range of policies and procedures in place to help prevent and control infections at all hospital sites within the Health Board, and these are underpinned by well-established infection prevention and control processes and practices which are detailed in the National Infection Prevention and Control Manual (NIPCM). The Infection Prevention Control Group (IPCG), a sub-group of the Quality, Safety and Experience Committee (QSE), monitors performance against the relevant Healthcare Standards.

However some of the current IP & C policies and procedures were un-available to staff on the Infection Prevention and Control intranet pages, or were out of date, and there was no link to some key IP & C documentation such as the NIPCM. The Terms of Reference for the IPCG was also out of date, and the membership list was in need of review.

Our audit also identified a number of other areas where improvements could be made. These include ensuring more regular update reports from the IP & C Senior Nurse and the minutes of the IPCG are submitted to the QS & E Committee and more IP & C audits are undertaken. In addition, IP & C team representation at Clinical Board QS & E meetings could be improved, and the completion of Root Cause Analysis could be improved with greater medical engagement.

4.6. Management of Health Board Policies

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

Overall, the UHB has controls in place to manage the risks identified in the audit scope, however the controls are not being consistently applied and operationally there are weaknesses.

The key issue identified relates to the significant number of out of date policies currently recorded on the register.

A number of additional issues were also identified including; non-compliances to the commitments set out in UHB 001, lack of register completeness and poor record keeping of communication for consultation and notifying staff of new, amended and exiting policies.

4.7. Pre-Employment Checks (Draft)

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

Overall, the controls in place to manage the risks associated with the systems and processes tested within the review are of a reasonable standard. However, we have identified a number of weaknesses in the areas reviewed.

We identified a number of issues concerning the Health Board and NWSSP's procedural guidance and process flow charts. Testing of pre-employment checks found some overall non-compliance with the six NHS Standards. We

identified some weaknesses in communication between the Health Board and NWSSP concerning internal appointments.

The testing undertaken identified that pre-employment checks for both internal and external candidates are not always completed within the target timescales. It is however noted that the reasons for the delays generally relate to external issues that are outside the control of both NWSSP Recruitment and the Health Board.

One high priority issue was identified in this review concerning pre-employment checks undertaken for bank staff.

4.8. Strategic Planning / IMTP (Draft)

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 current review has identified that there are generally good processes and controls in place for managing the risks associated with the development, evaluation approval and implementation of business cases.

There is a Health Board Business Case flow chart in place, however this needs to be updated to reflect the current practices of the system.

There was evidence that Clinical Boards and key staff responsible for the preparation of the business cases were being adequately supported by the corporate planning team.

The two sampled business cases had relevant backing and supporting documentation which explained the basis and need to fund the project. Although the selected copy of the business case documents were either not signed or only partly signed by key staff, they were found to be comprehensive having relevant fields to ease review and enable the Business Case Approval Group (BCAG) to reach an appropriate decision.

Adequate processes are in place for monitoring the on-going delivery of the developments and service changes that have been approved and funded through the business case process.

CARDIFF AND VALE UHB INTERNAL AUDIT ASSIGNMENT STATUS SCHEDULE

Planned output.	No	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	05	Governance	Q1	Final – Issued September 19	Substantial	Sept
Specialist CB – Rosterpro	34	COO	Q1	Final – Issued August 19	Reasonable	Sept
Legislative / Regulatory Compliance Follow-up	06	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	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	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
Rookwood Relocation Capital Project	**SSU**	**Planning**	**Q4**	**Final – Issued May 20**	**Reasonable**	**May**
Surgery CB – Enhanced Monitoring of Ward Patients	**31**	**COO**	**Q2**	**Final – Issued May 20**	**Reasonable**	**May**
UHW Neonatal Development Project	**SSU**	**Planning**	**Q4**	**Final – Issued May 20**	**Substantial**	**May**
Service Improvement Programme Team	**42**	**Planning**	**Q3**	**Final – Issued May 20**	**Substantial**	**May**
Infection Prevention and Control	**21**	**Nursing**	**Q2**	**Final – Issued May 20**	**Reasonable**	**May**
Management of Health Board Policies	**04**	**Governance**	**Q4**	**Final – Issued May 20**	**Reasonable**	**May**

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Pre-Employment Checks	**40**	**Workforce**	**Q4**	**Draft – Issued March 20**	**Reasonable**	**May**
Strategic Planning / IMTP	**08**	**Planning**	**Q3**	**Draft – Issued April 20**	**Reasonable**	**May**
Reviews 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		
Reviews deferred / removed from plan						
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	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	Removed from plan - ICO carrying out GDPR audit during Feb which will cover all actions from our audit. Agreed by March AC		
Cyber Security Follow-up	47	Transformation, Improvement & Informatics	Q3	Removed from plan - ICO carrying out Cyber audit during Feb which will cover all actions from our audit. Agreed 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**					**Removed / Deferred / Incomplete Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**	
Corporate Governance, Risk and Regulatory Compliance	6					● Legislative Comp Follow-up ● Risk Management ● Management of HB Policies	● Standards of Behaviour Follow-up ● Claims	● H&CS
Financial Governance and Management	5					● Private & Overseas Patients ● Charitable Funds	● Budgetary Control ● Core Financials	● Management of LTAs
Clinical Governance, Quality and Safety	5					● DoLS ● Safeguarding Adults & Children ● Infection Prevention & Control	● Annual Quality Statement	● Integrated Health Pathways
Strategic Planning, Performance Management and Reporting	7					● PCIC CB – Adult CHC Follow-up ● C&W CB – Child CHC Follow-up ● Brexit Planning ● *Strat Plan / IMTP (Draft)*		● Engagement Around Service Planning ● Strategic Performance Reporting ● Data Quality Performance Reporting
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

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**						**Removed / Deferred / Incomplete Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**		
Operational Service and Functional Management	10					● MH CB – Sickness Management Follow-up ● Specialist CB - Rosterpro ● PCIC CB – Business Continuity ● Surgery CB – Medical Staff Governance Follow-up ● C&W CB – Consultant Leave ● Surgery CB – Enhanced Monitoring	● 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)*			
Capital and Estates Management	10		● Kier Construction Compliance with the Fair Payment Charter			● Sustainability Reporting ● Maelfa Wellbeing Hub ● Control of Contractors ● Rookwood Relocation	● Carbon Reduction Commitment ● Service Improvement Team ● Neonatal & Obstetrics Project		● Commercial Outlets ● Facilities / Estates Service Board Governance

INTERNAL AUDIT REPORT RESPONSE TIMES								
Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G	
Annual Quality Statement	Substantial	Final	21/05/19	12/06/19	22/05/19	22/05/19	G	
MH CB – Sickness Man Follow-up	Reasonable	Final	25/06/19	16/07/19	18/07/19	22/07/19	A	
Sustainability Reporting	Reasonable	Final	12/07/19	02/08/19	05/08/19	16/08/19	A	
Carbon Reduction Commitment	Substantial	Final	24/07/19	12/08/19	07/08/19	16/08/19	G	
Standards of Behaviour Follow-up	Substantial	Final	03/09/19	24/09/19	03/09/19	05/09/19	G	
Specialist CB Rosterpro	Reasonable	Final	15/08/19	06/09/19	04/09/19	12/09/19	G	
Legislative / Regulatory Compliance Follow-up	Reasonable	Final	20/09/19	11/10/19	23/09/19	23/09/19	G	
Charitable Funds	Reasonable	Final	30/09/19	22/10/19	17/10/19	17/10/19	G	
Private & Overseas Patients	Reasonable	Final	24/09/19	16/10/19	14/10/19	21/10/19	G	
Maelfa: Wellbeing Hub	Reasonable	Final	03/10/19	25/10/19	21/10/19	22/10/19	G	
Surgery CB – Medical Staff Governance Follow-up	Reasonable	Final	01/10/19	23/10/19	22/10/19	31/10/19	G	
MH CB – Third Sector Contracts	Reasonable	Final	02/10/19	24/10/19	22/10/19	31/10/19	G	
Kier Construction Compliance with the Fair Payment Charter	n/a	Final	15/11/19	15/11/19	15/11/19	15/11/19	G	
PCIC CB – Business Continuity	Reasonable	Final	31/10/19	22/11/19	20/11/19	21/11/19	G	
Deprivation of Liberties Safeguards (DoLS)	Reasonable	Final	04/10/19	28/10/19	21/11/19	21/11/19	R	
PCIC CB – CHC Adult Follow-up	Reasonable	Final	20/11/19	12/12/19	21/11/19	21/11/19	G	
C&W CB – CHC Child Follow-up	Reasonable	Final	21/11/19	13/12/19	22/11/19	25/11/19	G	
Claims Reimbursement	Reasonable	Final	22/11/19	14/12/19	24/11/19	25/11/19	G	
Consultants Job Planning Follow-up	Limited	Final	17/12/19	10/01/20	02/01/20	07/01/20	G	
Freedom of Information Reviews	Reasonable	Final	20/12/19	16/01/20	23/01/20	24/01/20	R	

INTERNAL AUDIT REPORT RESPONSE TIMES								
Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G	
Tentacle IT System	Limited	Final	04/10/19	25/10/19	16/01/20	17/01/20	R	
Use of Digital Technology	n/a	Final	19/12/19	17/01/20	17/02/20	18/02/20	R	
Budgetary Control	Substantial	Final	12/02/20	05/03/20	13/02/20	17/02/20	G	
Safeguarding Adults & Children	Reasonable	Final	02/12/19	23/12/19	06/02/20	18/02/20	R	
C&W CB – Consultant Leave	Reasonable	Final	03/01/20	24/01/20	21/02/20	21/02/20	G	
Medical Staff Study Leave	Reasonable	Final	09/01/20	30/01/20	21/02/20	21/02/20	R	
Brexit Planning	Reasonable	Final	14/02/20	09/03/30	21/02/20	24/02/20	G	
Control of Contractors	Reasonable	Draft	06/02/20	28/02/20	20/02/20	24/02/20	G	
Risk Management	Reasonable	Final	05/03/20	27/03/20	27/03/20	30/03/20	G	
CD&T CB – Laboratory Turnaround Times (TAT)	Substantial	Final	23/03/20	16/04/20	29/03/20	30/03/20	G	
UHB Core Financial Systems	Substantial	Final	05/03/20	27/03/20	31/03/20	31/03/20	A	
Rookwood Relocation Capital Project	Reasonable	Final	23/03/20	16/04/20	15/05/20	18/05/20	R	
Surgery CB – Enhanced Monitoring of Ward Patients	Reasonable	Final	02/04/20	27/04/20	18/05/20	18/05/20	R	
UHW Neonatal Development Project	Substantial	Final	09/04/20	05/05/20	15/05/20	18/05/20	R	
Service Improvement Programme Team	Substantial	Final	28/04/20	20/05/20	19/05/20	19/05/20	G	
Infection Prevention and Control	Reasonable	Final	31/01/20	24/01/20	19/05/20	19/05/20	R	
Management of Health Board Policies	Reasonable	Draft	15/05/20	08/05/20	21/05/20	21/05/20	G	
Pre-Employment Checks	Reasonable	Draft	19/03/20	14/04/20				
Strategic Planning / IMTP	Reasonable	Draft	09/04/20	05/05/20				

AUDIT & ASSURANCE KEY PERFORMANCE INDICATORS						
Indicator Reported to NWSSP Audit Committee	**Status**	**Actual**	**Target**	**Red**	**Amber**	**Green**
Operational Audit Plan agreed for 2019/20	**G**	April 2019	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2019/20	**G**	100% 39 from 39	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	**G**	92% 36 from 39	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	**A**	65% 24 from 37	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	**G**	100% 37 from 37	80%	v>20%	10%<v< 20%	v<10%

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Report Title:	Report of the Losses and Special Payments Panel								
Meeting:	Audit and Assurance Committe						**Meeting Date:**	28th May 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**X**	**For Information**	
Lead Executive:	Executive Director of Finance								
Report Author (Title):	Head of Financial Accounting and Services								

Background and current situation:

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

The work of the panel supports the UHB's sustainability and ensures that we make the best use of the resources that we have.

The Losses and Special Payments Panel last met on 13th May 2020 to consider the 6 month period October 1st 2019 to March 31st 2020. This report informs the Audit and Assurance Committee of the items considered at this meeting and the recommendations made for formal Audit and Assurance Committee approval. The minutes of the last meeting of the Losses and Special Payments Panel are attached as Appendix 1. These minutes give more detail about the issues discussed at the meeting, including those items that have been recommended to the Audit Committee for approval.

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

These losses and special payments need to be considered and approved by the Audit and Assurance Committee so that they can be included with the UHB accounts for 2019/20.

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

The following losses have been identified for write off:

- Clinical Negligence claims of £19.626m and Personal Injury claims of £0.272m for the period 1st October 2019 to 31st March 2020;
- Bad Debt write offs of £128,492 for the period 1st October 2019 to 31st March 2020;
- Ex Gratia & Fruitless Payments of £354,630 for the period 1st October 2019 to 31st March 2020;

- Small Claims Losses of £15,878 for the period 1st October 2019 to 31st March 2020;
- Employment Tribunals settled of £15,000 for the period 1st October 2019 and 31st March 2020;
- Security thefts of £3,500 for the period 1st April 2019 and 31st March 2020;
- Stock Write offs of £258,794 for the period 1st April 2019 and 31st March 2020.

Recommendation:

The Audit and Assurance Committee is asked to:

- **APPROVE** the write offs outlined in the Assessment Section of this report.

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

MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS PANEL HELD ON 13th MAY 2020

PRESENT: Mr C Lewis – Deputy Director of Finance (Chair)
Mr A Crook – Head of Workforce Governance
Mrs H Lawrence – Head of Financial Accounting & Services
Mr S Monk – Losses & Taxation Accountant
Mrs S Wicks – Claims Manager
Mr A Williams – Head of Financial Services

APOLOGIES: Mr R Cockayne – Security Manager
Mr C Greenstock – Counter Fraud Manager

1. Minutes of Last Meeting

The minutes of the last meeting were reviewed for accuracy and the group endorsed the minutes as an accurate record. There were no matters arising which were not covered elsewhere on the agenda.

2. Clinical Negligence and Personal Injury Losses

Mr Monk presented the financial report on Clinical Negligence and Personal Injury Income & Expenditure (I&E) losses for the twelve month period ending 31st March 2020 and the finalised claims for write off for the period 1st October 2019 to 31st March 2020.

The I&E effect for the period was described as shown below: For comparison, the figures for the same period in 2018/2019 were also shown.

SUMMARY OF LOSSES

	2019/2020 £'000	2018/2019 £'000
Clinical Negligence	31,433	22,700
Personal Injury	2,202	359
Total Loss	33,635	23,059
Less WRP Receipts Due	-31,499	21,456
Total Net Cost to the UHB	2,136	1,603

With respect to Clinical Negligence claims, Mr Monk advised that the gross I&E charge for all recorded claims was £31.433m. This was an increase of £10.576m on the previous year. This movement was largely as a result of some large cases which had previously been assessed as having a possible or remote chance of success being reassessed as certain or probable by Legal & Risk Services.
The number of new cases was higher than the previous financial year, 79 of these new cases are deemed to be possible and therefore the defence fee element of the quantum of the claim is provided for. Mr Monk advised that it should be noted that this higher number of possible claims could potentially see a higher number of cases that turn to certain in the next and future financial years.

The impact of all recorded Personal Injury claims had been a gross I&E charge of £2.202m. This was £1.843m higher than in 2018/19 primarily due to one high value Health & Safety incident where C&V are vicariously liable.

Recommendation

The Panel recommended that the Audit and Assurance Committee note that following expected reimbursement from the WRP, the net expenditure incurred by the UHB on these Clinical Negligence and Personal Injury claims was £2.136m for the period 1st April 2019 to 31st March 2020.

Finalised Clinical Negligence (including Redress) Claims

During the six month period ending 31st March 2020, there were 54 claims (where liability had been conceded and settlements paid) which had concluded at a total settlement cost of £19.616m (which are treated as a loss). The UHB also incurred £0.477m in legal fees re these cases and was successful in recovering £19.221m from the Welsh Risk Pool for these claims, resulting in a net cost to the UHB of £0.872m.

Finalised Personal Injury Claims

During the six month ending 31st March 2020, 27 claims where liability had been conceded and settlements paid have concluded at a total settlement cost of £0.272m (which are treated as a loss). The UHB had also incurred £0.056m in defence fees and was successful in recovering £0.064m from the WRP for these claims, resulting in a net cost to the UHB of £0.264m.

Mr Monk reminded the group that expenditure on defence fees on Clinical Negligence and Personal Injury cases was not treated as a loss and also that it should be remembered that the loss is accrued over the lifetime of a claim which can span many years.

The cases finalised for the first 6 months of the financial year were approved by the Audit and Assurance Committee at the December meeting.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 54 Clinical Negligence claims totalling £19.626m and 27 Personal Injury claims totalling £0.272m for the period 1st October 2019 to 31st March 2020.

3. Debt Write Offs

Mr Williams presented a report on proposed invoice write-offs for the period 1st October 2019 to 31st March2020.

These were as follows:

Category of Debt	Value	Number
Dental	94	5
Medical Records	70	4
Payroll	19,698	60
Accommodation	1,222	1
O/Seas Patients	76,349	19
Private Patients	15,272	19
Misc	15,787	72
Total	**128,492**	**180**

The total value of write-offs actioned for the reporting period had been £128,492. (The Audit and Assurance Committee had approved the write off of 38 bad debts totalling £5,424 for the period 1st April 2019 to 30th September 2019 at the December meeting giving a total of 218 bad debt write offs totalling £133,916 for the year 2019/2020)

Mr Williams stated that the invoice for accommodation charges was referred to CCI Credit Management but they were unable to collect

Included in the Miscellaneous category are 3 invoices over £1k:-

One invoice for £1,080 re medical genetics tests carried out had been referred to CCI but they were unable to collect.

Two invoices in relation to Grant Agreements, one for £8,640 dated March 2017 to MacMillan Cancer, the request to write off came from the SDA. The other invoice was for £1,553

Of the overpayment of salary invoices submitted for write off 3 invoices are for between £1k-£2k and one invoice for £2.7k. All overpayment of salary invoices that relate to ex-employees are referred to CCI.

Private Patient invoices have been referred to CCI where appropriate and the write offs have been authorised by the Private & Overseas Patient Manager. Included in the total for Private Patients are 3 invoices each with a value of over £2.5k – one for £2.7k, one for £3.2k and a further invoice for £7.7k.

All of the Overseas Patient invoices have been referred to CCI. Included in the Overseas Patient category are 2 invoices where the patient is deceased, one for £37.3k and the other for £3.8k. Of the remaining invoices there is one for £7.8k and one for £6.7k, both of these were referred to CCI. The remaining invoices are between £1.2k and £3.5k. All requests for write off have been authorised by the Private & Overseas Patient Manager.

Mr Williams presented a table to give a comparison to amounts written off in previous years.

	2015/16		2016/17		2017/18		2018/19		2019/20	
	Value	No	Value	No	Value	No	Value	No	Value	No
Accommodation	8	1	1,049	8	0	0	2,668	6	1,222	1
Dental	130	10	81	6	203	15	401	16	164	10
Medical Records	360	22	650	35	1,070	47	672	42	70	4
Payroll	2,004	7	20,025	53	12,639	26	11,262	31	21,733	67
Private Patients	4,578	32	24,325	28	23,764	63	2,887	27	16,048	27
O/Seas Patients	53,011	48	16,475	10	58,632	40	74,450	26	76,415	19
IVF Wales	0	0	31,026	24	0	0	0	0	0	0
Misc	17,787	50	78,685	61	35,847	54	48,194	524	19,487	89
	77,877	**170**	**172,315**	**225**	**132,155**	**245**	**140,534**	**672**	**133,916**	**218**

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 180 bad debts totalling £128,492 for the period 1st October 2019 to 31st March 2020.

4. Permanent Injury Losses

Mr Monk presented a report on permanent injury costs for the period 1st October 2019 to 31st March 2020. He explained that permanent injury allowances were approved by the NHS Pensions Agency and the long term costs were picked up by the UHB. The costs must be treated as losses and should be noted by the Panel. The UHB made payments on a quarterly basis to the Pensions Agency based on bills received from them.

There are a total of 26 cases which during the period have had an Income and Expenditure (I&E) impact of £333k. Mr Monk stated that this charge was primarily due to a change in the discount rate prescribed by HM Treasury from 0.29% to minus -0.5%. There were payments made of £114k in respect of these cases over the reporting period.

Recommendation

The panel recommended that the Audit and Assurance Committee note the Income and Expenditure impact of £333k for the period 1st October 2019 to 31st March 2020. As no cases finalised during the period there are no cases for write off.

5. Ex Gratia and Other Losses

Mr Monk presented a report on the ex-gratia losses for the period 1st October 2019 to 31st March 2020. Mr Monk stated that 13 payments totalling £354,630 had been made during the period.

6 of these payments were as a result of complaints made against the UHB where, following investigations, the Public Services Ombudsman for Wales (PSOW) made recommendation to the UHB to compensate the claimants.
There was 1 instance of a counterfeit bank note passed through a till at the UHB.
There were 2 payments in respect of charges due to late payment of the UHB's pension contributions.
There was 1 Claimant costs payment awarded by the Court against the UHB in respect of a Continuing Healthcare case.
There were 2 HMRC charges, one in respect of tax due in respect of a former employee and the other in respect of a VAT assessment on various income streams of the UHB where no VAT had been charged. It was noted that the UHB had a provision in place in respect of this assessment. Mr Monk stated that processes had been developed and implemented to ensure that invoices in the various income streams were raised with the appropriate VAT

treatment. Mr Monk also stated these payments are made under Legal Obligation to HMRC and in such cases the UHB has full delegated authority. Additionally and finally there was a HMRC interest charge on the VAT Income assessment.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 13 ex-gratia payments totalling £354,630 for the period 1st October 2019 to 31st March 2020.

6. Small Claims Losses

Mr Monk presented a report on the small claims made during the period 1st October 2019 to 31st March 2020. During the period 34 claims had been settled at a total cost of £15,878. Mr Monk stated that the corresponding figure for the same period in 2018/2019 was £9,198.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 34 small claims totalling £15,878 for the period 1st October 2019 to 31st March 2020.

7. Employment Tribunal Costs

Mr Crook presented a report outlining the claims and costs for the period 1st October 2019 to 31st March 2020. Mr Crook stated that during the period, Cardiff and Vale University Health Board had been involved with 12 Employment Tribunal claims. 7 of these cases were still live as of 31st March 2020. 2 cases had been won, 2 cases had been withdrawn and 1 had settled at a cost of £15,000.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 1 Employment Tribunal case of £15,000 for the period 1st October 2019 to 31st March 2020.

8. Voluntary Early Release Payments

Mr Crook stated that there were no VERS payments made during the period 1st October 2019 to 31st March 2020.

9. Security Losses

Mr Cockayne was not able to attend the meeting but had presented Mr Monk with a report for the year 2019/2020. Mr Monk stated that there had been one security loss reported to the security department. The incident was the theft of medical gas cylinders from the UHW main cylinder store. The value of the cylinders was assessed to be £3,500. Improvement works had subsequently been carried out in order to enhance the security of the storage facility.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 1 security theft of £3,500 for the period 1st April 2019 to 31st March 2020.

10. Stock Write Offs

Mr Monk presented a report on stock identified for write off during the year 2019/2020. A stock take is carried out across all stock control areas at year end. During the period obsolete stock totalling £241,166 and lost or damaged stock totalling £17,628 had been identified giving a total of 10 stock write offs of £258,794 for the year. Mr Monk stated that the corresponding figure for 2018/2019 was £442,289.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the 10 stock write offs totalling £258,794 for the period 1st April 2019 to 31st March 2020.

11. Counter Fraud

Mr Greenstock was unable to attend the meeting but had presented Mr Lewis with a report for the year 2019/2020. Mr Lewis stated that there were 3 ongoing cases under investigation with a potential loss of £52,000. There had been no cases during the period 1st April 2019 to 31st March 2020 that had resulted in a loss.

12. Any Other Business

The next meeting of the panel would be in November 2020.

University Hospital of Wales Neonatal Development

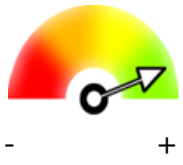
Final Internal Audit Report 2019/20

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Substantial Assurance

Previous assurance Reasonable

CONTENTS

Review reference:	SSU_CVU_1920_01
Report status:	Final Report
Fieldwork commencement:	8 January 2020
Fieldwork completion:	27 March 2020
Draft Report issued:	9 April 2020
Management response received:	15 May 2020
Final report issued:	18 May 2020
Auditor:	NWSSP: Audit & Assurance - Specialist Services Unit
Executive sign off:	Abigail Harris, Executive Director of Planning
Distribution:	Geoff Walsh, Director of Capital, Estates and Facilities Jeremy Holifield, Head of Capital Planning
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 Chartered Institute of Internal Auditors.

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

Please note:

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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 & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

BJC 1 was developed identifying the need to refurbish the HDU and SCBU as part of the wider refurbishment and reconfiguration of the Neonatal and Obstetric services at the University of Wales Hospital (UHW).

BJC 1 was approved in November 2015, with associated funding of £7.472m and handed over in April 2017.

An audit was undertaken in July 2016 on this element that provided '*reasonable*' assurance.

A further BJC 2 was produced for the remaining phases of the programme (e.g. ICU, support accommodation, clinical support, office accommodation). Welsh Government approval was received in November 2016.

In February 2017, further approval was received for the addition of a replacement MRI; accordingly, the total approval for BJC 2 was increased to £37.092m.

An audit review was completed on this element in March 2018 that also provided '*reasonable*' assurance.

All aspects of BJC 2 were concluded in October 2019. Accordingly, this is a post completion review audit.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the University Health Board ('the UHB') for the management of the UHW Neonatal development, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

Accordingly, the focus of the audit was directed to the following areas:

- **Previously agreed management action –** a review of the status of the remaining previously agreed management action.
- **Approvals –** assurance that appropriate approvals have been obtained and the project(s) progressed within those approvals.
- **Monitoring –** assessment of the adequacy of systems to capture build delivery performance information (e.g. Key Performance Indicators); and assessment of the accuracy of time and cost reporting (including variations and their impact on the final account).
- **Valuation / Final Account –** assurance that adequate processes and procedures were in place to allow the progressive build-up of the final account e.g. change management, contingency management, pain/gain calculation etc.

- **Project delivery (PPE / Benefits Realisation)** – assessment as to whether there were any relevant issues that limited the successful delivery of the project and that lessons learnt have been captured to inform future developments.
- Identification of **any other issues** material to the successful achievement of the project's objectives.

3. Associated Risks

The potential risks considered at this audit included:

- Poorly defined and measured objectives;
- Failure to deliver appropriate quality of output within scheme time and cost targets; and
- Poor project control.

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 following positive aspects were noted at the project:

- Appropriate business case and funding approvals were in place;
- The project was delivered within project budget generating gain share for the UHB and Supply Chain Partner;
- Robust cost control and monitoring systems were in place;
- A full post project evaluation is planned to be undertaken [albeit timing not confirmed]; and
- A benefits realisation exercise was undertaken by service-users.

Certain enhancements, noting that they will be applicable for future projects, have been recommended in respect of:

- Performance management submissions to be completed as per Framework guidance; and
- Assurances from the Cost Adviser regarding routine review of source documentation to confirm calculations attributed to projects.

Noting the positive delivery arrangements at the highly complex project, the effectiveness of the system of internal control in place to manage the risks associated with the delivery of the individual phases of the Neonatal Development has been assessed as providing **Substantial Assurance** subject to the completion of the benefits realisation/PPE as scheduled.

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 management attention in control design or compliance with **low impact on residual risk** exposure.

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 following table:

Assurance Summary					
1	Previously agreed management action				✓
2	Approvals				✓
3	Monitoring			✓	
4	Valuation / Final Account			✓	
5	Project Delivery			✓	

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

Design of Systems/Controls

The findings from the review highlighted **no** issues that were classified as a weakness in the system control/design for managing the requirements of the UHW Neonatal development

Operation of System/Controls

The findings from the review highlighted **two** issues that was classified as weaknesses in the operation of the designed system/control for managing the requirements of the UHW Neonatal development.

6. Summary of Audit Findings

Previously Agreed Management Action

We sought assurance that previously agreed management actions had been implemented.

The status of these actions arising from the previous review (reported April 2018) was as follows:

Closed	Outstanding	Superseded	Total
7	-	-	**7**

The detail in support of the above summary is included in **Appendix B.**

Accordingly, **substantial assurance** has been determined in respect of the action taken to address previously agreed audit recommendations.

Approvals

We sought assurance that appropriate approvals had been obtained and the project progressed within those approvals.

As previously reported, appropriate approvals were sought by the UHB for BJC1 (£7.472m) and BJC2 (£37.092m). No further approvals were sought.

Works were completed three weeks after the original contract completion date (with practical completion achieved on 4 October 2019). However, this delay had no financial impact on the project.

The project was delivered within the overall funding envelope. Within this, an underspend of circa £2m was achieved generating a total gain share for the UHB, relating to all of the phases, of £1.8m.

Accordingly, **substantial assurance** has been determined for this area.

Monitoring

We sought assurance that adequate systems were in place to capture build delivery performance information. Further, we sought assurance that appropriate arrangements were in place to assess accuracy of time and cost reporting (including variations and their impact on the final account)

Robust progress and cost reports were prepared by the external advisers on a monthly basis, with internal progress reported through Highlight Reports which were presented on a monthly basis to the Capital Management Group.

The project was delivered under the NHS: Building for Wales Framework (Designed for Life: 2). Guidance for performance measurement / key performance indicators (KPIs) was provided to the UHB by NWSSP: Specialist Estates Services (SES). The KPI system was designed to measure critical aspects of Employer, Framework and Project performance. Returns to NWSSP: SES were expected twice a year for live projects.

For the period 1 April 2019 to the date of this review, two returns should have been submitted to NWSSP: SES. However, it was noted that the UHB had failed to submit its return for April 2019 **(recommendation 1).**

Noting that the associated risk has now passed and a subsequent KPI return was made, **reasonable assurance** has been determined.

Valuation / Final Account

We sought assurance that adequate processes and procedures were in place to allow the progressive build-up of the final account e.g. change management, contingency management and pain/gain calculation.

The final accounts[1] for each phase related to this project were as follows:

- Phase 1A & 1B- £5,220,600 *
- Phase 3 - £783,533
- Phase 2A - £1,868,249
- Phase 2B and MRI - £12,017,631 *
- Obs 1 – £3,990,693 *
- Obs 2 - £3,286,049

*The audit focused on these highlighted phases of the project; the total of which constitutes circa 51% of the total project budget.

The final account and supporting documentation was reviewed for the sampled phases of the project, and found to be appropriately substantiated.

[1] The final account figures quoted above have been extracted from the calculations used to determine the gain share.

However, some discrepancies were noted in the staff and labour figures when reviewed against the timesheets provided by the Supply Chain Partner to the values used in the calculations by the Cost Adviser **(recommendation 2)**.

Refer to **Appendix C** for details of the final account testing.

Compensation events reviewed had been progressed in accordance with the formal contractual arrangements and defined delegated limits.

As referenced in the 'Approvals' section of this report, the project generated a total gain share for the UHB, relating to all of the phases, of £1.8m. The calculations attributed to this figure were reviewed with no issues noted.

Recognising the discrepancies in staff and labour calculations, **reasonable assurance** has been determined in respect of the final account.

Project Delivery (PPE / Benefits Realisation

We sought to determine whether there were any relevant issues that limited the successful delivery of the project and that lessons learnt had been captured to inform future developments.

A comprehensive post project evaluation (PPE) procedure was documented at the business case (section 7.6.4). At the date of the review, a PPE exercise had yet to be undertaken. Management advised that a timeframe for completion had yet to be determined but noted that it was likely to be towards the end of the defects period for the final phase of the project i.e. October 2020.

Also documented at the business case was a Benefits Realisation Register that outlined the strategic benefits of the development. A high-level benefits realisation exercise had been undertaken by members of the clinical staff.

Through discussion, we were advised that the improved infrastructure ensured that the Neonatal unit meets regulations; with particular qualitative improvements noted in the additional facilities for families. The next stage, in order to operate at full capacity, will require additional investment in staffing levels. Regular monitoring and reporting mechanisms were also evidenced from a service-user perspective.

Acknowledging that a full post project evaluation is scheduled [albeit timing not confirmed] and the benefits realisation exercise undertaken by service-users, **reasonable assurance** has been determined at this stage.

7. Summary of Recommendations

The audit findings, recommendations are detailed in **Appendix A** together with the management action plan and indicative implementation timetable, recognising that the majority of UHB staff will be fully focused on responding to COVID-19 and this will dominate the agenda for the foreseeable future.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Current year recommendations	-	-	2	**2**

Finding: Project Performance Measurement	Risk
The project was delivered under the NHS: Building for Wales Framework (Designed for Life: 2). Guidance for performance measurement / key performance indicators (KPIs) was provided to the UHB by NWSSP: Specialist Estates Services (SES). The KPI system was designed to measure critical aspects of Employer, Framework and Project performance. Returns to NWSSP:SES were expected twice a year for live projects from the following parties: • Cost adviser • Project Manager; • Supply Chain Partner; and • UHB For the period 1 April 2019 to the date of this review, two returns should have been submitted to NWSSP: SES for each of the above. However, it was noted that the UHB had failed to submit its return for April 2019.	Lack of regular monitoring ensuring stakeholders are meeting performance targets
Recommendation 1	**Priority level**
The UHB should ensure KPI / performance management submissions are completed as per Framework guidance **(O)**.	**Low**

Management Response	Responsible Officer/ Deadline
Agreed. Management will ensure that the Project Manager provides reminders to the key officers at the UHB facilitate submission of the KPIs as per the Framework guidance.	Director of Capital, Estates & Facilities At future projects

Finding: Staff / Labour Calculations	Risk
A review of the staff costs and labour costs attributed to the final account to source documentation i.e. timesheets was undertaken to confirm they had been applied as incurred. Refer to **Appendix C** for details of the final account testing undertaken. Across the three phases of the project reviewed, ten members of staff were reviewed. The timesheets for the sample were requested from the Cost Adviser. However, it was noted that this source documentation had not been retained at the date of final account; and a further request was made of the Supply Chain Partner to provide the data. The hours recorded for each member of staff were reviewed against the valuation spreadsheet used in the final account calculations by the Cost Adviser: • The calculations were based on the number of weeks rather than total of hours as per the timesheets; • Calculations assume weeks worked are based on a 42.5 hour week • Applying this assumption, the hours as per the timesheets indicate that more weeks have been worked that those included within the calculation.	Time attributed to the project is not adequately controlled.

The variance in calculation noted for the sampled staff members was £16,369 which is 4% of the total staff / labour costs reviewed. However, the final account had been calculated on the lower figure in all instances. Whist recognising this, it is not clear that the Cost Adviser has routinely been scrutinising the timesheet information.	
Recommendation 2	**Priority level**
Assurances should be provided by the Cost Adviser that source documentation is reviewed routinely, not limited to final account, in confirming calculations of staff / labour costs attributed to the project **(O)**.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. Management will write to the Cost Advisers setting out the requirements to provide assurances that source documentation has been appropriately reviewed prior to the sign off of the monthly certificates.	Director of Capital, Estates & Facilities At future projects

Prior ref	Recommendation	Action / Status	Updated responsibility and timescale	Current year priority rating
High				
1 (17/18)	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.	**Closed**. The Early Warning Notice tracker maintained for the project provided assurances of the MRI design freeze.	N/A	N/A
3 (17/18)	(i) An agreed timetable should be developed for design completion and validation of cost estimates. Any subsequent issues arising from the same will be formally reported to the Project Board. (ii) At future projects, increased focus should be given to obtaining a definitive statement of affordability at any early stage of the planning process. This should involve the identification and assessment of the expected risk profile and completion and sign off of the design.	**Closed** (i) Management advised that both the master programme schedule and change tracker were used to outline any impact. (ii) This recommendation was raised due to the phased nature of the Neonatal/MRI project and re-assessing the overall affordability prior to the commencement of the next phase. The affordability concept is governed by award of funding from Welsh Government; therefore can't be determined until	N/A	N/A

	(iii) Design changes should be minimised in order to ensure that costs can be effectively managed. User requests for additional changes, made after details have been issued to the market, and that do not fall within the agreed scope, should be discouraged.	the UHB has been given the 'green light' from Welsh Government. (iii) Refer to **Ref 1** above.		
Medium				
2 (17/18)	The value of identified risk will be included within the assessment of affordability.	**Closed** Review of the report presented to the Capital Management Group in December 2018 confirmed inclusion of a statement detailing the impact should all risks recognised on the project risk registers were to be realised.	N/A	N/A
4 (17/18)	A formal evaluation of the adequacy of the ground investigation reports will be undertaken and any recourse against advisers determined.	**Closed** Ground investigation and air monitoring reports were received by the UHB in 2017.	N/A	N/A
5 (17/18)	Risk mitigation plans will continue to be actively managed by the UHB, contractor and design team, so as to avoid unnecessary additional cost and/or delays to the project.	**Closed** Risk registers were a standing agenda item for the monthly progress meetings held; and updated accordingly for movements / changes noted.	N/A	N/A

6 (15/16)	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 Capital Projects Manual pro-forma, Single Tender Action Request form should be brought into line with the requirements of the Scheme of Delegation. Approval signatures for all Single Tender Actions should be obtained in accordance with the requirements of SFIs.	**Closed** A sample of three single tender actions was reviewed. All demonstrated compliance with the Standing Financial Instructions and the UHB Scheme of Delegation.	N/A	N/A
Low				
3 (15/16)	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.	**Closed** Whilst the completion of a certificate is acknowledged as best practice amongst other Health Boards, the UHB's Capital Manual states the role of Project Director is assigned to the Director of Capital, Estates & Facilities for all major capital schemes. Review of WG Dashboard Reports confirms this; therefore the current arrangements are deemed to be an acceptable mitigating control.	N/A	N/A

Phase	% of expenditure of final account	Value tested	% of final account	Comments
Phase 1a/1b				
Subcontractors	77%	£3,205,649	83%	Reconciled to final approved valuations.
Staff	12%	£104,515	18%	Timesheets obtained from the SCP. Time recorded could not be reconciled to the calculation that has been used in the final account. For the three staff members reviewed, the number of weeks used was less than the number as per the timesheet [£6,429].
Labour	4%	£53,660	30%	Timesheets obtained from the SCP. Time recorded could not be reconciled to the calculation that has been used in the final account. For the two staff members reviewed, the number of weeks used was less than the number as per the timesheet [£3,944].
Plant & Materials	5%	£52,420	22%	Reconciled to expenditure report.
Obs 1				
Subcontractors	76%	£1,834,694	62%	Reconciled to final approved valuations.
Staff	13%	£41,278	8%	Timesheets obtained from the SCP. Time recorded could not be reconciled to the calculation that has been used in the final account. For the one staff member reviewed, the number of weeks used was less than the number as per the timesheet [£2,752].
Labour	4%	£21,359	13%	Timesheets obtained from the SCP. Time recorded could not be reconciled to the calculation that has been used in the final account. For the one staff member reviewed, the number of weeks used was less than the number as per the timesheet [£251].
Plant & Materials	5%	£175,750	100%	Reconciled to expenditure report.

Phase	% of expenditure of final account	Value tested	% of final account	Comments
Phase 2B / MRI				
Subcontractors	71%	£5,674,964	68%	Reconciled to final approved valuations.
Staff	16%	£225,145	12%	Timesheets obtained from the SCP. Time recorded could not be reconciled to the calculation that has been used in the final account. For the two staff members reviewed, the number of weeks used was less than the number as per the timesheet [£2,479].
Labour	5%	£24,550	4%	Timesheets obtained from the SCP. Time recorded could not be reconciled to the calculation that has been used in the final account. For the one staff member reviewed, the number of weeks used was less than the number as per the timesheet [£514].
Plant & Materials	2%	£244,428	100%	Reconciled to expenditure report.

Audit Assurance Ratings

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

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

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment

Cardiff & Vale University Health Board

Service Improvement Programme Team

Final Internal Audit Report

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	C&V-1920-42
Report status:	Final Internal Audit Report
Fieldwork commencement:	3rd March 2020
Fieldwork completion:	20th April 2020
Draft report issued:	28th April 2020
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Final report issued:	19th May 2020
Auditor/s:	Jayne Gibbon Audit Manager Ian Virgil Head of Internal Audit
Executive sign off:	Bob Chadwick, Executive Director of Finance
Distribution:	Geoff Walsh Director Capital, Estates & Facilities Service Board Lee Wyatt, Head of Estates & Facilities Sarah Maggs, Operational Services Manager John Penrhyn-Jones, Principal Finance 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
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1. Introduction and Background

The review of the Capital, Estates and Facilities 'Service Improvement Programme' Team was completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board.

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

The Service Improvement Programme (SIP) Team was established in 2018 by The Capital, Estates & Facilities (CEF) Service Board. The resources and funding for the Team were provided internally from within the Service Board.

The SIP Team was set up with an aim to investigate, recommend, support and facilitate the implementation of best practice, drive service improvement and together achieve the Service Board's financial challenges.

2. Scope and Objectives

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

The purpose of the review was to provide assurance that the SIP Team is appropriately set up and managed and is enabling the effective delivering of service improvements.

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

- The SIP Team has been appropriately set up with a clear remit and objectives;
- Appropriate on-going operational processes, management and reporting arrangements are in place for the SIP Team; and
- The SIP Team is effectively delivering against its objectives and is adding value to the Service Board by enabling the delivery of service improvements.

3. Associated Risk

- The SIP Team doesn't operate effectively and fails to deliver added value for the Service Board.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Service Improvement Programme Team 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.

The review of the Capital, Estates and Facilities Service Improvement Programme Team found that overall the controls and process in place were of a high standard.

The setting up of the team was outlined in a Project Brief which detailed clearly the remit of the team and its objectives.

The processes in place for recording all ideas and ongoing management of those 'projects' going forward were found to be appropriate.

The conclusion we have reached for the audit is based on only completing work related to two of the three objectives detailed in the Scope and Objectives. We were unable to undertake any fieldwork regarding objective 3 'The SIP team is effectively delivering against its objectives and is adding value to the Service Board by enabling the delivery of service improvements' as in order to determine this we needed to select a sample of ideas proposed and test that objectives have been met. At the time that this information was requested audit were informed that the SIP team had been suspended as a result of the Covid 19 situation and all staff have been drafted into the main CEF team to support the Health Board with COVID 19

issues, so it was unlikely that they would be able to provide the necessary information.

If in the future management determine that they still require assurance around the third objective, then Internal Audit will assess the possibility of re-visiting the SIP team and completing the outstanding testing.

5. Assurance Summary

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

Assurance Summary					
1	The SIP Team has been appropriately set up with a clear remit and objectives				✓
2	Appropriate on-going operational processes, management and reporting arrangements are in place for the SIP Team				✓
3	The SIP Team is effectively delivering against its objectives and is adding value to the Service Board by enabling the delivery of service improvements	n/a	n/a	n/a	n/a

** 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 Service Improvement Programme Team.

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 Service Improvement Programme Team.

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.

Objective 1: The SIP Team has been appropriately set up with a clear remit and objectives.

The following areas of good practice were noted:

- The setting up of the Service Improvement Programme (SIP) Team was supported by a Project Brief that was approved by the Capital, Estates and Facilities Project Board.
- The Project Brief for the Service Improvement Programme Team sets out clearly the objectives, focus areas, and deliverables for the SIP.
- The governance arrangements for the SIP Team within the Capital, Estates and Facilities Service Board are clearly defined and deemed appropriate.

We did not identify any findings in respect of this objective.

Objective 2: Appropriate on-going operational processes, management and reporting arrangements are in place for the SIP team.

The following areas of good practice were noted:

- The SIP Team has a database in place that records details of all ideas that have been proposed by staff.

  Information recorded on the database includes:

  - Idea description;
  - Name of person and suggestion source;
  - Areas/departments idea relates to;
  - SIP Owner; and
  - Operational Lead.
- The SIP team utilises an appropriate scoring matrix that is applied where applicable to all ideas received. The matrix takes into consideration:
  - Implementation costs;
  - Impact of the idea;
  - Service Improvements;
  - Payback period; and

- Saving costs.

- Ideas are not progressed unless they have been authorised by either the Director of Capital, Estates and Facilities or the Head of Estates & Facilities.
- Following authorisation to progress with an idea, in some cases a Project Outline Document (POD) will be required. The information recorded in the POD will include but is not limited to the following information:
  - Project Summary and Purpose;
  - Project objectives and scope;
  - Non-financial benefits;
  - Financial savings;
  - Risks;
  - Key milestones; and
  - Proposed resources.
- When completing a POD the SIP team will liaise with key staff within the Health Board as well as the Procurement Services of the NHS Wales Shared Services Partnership if required.
- Once the POD is completed it will be submitted to the Capital, Estates and Facilities Service Board for approval.
- The SIP team will review the ideas log on a monthly basis.
- Whilst there is no formal timetable in place for the team to review ongoing projects, as the team are all based in the same office reviews tend to occur as and when required.
- With regards to updating the Service Board, a member of the team attends the 'Team Brief' and provides an update on the progress the team has made.
- The Region Facility Manager who leads the SIP team also meets regularly with the Head of Estates & Facilities to provide an update on the progress of the team.
- Presentations on the projects that the SIP team have implemented and are working on have been given to a number of departments within the Service Board.

We did not identify any issues in respect of this objective.

Objective 3: The SIP Team is effectively delivering against its objectives and is adding value to the Service Board by enabling the delivery of service improvements.

Due to the Coronavirus situation we were unable to undertake any testing for this objective.

Appendix A - 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.

Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)

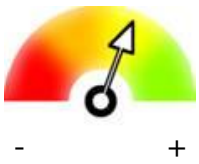
Final Internal Audit Report

Cardiff & Vale University Health Board

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance

Previous review rating Reasonable Assurance

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Review reference:	SSU_CVU_1920_05
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Auditor/s:	NWSSP: Audit & Assurance - Specialist Services Unit
Executive sign off	Abigail Harris, Executive Director of Planning
Distribution	Geoff Walsh, Director of Capital, Estates and Facilities Jeremy Holifield, Head of Capital Planning
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 Chartered Institute of Internal Auditors.

ACKNOWLEDGEMENT

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

1. Introduction and Background

The project aims to provide accommodation to support the future configuration of specialist neuro and spinal rehabilitation at University Hospital Llandough (UHL) and elderly care services at St David's Hospital in Cardiff, thus enabling the UHB to dispose of the Rookwood Hospital site.

The project also takes account of the investment required that underpins and facilitates the implementation of these developments by relocating some other services to facilities better suited to supporting their models of care across other areas of the existing University Health Board (UHB) estate to release the space required.

The Welsh Government announced capital funding of £30.8 million in November 2018 to progress works.

The construction contract commenced in January 2019 with an anticipated overall contract completion date of December 2020. A sectional completion date of January 2020 was included, for internal and external works, at Cardiff Royal Infirmary (CRI) – this has been achieved.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the UHB for the management of capital projects, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

Accordingly, the focus of the audit was directed to the following areas:

- **Follow up -** review the status of previously agreed audit recommendations and associated management actions.
- **Project Management –** assurance that appropriate project management controls were in place including risk, programme and performance monitoring.
- **Budgetary / Cost Management –** arrangements were in place to monitor, review and control and financial performance and progress of project delivery.
- **Valuation –** assurance that adequate processes and procedures were in place to ensure that the contractor was correctly reimbursed in accordance with the contract.
- **Change Management –** assurance that changes were processed / authorised in accordance with the contract and local internal control procedures.

3. Associated Risks

The mitigation and management of negative impacts to time, cost and quality of the delivered project were considered.

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.

At the date of the review, issues regarding the cost and programme at UHL had been highlighted:

- Unforeseen works associated with relocating staff, leading to a funding shortfall [£288k as per November 2019 cost report];
- Potential delay to programme arising from the resolution of the requirements for fire protection to steelwork, for which no definitive cost had yet been provided.

Furthermore, whilst outside the scope of the contractors work, the UHB are experiencing issues with the PFI provider regarding acceptance of the instruction of works issued for St David's Hospital: affecting the timing of repatriation of the elderly care services within the wider Rookwood relocation programme.

Whilst being cognisant of the above issues, general compliance was noted with the established control frameworks in each of the objective areas sampled, particularly in relation to change management, budgetary /cost management and valuation.

The audit identified the following control weakness:

- the accuracy of the project risk register including the need for risk mitigation arrangements and potential costs etc.

In addition, certain enhancements have been recommended in respect of:

- the need to formally approve the plan to manage the identified funding shortfall for the remaining 11 months of the programme;
- the timeliness of payments to the main contractor; and
- the need to reconcile the Welsh Government dashboard reports to the cost reports prepared.

Accordingly, against this context, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the re-provision of Specialist Neuro and Spinal Rehabilitation and Elderly Care Services from Rookwood Rehabilitation Hospital is **Reasonable Assurance**.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Follow Up			✓	
2	Project Management				✓
3	Budgetary / Cost Management			✓	
4	Valuation			✓	
5	Change Management				✓

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

Design of Systems/Controls

The findings from the review highlighted **no** issues that are classified as a weakness in the system control/design for managing the requirements of the re-provision of Specialist Neuro and Spinal Rehabilitation and Elderly Care Services from Rookwood Rehabilitation Hospital.

Operation of System/Controls

The findings from the review highlighted **three** issues that are classified as weaknesses in the operation of the designed system/control for managing the requirements of the re-provision of Specialist Neuro and Spinal Rehabilitation and Elderly Care Services from Rookwood Rehabilitation Hospital.

6. Summary of Audit Findings

Follow Up

We sought assurance that previously agreed management actions had been implemented.

The status of these actions arising from the previous review (April 2019) was as follows:

Closed	Outstanding	Superseded	Total
2	1	-	**3**

The detail in support of the above summary is included in **Appendix B**.

Accordingly, **reasonable assurance** has been determined in respect of the action taken to address previously agreed audit recommendations.

Project Management

We sought assurance that appropriate project management controls were in place including risk, programme and performance monitoring.

Appropriate project management arrangements and tools continued to be applied at the project.

Project team meetings were held on a monthly basis with appropriate attendance from nominated members. Accountability to the Board continued to be demonstrated via the Specialist Services Major Project Board; and financial reporting via the Service & Delivery Committee. The transparency of reporting on the status of both programme and finances was evident.

Performance monitoring of the contractor was undertaken through the suite of SCAPE framework key performance indicators including:

- Time and cost;
- Quality;
- Social [including fair payment, local labour, local spend, SME engagement and SME spend];
- Environmental.

Further performance monitoring was undertaken of the appointed professional advisers by the UHB.

In both instances, no areas of concern were highlighted in respect of adviser and contractor performance; and the anticipated deviation from the contract's outturn delivery and cost positions had been openly reflected.

In the context of the stage of the project at the point of our review, and issues identified elsewhere within this report **substantial assurance** has been determined.

Budgetary / Cost Management

We sought assurance that arrangements were in place to monitor, review and control the financial performance and progress of project delivery.

The project budget was developed and market tested for the development of the target cost and inclusion within the Full Business Case (FBC). The budget has been subject to ongoing review through the monthly cash flow profiling exercise, managed by the appointed cost adviser.

The project contingency (£583k) is currently in deficit (i.e. 39.25% overspent). It is acknowledged, however, that management and their appointed advisers continue to challenge the contractor and design team to identify savings at the project (not adversely impacting on the overall quality and delivery of the scheme).

At the time of the current review, contingency management arrangements for the remaining duration of the project (i.e. the remaining 11 months) had not been formally approved **(recommendation 1)**. Management advised that a review of the outturn Discretionary Capital Programme for 2019/20 will be undertaken to identify any surplus to be used to offset the deficit. Subject to this, there may also be a call for an allocation from the 2020/21 programme to manage the project outturn.

A project risk register was operated, reviewed monthly and reported through the Project Manager's progress report, however it was noted that not all open risks (i.e. 20%) had appropriately identified management/mitigation arrangements or had been appropriately costed

(10%) Accordingly the potential impact (best case / worse case / likely scenarios) on the outturn cost was not fully determined **(recommendation 2).** One such risk is #110 [Fire Protection to Steelwork]. Whilst it was acknowledged final costings were awaited from the specialist supplier, earlier notifications stated a cost of circa £350k. However, this had not been reflected at the risk register. There is the expectation that all such information should be included at the point of entry.

Regular cost reports provided by the cost adviser were noted. The cost reports were embedded within the Project Manager progress reports and discussed at the Project Team meetings.

As noted within the *Follow Up* section above, whilst the funding shortfall for the project had been highlighted within the cost reports (and the delays to the programme), these were not reflected on the face of the Welsh Government dashboard submissions.

Whilst financial performance reporting was noted to appropriate levels within the UHB, noting the requirement to formally approve the management of the current reported overspend position at the project in the context of the remaining delivery timetable for the project, **reasonable assurance** has been determined.

Valuation

We sought assurance that adequate processes and procedures were in place to ensure that the contractor was correctly reimbursed in accordance with the contract.

Section 13 of the Project Executive Plan (PEP) [last updated August 2019] set out the requirements for review and recommendation of contractor and adviser payments.

Appropriate cost adviser valuation assessment arrangements (in accordance with the NEC contract) were noted, affirming the value of work completed by the main contractor prior to passing to the Project Manager for approval for payment by the UHB.

At the date of fieldwork, total contractor payments [from the commencement of the project] were £13,262k.[1] A sample of payments were reviewed to confirm completeness and timeliness. Eight of the payments reviewed had been made after the due date **(recommendation 3).**

Acknowledging the processes in place, but noting issues regarding timeliness of payment, **reasonable assurance** has been determined.

[1] *Whilst included in the total, the due date for payment of the November 2019 valuation had not been reached at the date of fieldwork.*

Change Management

We sought assurance that changes were processed / authorised in accordance with the contract and local internal control procedures.

Section 10 of the PEP details the change management process: *all changes to the contract shall be made using early warning notices and compensation event procedures as set out in the NEC form of contract*. The PEP also made reference to a Project Issues Form (PIF). Whilst not a recognised NEC reporting process, the PIF was utilised by the UHB to further aid and manage the change control process.

The cost adviser's cost report includes a Change Control Tracker. Reference was made to the cost report to end November 2019: 177 changes were included with a total value of £1,741k.

It was noted that within the same were changes attributed to work for the Domestic Violence Unit (£771k) and Retaining Wall [for Horatio's Garden] (£311k); both of which are being funded through separate funding streams but are being undertaken by the contractor at the same time as the Rookwood Relocation works.

All of the changes reviewed had progressed in accordance with the formal contractual arrangements and defined delegated limits.

Noting the above, **substantial assurance** has been determined in respect of the change management procedures applied at the project to date.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Current year recommendations	-	3	-	**3**
Prior year recommendations	-	1	-	**1**
Total	-	4	-	**4**

Finding: Management of risk contingency	Risk
At FBC stage, the risk contingency for the UHB was reported as £583k. Whilst noting that a number of compensation events issued have been funded from outside of the project allocations [total of £1,253k], the contingency figure is currently 39.25% overspent. The latest Project Manager's report [accompanying the Welsh Government dashboard submission in January 2020], has indicated that the current reported overspend is mainly attributed to significant unforeseen works associated with relocating staff from the existing templates into the Cytology building. The cost adviser report [embedded within the Project Manger report] predicts a funding shortfall of £228,804. Noting that there is currently eleven months to project completion, cost pressures remain extant: • Minimal remaining contingency due to the aforementioned unavoidable costs; • £576k costed risks remain open, as per the latest risk register; and • Five 'open' risks recorded for which there is currently no risk value assigned. Management advised that a review of the outturn Discretionary Capital Programme for 2019/20 will be undertaken to identify any surplus to be used to	• The project is not affordable. • Approvals for additional funding to address the overspend may not be secured. • Use of discretionary capital funds to manage the overspend position to the detriment of other capital projects.

offset the deficit. Subject to this, there may also be a call for an allocation from the 2020/21 programme to manage the project outturn.	
Recommendation 1	**Priority level**
Management, in consultation with their advisers, should seek approval of plans for financing the shortfall in the 2020/21 financial year. Continued scrutiny will be applied of the reasonableness for further changes requested / required to the project. **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. Any changes to the project are routinely scrutinised by Project Board. The potential project overspend has been reported at every Capital Management Group so Executives are fully aware of the position. This will continue to be monitored as the project moves towards closure with the expectation that any shortfall will be met from the UHB's discretionary capital programme.	Director of Capital, Estates & Facilities Ongoing [to end of project]

Finding: Risk Register – mitigating measures	Risk
Whilst there is a project risk register in place, which is reviewed monthly and reported through the Project Manager progress report, it was identified that not all open risks had an appropriate countermeasure detailed. Review of the risk register, as at 30 November 2019, noted 15 risks [of the 51 recorded] with no management/mitigation arrangements identifi: • Five [105; 105; 108; 110 and 111] relate to new Early Warning Notices where discussions and finalisation of costs remain ongoing at date of issue (including fire protection to steelwork where early discussions had noted a possible cost of £350k); and • Ten [2; 13; 39; 40; 47; 49; 55; 56; 58 & 68] relate to open risks.	Project risks, and mitigating actions, are not accurately stated.
Recommendation 2	**Priority level**
The risk register will be updated to extend consideration of mitigation actions for the ten open risk identified; and consideration will be given for new risks as they arise. **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The Project Director will write to the Project Manager as custodian of the project risk register to ensure: a) It is completed appropriately; and	Director of Capital, Estates & Facilities May 2020

b) It is considered at all progress meetings.	

Finding: Timeliness of payments	Risk
Total payments from the commencement of the project were £13,262k. A sample of ten payments was selected [82% coverage of the valuations]. Of these payments: • One was paid in advance of the due date (prior to the end of the 2018/19 financial year); • One had yet to be paid (due date 6 December; Oracle information provided 11 December); and • Eight had been paid after the expected due date (max. 10 days, min. 3 days).	Breach of agreed payment terms
Recommendation 3	**Priority level**
All payments should be made in accordance with the terms of the contract. **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The Capital Planning leads will be reminded to process payments within seven days of receipt of the Project Manager's certification.	Director of Capital, Estates & Facilities May 2020

Prior ref	Recommendation	Responsibility & timeline	Action / Status	Updated responsibility and timescale	Current year priority rating
Low					
1	Letters of intent should only be utilised on an exception basis at future projects.	Director of Capital, Estates & Facilities At future projects	**Closed** Discussions held with the Head of Capital Planning noted that there are no projects starting on site, at the moment, for which contracts are required. It is acknowledged that some are scheduled for 2020/21 but have not had contractors appointed therefore no contracts / letter of intent have been issued. The UHB is mindful that this remains a prevalent area when reviewing contractual arrangements put in place.	N/A	N/A
Medium					
2	A formal SCAPE KPI process should be introduced at the project, to monitor the	Head of Capital Planning	**Closed** A KPI process has been implemented by the Project Manager with reporting	N/A	N/A

	performance of the contractor.	With immediate effect	undertaken on a six-monthly basis.		
3	The monthly Welsh Government dashboard reports should reconcile with internally generated cost, progress and risk reporting.	Head of Capital Planning April 2019	**Outstanding** The latest Welsh Government dashboard report was submitted January 2020; relating to the end of November 2019. Embedded in the submission was the November Project Manager progress report, which includes the cost report. Review of both documents noted that there remain discrepancies in the content reported: • Main contract outturn cost as per dashboard (forecast): £19.902m • Adjusted final target cost as per cost report: £21.094m • Total project cost as per dashboard (forecast): £30.881m The total project cost (as per the dashboard) reconciles to the budget. However, as per the cost report, noting the adjusted final target cost, there is a predicted funding shortfall of £229k.	Head of Capital Planning April 2020	**Medium**

			It is acknowledged that this information is clear within the embedded report; however, it should be shown within the relevant sections of the dashboard report.		

Audit Assurance Ratings

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

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

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment

Surgery Clinical Board – Enhanced Supervision

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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Auditors:	Ian Virgill, Stuart Bodman
Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Clare Wade, Director of Nursing
	Mike Bond, Director of Operations
	Andy Jones, Senior Nurse
	Andrea Sullivan Senior Nurse
	Sharon Irving, Senior Nurse
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.

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1. Introduction and Background

The review of the management of Enhanced Supervision within the Surgery Clinical Board was completed in line with the 2019/20 Internal Audit Plan for Cardiff and Vale University Health Board.

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

Sometimes known as 1:1 nursing or 'specialling', enhanced supervision is an important part of the patients plan. It involves safe and sensitive monitoring of the patients' physical and mental well-being while at the same time encouraging the patient to take part in meaningful activity.

The use of enhanced supervision in hospital is aimed at preventing harm or injury to the patient or to other people.

There are 4 different levels of enhanced supervision, ranging from intermittent observation to the patient having a member of staff by their side at all times.

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of arrangements for the management of enhanced supervision in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The scope of the review was to ensure that there are appropriate systems and processes are in place for the management of enhanced supervision so that risk assessments are undertaken and care is given accordingly and is subject to on-going monitoring.

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

- Appropriate documented procedures are in place for the management of enhanced supervision;
- Patients that may require enhanced supervision are identified at an early stage;
- The decision to utilise enhanced supervision is appropriately made and subject to required authorisation;
- Risk assessments are carried out appropriately and a care plan / pathway defined;
- Appropriate staff are identified to deliver the required level of enhanced supervision;
- The Care plan is met and is subject to on-going monitoring.
- The on-going need for enhanced supervision is formally assessed on a daily basis; and

- Effective processes are in place for monitoring and reporting the use and cost of enhanced supervision.

Testing was undertaken at the following sampled Wards:

- Ward A2, UHW;
- Ward A3 Link, UHW;
- Ward A5, UHW; and
- Ward B6, UHW.

3. Associated Risks

The potential risk considered in this review is as follows:

- Patient harm due to insufficient nursing provision; and
- Financial loss due to unnecessary use of enhanced supervision.

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 Surgery Clinical Board – Enhanced Supervision 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.

Overall there are processes in place in each of the four sampled Wards that enable nursing staff to; assess risk, appraise need and request, approve and record patients that are undergoing enhanced supervision.

There are also efficient processes in place at both Ward and Senior Nurse Management level for monitoring and reporting the use and cost of enhanced supervision to Clinical Board and Executive Board level.

However, testing identified that these processes undertaken at Ward level are not always documented in a complete and consistent manner, and in a small number of instances supporting documentation could not be located on patient's notes.

There is also currently an absence of any formal Surgery Clinical Board overarching procedure/guidance provided to Ward Managers in respect of the management and oversight of enhanced supervision.

A number of key findings were identified that require management attention in order to reinforce the current processes that are in place and are generally working well;

Additionally, it is noted that there is no section within patient's files specifically for enhanced supervision documentation which would act as a central repository and aid ease of access.

Currently, nursing notes were found to be out of date order and obtaining a sequential 'story' of enhanced supervision documented by all clinical participants was time consuming.

5. Assurance Summary

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

Assurance Summary					
1	Documented procedures		✓		
2	Early identification			✓	
3	Decision to utilise enhanced supervision appropriately			✓	
4	Risk assessments / care plan / pathways defined			✓	
5	Appropriate staff cover identified				✓

Assurance Summary					
6	Care Plan met and Ongoing monitoring			✓	
7	Formal assessments of on-going need for enhanced supervision			✓	
8	Effective processes in place for monitoring and reporting				✓

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

Design of Systems/Controls

The findings from the review have highlighted 2 issues that are classified as weaknesses in the system control/design for Surgery CB – Enhanced supervision.

Operation of System/Controls

The findings from the review have highlighted 5 issues that are classified as weaknesses in the operation of the designed system/control for Surgery CB – Enhanced supervision.

6. Summary of Audit Findings

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

Objective 1: Appropriate documented procedures are in place for the management of enhanced supervision.

The following area of good practice was noted:

- The Surgery Clinical Board has introduced the 'Enhanced Supervision Framework Patient Record' booklet following its use within the Medicine Clinical Board.

The following finding was noted:

- Absence of a Surgery Clinical Board procedure/guidance provided to Ward Managers that outlines the active management, oversight and activity reporting of enhanced supervision to be undertaken.

Objective 2: Patients that may require enhanced supervision are identified at an early stage.

The following areas of good practice were noted:

- Enhanced supervision and monitoring is undertaken on the basis of early indicator requirements or 'triggers' that would instigate a request to Senior Nurses for use; and
- There is a uniformity and consistency of enhanced supervision early identification requirements in use across all four Wards.

The following finding was noted:

- The Enhanced Supervision Patient Record Booklet does not currently state early identification requirements to support the decision making process to commence enhanced supervision.

Objective 3: The decision to utilise enhanced supervision is appropriately made and subject to required authorisation.

The following finding was noted:

- The majority of patients sampled across the four Wards did not hold a Specialling Risk Assessment Form on their respective patient notes.

Objective 4: Risk assessments are carried out appropriately and a Care Plan / pathway defined.

The following areas of good practice were noted:

- Sampled patient notes on Wards A2 and A5 both held recent medical reviews, Falls Risk Indicator Assessments and 'Read about Me' - Life style Questionnaires that underpinned the enhanced supervision provided.
- When appropriate, Deprivation of Liberty Safeguards (DoLS) proformas were completed.

The following findings were noted:

- Sampled Specialling Risk Assessment Forms on Wards A3 Link and B6 are not consistently scored by Ward Management and signed off by Senior Nurse Management to justify the ongoing use of enhanced supervision.
- Sampled patients on Wards A2 and A3 Link did not have Specialling Care Plans.

Objective 5: Appropriate staff are identified to deliver the required level of enhanced supervision.

The following area of good practice was noted:

- Care requirements of patients on all four sampled Wards undergoing enhanced supervision are discussed at shift handovers and morning Ward safety briefing meetings.

The following finding was noted:

- Absence of awareness of the Enhanced supervision management module on Clinical Workstation.

Objective 6: The Care Plan is met and is subject to ongoing monitoring.

The following area of good practice was noted:

- Majority of sampled Wards held Behaviour Monitoring Charts that were completed for 7 days, evidencing the hourly review of the level of enhanced supervision and a formal written assessment of need for continuation.

The following findings were noted:

- None of the sampled patients on Wards A2 and A3 Link showed evidence of a Care Plan being monitored and reviewed.
- Inconsistent recording within nursing notes that engagement was undertaken to stimulate, motivate and undertake activities with patients during the day.
- Inconsistent completion and use of all of the documents for half the sampled patients within Ward B6.

Objective 7: The ongoing need for enhanced supervision is formally assessed on a daily basis.

The following areas of good practice were noted:

- Patients undergoing enhanced supervision are discussed as part of the handover process and morning Ward safety briefing meetings.

The following finding was noted:

- Nursing notes for sampled patients did not always record that that family and carers were informed and engaged with the provision of enhanced supervision.
- Half of the patients sampled on Ward B6 did not document ongoing communication of risk to all members of the multi-disciplinary team.
- Half of the patients sampled on Ward B6 did not hold documentation to confirm hourly and daily review during the period of enhanced supervision.

Objective 8: Effective processes are in place for monitoring and reporting and discussion relating to the use and cost of enhanced supervision.

The following area of good practice was noted:

- Surgery Clinical Board has effective processes that report, escalate, and monitor the use and cost of enhanced supervision identified and used on Wards.

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**	**5**	**2**	**7**

Finding 1 - Enhanced Monitoring Guidance/Procedures (Control design)	Risk
Currently there is no formal Surgery Clinical Board procedure or guidance provided to Ward Managers that outlines and defines the need to initiate enhanced supervision of patients in their area (e.g. the use of the Specialling Risk Assessment Form) and states the processes in place relating to the recording and reporting of activity within the Clinical Board relating to patients that undergo enhanced supervision; especially those that are receiving 1:1 nursing and would require additional staffing costs where required. Additionally, such a formal procedure should mandate the requirement to use the 'Enhanced Supervision Framework Patient Record' booklet which the Clinical Board are in the process of implementing following its use within the Medicine Clinical Board and document its use in conjunction with the Specialling Risk Assessment Form.	Patient harm due to insufficient nursing provision.
Recommendation	**Priority level**
Surgery Clinical Board should introduce an overarching procedure/guidance provided for Ward Managers that formalises the governance arrangements relating to the use, monitoring and reporting of enhanced supervision of patients.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Surgery Clinical Board agreed with the above recommendation. The Surgery Clinical Board will (via a task and finish group) review the reporting of enhanced monitoring booklet and its suitability for use within Surgery Clinical Board. A supporting document/ guidance can be developed and produced to assist in use	Director of Nursing for Surgery Clinical Board

of the enhanced supervision document. This updated document will be agreed via the Surgery Nursing Board formal meeting structure	September 2020

Finding 2 - Specialling Risk Assessment Forms (Operating effectiveness)	**Risk**
A Specialling Risk Assessment Form should be completed by Ward Management and then authorised by Senior Nurses to justify the commencement of enhanced supervision. A review of a sample of 12 patients that underwent enhanced supervision across the four UHW Wards tested (Ward A2, A3 Link, A5 and B6) identified that 7 patients did not hold a Specialling Risk Assessment Form. The ward managers on all four wards did however confirm that any decisions to commence enhanced supervision would be based upon them carrying out an assessment of the patient.	Patient harm due to insufficient nursing provision.
Recommendation	**Priority level**
Specialling Risk Assessment Forms should be completed by Ward Managers and authorised by Senior Nurses for all patients that commence enhanced supervision so as to formally record and justify its use.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The enhanced supervision document will be reviewed by Surgery Clinical Board and updated to ensure that a risk assessment is included and that there is a section which documents and records agreement to commence enhanced	Director of Nursing for Surgery Clinical Board

supervision by the Senior/ Lead Nurse. This updated document will be agreed via the Surgery Nursing Board formal meeting structure	September 2020

Finding 3 - Risk assessment and care planning documentation. (Operating effectiveness)	**Risk**
Patient notes were reviewed at each of the four Wards to confirm the existence and completion of the following documentation to support enhanced supervision provision: • Care Plans; • Medical reviews; • 'Read about Me' lifestyle questionnaires; • Falls Risk Assessments; • Deprivation of Liberty (DoLs) Proformas - if appropriate; • Specialling Risk Assessments scored on an ongoing basis and authorised by Ward Management and Senior Nurse to document evidence of renewal/continued use of enhanced monitoring. The key finding relates to the inconsistent completion and use of these documents across all sampled patients, whereby no one Ward held all the above documentation. For example, wards A2 and A3 Link did not have Specialling Care Plans for the sampled patients and Ward B6 did not hold Falls Risk Assessment Forms. Furthermore, with the exception of those Specialling Risk Assessments located on Wards A2 and A5, others held on Wards A3 Link and B6 are not consistently	Patient harm due to insufficient nursing provision.

scored by Ward Management and signed off by Senior Nurse Management to justify the ongoing use of enhanced supervision.	
Recommendation	**Priority level**
All patients that receive enhanced supervision should retain a fully completed Specialling Care Plan, medical review, 'Read about Me' - Life style Questionnaire, Falls Risk Indicator Assessment and DoLs Proforma (if applicable). Specialling Risk Assessments must be retained on the patient's notes and regularly reviewed and scored to justify ongoing use of enhanced supervision.	**Medium**
Management Response	**Responsible Officer/ Deadline**
After updating the Enhanced supervision document Surgery Clinical Board will re audit the use of the document and how the document is used alongside 'Read about Me' - Life style Questionnaire, Falls Risk Indicator Assessment and DoLs Proforma (if applicable). The results will be reported to Surgery Clinical Nursing Board Formal meeting.	Director of Nursing for Surgery Clinical Board November 2020

Finding 4 - Patient monitoring and care planning (Operating effectiveness)	Risk
We reviewed patient's notes from the four sampled Wards to establish how often the patient Care Plan is reviewed and up dated, and if a Behaviour Monitoring Chart had been completed for 7 days for each patient undergoing enhanced supervision. Attention was also paid to the existence of documentation within nursing notes relating to patient engagement during the episode. Good practice is noted that all sampled patients on Wards A2, A3 Link and A5 held Behaviour Monitoring Charts that were completed for 7 days, evidencing the hourly review of the level of enhanced supervision and a formal written assessment of need for continuation of enhanced supervision carried out by a registered nurse on a daily basis. Additionally, all sampled patients on Wards A3 Link and A5 had documented within their nursing notes that engagement was undertaken to stimulate, motivate and undertake activities with them during the day. However, none of the 3 sampled patients on Wards A2 and A3 Link showed evidence of a Care Plan being reviewed and there is also inconsistent completion and use of all of the documents across all sampled patients within Ward B6.	Patient harm due to insufficient nursing provision.
Recommendation	**Priority level**
Behaviour Monitoring Charts must be completed for 7 days, evidencing the hourly review of the level of enhanced monitoring and a formal written assessment of	**Medium**

need for continuation of enhanced monitoring carried out by a registered nurse on a daily basis. Care Plans should be monitored and reviewed to reflect ongoing enhanced monitoring and any changes should be documented accordingly. All patients undergoing enhanced supervision should have documented within their nursing notes the engagement undertaken to stimulate/provide activities for them during the day.	
Management Response	**Responsible Officer/ Deadline**
A guidance document will be developed to support the Enhanced supervision document by Surgery Clinical Board which will help support what the requirement is for recording engagement by all members of the MDT.	Director of Nursing for Surgery Clinical Board September 2020

Finding 5 - Ongoing Review of Enhanced Monitoring (Operating effectiveness)	**Risk**
Patients undergoing enhanced supervision are discussed as part of the handover process and morning Ward safety briefing meetings to ensure that key risks, behaviour and needs of the patient are known to the incoming nurse at the commencement of a new shift. All sampled Wards, with the exception of Ward B6, consistently documented ongoing communication of risk to all members of the multi-disciplinary team (e.g. Physiotherapists, Dieticians etc.) within patient notes. This was also the case regarding documentation to confirm hourly review during the period of enhanced supervision and formal written assessments carried out	Patient harm due to insufficient nursing provision.

by registered nurses on a daily basis to support justification to continue the supervision. However, there is no documentary evidence retained in the nursing notes for sampled patients within Wards A2 and B6 that family and carers were informed and engaged with the provision of enhanced supervision.	
Recommendation	**Priority level**
Hourly reviews during the period of enhanced supervision, and formal written assessments should be carried out by registered nurses on a daily basis to support justification to continue the supervision. Communication of risks to all members of the multi-disciplinary team relating to patients undergoing enhanced supervision should be documented within patient notes. Nursing notes should also document that family and carers were informed and engaged with the provision of enhanced supervision.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A guidance document will be developed to support the Enhanced supervision document by Surgery Clinical Board which will help support what the requirement is for recording engagement by all members of the MDT.	Director of Nursing for Surgery Clinical Board September 2020

Finding 6 - Formalisation of early identification criteria in Enhanced Supervision Patient Record Booklet (Control design)	Risk
Good practice is noted that all four Ward Managers (Wards B6, A2, A3 and A5) described in detail the early indicator requirements or 'triggers' (e.g. behaviour, mobility, delirium) that would instigate a request to their respective Senior Nurses to commence enhanced supervision of patients. There is also a uniformity and consistency of enhanced supervision early identification 'triggers' applied across all four Wards. However, the Enhanced Supervision Patient Record Booklet does not currently state these 'triggers', and as such it could be helpful to the decision making process as to whether to commence enhanced supervision to have these as part of the current flowchart in place.	Patient harm due to insufficient nursing provision.
Recommendation	**Priority level**
Enhanced Supervision Patient Record Booklet should be revised to include early indicator requirement 'triggers' which would aid the nurses' decision making process as to whether to commence enhanced supervision.	**Low**
Management Response	**Responsible Officer/ Deadline**
The enhanced supervision document will be reviewed by Surgery Clinical Board and updated to ensure that a risk assessment is included and that there is a section which documents and records agreement to commence enhanced supervision by the Senior/ Lead Nurse. This updated document will be agreed via the Surgery Nursing Board formal meeting structure	Director of Nursing for Surgery Clinical Board September 2020

Finding 7 - Clinical Workstation - Enhanced Monitoring Module (Operating effectiveness)	Risk
Good practice is noted that patients undergoing enhanced supervision are cared for by a mix of Healthcare Support Workers and qualified nursing staff according to the level of care required. However, discussions with each of the four Ward Managers identified that they were not aware that Enhanced supervision could be recorded and tracked on Clinical Workstation via the use of an 'eye' icon, and also none have been provided with training as to the use of this facility.	Patient harm due to insufficient nursing provision.
Recommendation	**Priority level**
Ward Managers should be provided with training relating to the use of the enhanced supervision facility on Clinical Workstation as it would provide 'real time' information and aid the active monitoring and management of patients undergoing observation.	**Low**
Management Response	**Responsible Officer/ Deadline**
Awareness will be raised on the use of the icon on the Clinical Work station via professional nursing forums and by local communication routes	Director of Nursing for Surgery Clinical Board 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.

Infection Prevention and Control

Final Internal Audit Report

Cardiff and Vale University Health Board

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Distribution:	Yvonne Hyde, Senior IP & C Nurse Jason Roberts, Deputy Executive Nurse Director
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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 Infection Prevention & Control (IP&C) was completed in line with the 2019/20 Internal Audit Plan for Cardiff & Vale University Health Board.

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

NHS Wales had teamed up with NHS Scotland to host and utilise their electronic National Infection Control Manual (NICM) to ensure all health care organisations in Wales have access to consistent, current and standardised policies to support practice.

Model policies for Infection, Prevention and Control for Standard Infection Control Precautions and Transmission-based Precaution Policies previously developed by Public Health Wales have been superseded by the adoption of the Scottish National Infection Control Manual (NICM).

All Health Boards in Wales must ensure the adoption and implementation of this manual in accordance with their existing local governance processes. They must also ensure that systems and resources are in place to facilitate implementation and compliance monitoring of infection prevention and control as specified in the manual in all care areas.

2. Scope and Objectives

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

The purpose of the review was to provide assurance to the Audit Committee that the Health Board has appropriate structures, plans, monitoring and reporting arrangements in place to ensure that the risk of infection is minimised and the spread of infection is effectively controlled and all relevant guidelines and legislation are complied with.

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

- The UHB has appropriate, up to date infection control policies and procedures in place that comply with Welsh Government requirements, relevant legislation and the requirements within the NICM;

- An effective infection control structure is in place within the UHB including Executive responsibility, clinical leads, management structures, Clinical Board level staff and groups and there is an appropriate level of IPC Consultant cover per Health Board site;

- An appropriate infection control framework and / or plan is produced and effectively communicated and implemented across the UHB;
- Appropriate training is provided to all relevant staff;
- Robust incident reporting and monitoring processes are in place across the UHB to allow for accurate and timely identification and recording of all infection control related incidents and actions taken;
- Specific high risk infection control incidents are adequately reported and escalated through the organisation to ensure appropriate actions are taken;
- Regular infection control reports are produced and they are submitted to appropriate management and Board level Groups for information and action; and
- The UHB complies with all reporting requirements relating to reportable diseases and infections.

3. Associated Risks

The potential risks considered in this review were as follows:

- The UHB fails to prevent the spread of infection.
- Non-compliance with infection control reporting requirements and / or legislation.

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 Infection Prevention and Control is **Reasonable Assurance**.

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

The Infection Prevention and Control Team has a range of policies and procedures in place to help prevent and control infections at all hospital sites within the Health Board, and these are underpinned by well-established infection prevention and control processes and practices which are detailed in the National Infection Prevention and Control Manual (NIPCM). The Infection Prevention Control Group (IPCG), a sub-group of the Quality, Safety and Experience Committee (QSE), monitors performance against the relevant Healthcare Standards.

However some of the current IP & C policies and procedures were un-available to staff on the Infection Prevention and Control intranet pages, or were out of date, and there was no link to some key IP & C documentation such as the NIPCM. The Terms of Reference for the IPCG was also out of date, and the membership list was in need of review.

Our audit also identified a number of other areas where improvements could be made. These include ensuring more regular update reports from the IP & C Senior Nurse and the minutes of the IPCG are submitted to the QS & E Committee and more IP & C audits are undertaken. In addition, IP & C team representation at Clinical Board QS & E meetings could be improved, and the completion of Root Cause Analysis could be improved with greater medical engagement.

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	Policies & Procedures			✓	
2	Infection Control structure			✓	
3	Infection Control Framework			✓	
4	Staff Training				✓
5	Incident Reporting & Monitoring				✓
6	High Risk Infections			✓	
7	Internal IP & C Reporting		✓		
8	External Reportable Diseases & Infections				✓

** 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 Infection Prevention and Control.

Operation of System/Controls

The findings from the review have highlighted eight issues that are classified as weaknesses in the operation of the designed system / control for Infection Prevention and Control.

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: The UHB has appropriate, up to date infection control policies and procedures in place that comply with Welsh Government requirements, relevant legislation and the requirements within the NICM.

Our audit identified the following areas of good practice under this objective:

- The IP & C policies and procedures are available to staff on the UHB intranet pages.

Our audit identified the following findings under this objective:

- Some of the Infection Prevention & Control Policies published on the intranet were out of date or inaccessible, and there was no link to the National Infection Prevention and Control Manual (NIPCM).

Objective 2: An effective infection control structure is in place within the UHB including Executive responsibility, clinical leads, management structures, Clinical Board level staff and groups and there is an appropriate level of IPC Consultant cover per Health Board site.

Our audit identified the following areas of good practice under this objective:

- The UHB had an Infection Control Group underpinned by Clinical Board Infection Control and / or Quality, Safety and Experience sub groups; and
- The Clinical Board Quality, Safety and Experience sub groups reported in to the Health Board's Quality, Safety and Experience Committee.

Our audit identified the following findings under this objective:

- The Terms of Reference for the Infection Control Group was out of date and meetings were generally poorly attended, with some key areas such as Estates not represented at meetings.

Objective 3: An appropriate infection control framework and / or plan is produced and effectively communicated and implemented across the UHB.

Our audit identified the following areas of good practice under this objective:

- The UHB had a documented Framework for the Management and Reduction of Healthcare Associated Infections and Antimicrobial Resistance for the period April 2019 to March 2020; and
- The IP & C Framework includes a requirement for the IP & C Team to undertake a programme of IP & C audits.

Our audit identified the following findings under this objective:

- The Infection Prevention and Control Framework and Annual Programme for 2019/20 had not been published on the IP & C pages of the Health Boards intranet; and
- There were insufficient IP & C audits being carried out.

Objective 4: Appropriate training is provided to all relevant staff.

Our audit identified the following areas of good practice under this objective:

- The IP & C Department provides classroom training on infection prevention and control for the Health Board and also provides training to new staff at the Health Board's Corporate Induction Training Day.

Our audit did not identify any findings under this objective:

Objective 5: Robust incident reporting and monitoring processes are in place across the UHB to allow for accurate and timely identification and recording of all infection control related incidents and actions taken.

Our audit identified the following areas of good practice under this objective:

- All incidents that could potentially cause or spread infection are recorded on the Datix and / or ICNET system; and
- Weekly outbreak reports received from Public Health Wales are monitored by the Senior Nurse, Infection Prevention and Control to identify any potential IP&C risks to the Health Board.

Our audit did not identify any findings under this objective.

Objective 6: Specific high risk infection control incidents are adequately reported and escalated through the organisation to ensure appropriate actions are taken.

Our audit identified the following areas of good practice under this objective:

- Weekly infection alerts are received from Public Health Wales that are monitored by the IP & C Team;
- A log is maintained of all infection incidents that may lead to the loss of beds;
- An Outbreak Table is completed for all infection incidents on the incident log; this is updated each day of the infection and sent out to all relevant areas in the hospital by e-mail; and
- The IP & C Team are notified by the microbiology lab of any positive test results which are recorded on the ICNET system; the infected areas are then required to complete a root cause analysis which is returned to the IP & C Team.

Our audit identified the following findings under this objective:

- There was a lack of medical engagement when undertaking root cause analysis of incidences of infection; and
- Infection incident data recorded in the incident log did not always match that recorded on the corresponding Outbreak Table.

Objective 7: Regular infection control reports are produced and they are submitted to appropriate management and Board level Groups for information and action.

Our audit identified the following areas of good practice under this objective:

- The IPC Group reports to the Health Board's Quality, Safety & Experience Committee half yearly in June and December via a highlight report of the HB's performance against Health Care Associated Infections (HCAI) targets;
- IP & C matters are discussed at Clinical Board QS & E meetings, and the minutes of each Clinical Board's QS & E meetings are also presented to the Health Board QS & E Committee; and
- The IP & C Senior Nurse periodically prepares update reports for the Health Board Quality, Safety and Experience Committee.

Our audit identified the following findings under this objective:

- IP & C Team representatives were only present at 45% of the Clinical Board Quality, Safety and Experience meetings reviewed; and
- The most recent IP & C report prepared by the IP & C Senior Nurse was submitted to the UHB's Quality, Safety & Experience Committee in December 2018.

Objective 8: The UHB complies with all reporting requirements relating to reportable diseases and infections.

Our audit identified the following areas of good practice under this objective:

- All UHB infection incidents are recorded on the ICNET system which is monitored by Public Health Wales.

Our audit 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	**1**	**6**	**1**	**8**

Finding 1 - Policies and Procedures (Operating effectiveness)	Risk
Review of the Health Board's Infection Prevention and Control policies and procedures identified the following issues: Although some policies and procedures were updated during the course of our audit, a number of policies on the Health Board's list of Infection Prevention and Control Policies which is presented to the Infection Prevention Control Group for information, remain out of date or not accessible on the IP & C intranet pages, for example: • Mycobacterium Tuberculosis (TB) Procedure - review date 12/09/2016 • MRSA Procedure - bad link • Transmission Based Precautions - review date 23/06/2018 • Diarrhoea, Vomiting & Flu Guidance - covers 2017/18 winter pressures • MDRO Procedure - requires sign in via user name & password • Viral Hepatitis - bad link • Chicken Pox - bad link There was also no link on the C & V IP & C intranet pages to the National Infection Prevention and Control Manual (NIPCM). In addition it was noted that the list of current IP & C policies and procedures submitted to the Health Board's IPC Group did not match the policies and procedures available on the infection prevention and control pages of the Cardiff and Vale intranet.	The UHB fails to prevent the spread of infection.

Recommendation	Priority level
All out of date Infection Prevention and Control policies and procedures should be reviewed and updated, and any bad links reinstated. The C & V Infection Prevention and Control intranet pages should be updated to reflect the list of current policies and procedures submitted to the IPC Group. The C & V Infection Prevention and Control intranet pages should have a link to the National Infection Prevention and Control Manual (NIPCM).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Infection Prevention and Control policies and procedure are reviewed, updated and ratified as required by the core IP&C team and the Infection Prevention and Control Group. Since a member of the IP&C team with administrative rights for the Intranet left the organisation in July 2018 we have been unable to get anyone new within the team trained and given administrator to upload the updated procedures. At attempt to get support from another corporate department but this has proved difficult. This has still not been resolved. Impacted by COVID-19.	Deputy Executive Nurse Director September 2020

Finding 2 - Infection Control Group (Operating effectiveness)	Risk
The Terms of Reference (ToR) for the Infection Prevention Control Group (IPCG) was dated 19/09/2010 and was marked as draft. The membership list for the IPCG, which is maintained separately to the ToR, had 52 members. Review of the minutes from the Group's last three meetings showed that whilst all the meetings were quorate and well attended, 32/52 members (61.6%) had not attended any of the three meetings reviewed. There was also no attendance at any of the three meetings by a representative from the Estates Department. This is important given the poor condition of some parts of the Health Boards Estate which can hamper effective infection control, and that cleaning staff, who have an essential role in helping prevent and control the spread of infection, are managed by the Estates Department.	The UHB fails to stop the spread of infection.
Recommendation	**Priority level**
The IPCG Terms of Reference and membership list should be reviewed, updated and formally approved by the Group. In particular, the Estates Department should be requested to ensure they provide a regular representative for the Group.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The TOR will be reviewed by the Infection Prevention and Control Group as a priority. This was on the agenda for February 2020 before it was impacted by COVID-19; there is a plan to re-agenda in 2020.	Deputy Executive Nurse Director June 2020

A representative from Estates is invited to attend all IPCG meetings, all papers for the meetings are sent to the Head of Estates.	

Finding 3 - IP & C Framework and Annual Plan (Operating effectiveness)	**Risk**
The UHB had a documented Framework for the Management and Reduction of Healthcare Associated Infections and Antimicrobial Resistance for the period April 2019 to March 2020. However the Framework was not available to staff on the C & V IP & C intranet site. In addition to the Framework there was an IP & C Annual Programme for 2019/20, and this was approved by the Infection Control Group (ICG) at their meeting held on the 10th July 2019. However the copy provided to audit was marked as 'Draft', and some sections within the document made reference to 2018/19, for example the 'Aim' and 'Audit and Education Plans'. The Annual Programme was also not published on the Infection Prevention & Control pages of the C & V intranet site, so was not readily available to Health Board staff.	The UHB fails to prevent the spread of infection.
Recommendation	**Priority level**
The IP & C Annual Programme should be updated to reflect the period it covers, and all references to it being a draft document should be removed. The IP & C Annual Programme and Framework should be uploaded to the IP & C pages of the Cardiff and Vale intranet site.	**Low**

Management Response	Responsible Officer/ Deadline
The Annual Programme for IP&C will be uploaded to the Intranet.	Senior IP&C Nurse September 2020

Finding 4 - Reporting to the UHB Quality, Safety and Experience Committee (Operating effectiveness)	Risk
The Infection Prevention Control Group (IPCG) is required to report to the Board via the Quality, Safety & Experience (QS & E) Committee in accordance with their Terms of Reference. A highlight report of the Health Board's performance against Health Care Associated Infections (HCAI) targets is taken to the Committee by the Executive Nurse Director and Chair of the Group half yearly in June and December. The half year position against the HCAI targets (Jan to June) is reported to the December Q, S & E committee meeting and the full year figures (Jan to Dec) is reported to the June meeting. IP & C matters are discussed at Clinical Board QS & E meetings, and the minutes of each Clinical Board's QS & E meetings are also presented to the Health Board QS & E Committee. In addition the IP & C Senior Nurse periodically prepares update reports for the Health Board QS & E Committee when requested by the Executive Nurse Director. However this is not done on a regular basis. The most recent report was submitted to the Committee in December 2018. It was also identified from a review of the Health Board Quality, Safety and Experience Committee minutes between April 2018 and December 2019 that the	The UHB fails to prevent the spread of infection.

minutes of the IPCG which meets quarterly are not being presented to the UHB's Q, S & E Committee.	
Recommendation	**Priority level**
The minutes of each IPCG meeting should be presented to the Health Board Quality, Safety and Experience Committee for information and monitoring purposes. The IP & C Senior Nurse should prepare update reports for the Q, S & E Committee on a more regular basis. We would suggest half yearly updates for reporting in September and March each year, in between the HCAI highlight reports submitted in June and December each year.	**High**
Management Response	**Responsible Officer/ Deadline**
IPC reports to QSE bi-annually as part of the Health and Care Standards self-assessment and follow up report. Exception reports are brought as appropriate. Reporting mechanisms to QSE currently under review and future IP&C reporting will align with the output of that review.	Deputy Executive Nurse Director September 2020

Finding 5 - IP & C Audit Programme (Operating effectiveness)	Risk
In accordance with the IPC Annual Programme and the HCAI Framework, the IP & C Team undertake an annual programme of IP & C audits. The full range of IP & C audits covers Environmental, Commode, Hand Hygiene & Bare Below Elbows, Bed Audit, Mattress Audit, Equipment, Linen, MRSA, PVC / VIPS and Urinary Catheter. There is a standard audit programme and documentation to record the results of each audit which are carried out without prior notice. A central record is maintained of the audits carried out at each site and the results of the audit. Once completed the results of the audit are shared with the audited area, and where standards were found not to have been met the audited area is required to provide an Action Plan to the IP & C Team. The audit programmes and record of audits undertaken at UHW, UHL and outlying hospitals were reviewed for adequacy and to assess whether the number of audits carried out during 2019 was reasonable and in line with the requirements of the IPC Annual Programme. Our review of the audit logs identified that no audits were undertaken at UHW during November 2019, no audits were undertaken at UHL during October and November 2019 and audits were only undertaken during May 2019 at outlying hospitals. In addition, no CVC/VIPS or Catheter audits had been carried during 2019/20 in UHW, no Bed, Mattress or CVC/VIPS audits had been undertaken during 2019/20 at UHL and there was generally a downward trend in the number of audits carried out at both UHW and UHL during 2019/20. Where standards were not being met there was also an absence of Actions Plans recorded as being received by the IP & C Teams.	The UHB fails to prevent the spread of infection.

Recommendation	Priority level
The IP & C Team should consider how the number of IP & C audits undertaken can be increased. An annual programme of planned IP & C audits should be drawn up with targets set for the number of audits to be carried out by type and area. Where it becomes clear that targets will not be met, priority should be given to the most high risk audits / areas. Reminders should be sent to those areas that have unacceptable audit results but do not submit action plans.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The IPC Team are now at full complement which will allow for more audits to be undertaken. This was a priority set for 2020 but has been impacted by COVID-19; we will be reviewing through 2020.	Senior IP&C Nurse December 2020

Finding 6 - Root Cause Analysis (Operating effectiveness)	Risk
A sample of 5 completed Root Cause Analysis (RCA) forms was reviewed to ensure they had been fully completed and returned in a timely manner. Although all the RCA's tested had been completed in a timely manner, two of the five had not had any medical engagement. Within the Health Board when a test result is reported as positive by the Microbiology Lab for infections such as CDIFF or MRSA the test result is recorded on the ICNET system. The result of the test is e-mailed to the relevant department / ward and the IP & C team will also be notified. On receipt of the positive test the IP & C team will then issue a standard e-mail with templates for the department / ward to complete a Root Cause Analysis (RCA) and Lessons learned Summary. The RCA should be completed jointly by both Nursing and Medical staff. However review of a sample of completed RCA forms identified that in some instances there was a lack of medical engagement when undertaking the RCA investigation. This lack of engagement was confirmed by the IP & C Senior Nurse.	The UHB fails to prevent the spread of infection.
Recommendation	**Priority level**
Staff completing RCA investigations should be reminded that they should be undertaken jointly by Nursing and Medical staff.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Ruth/Jason	

Finding 7 - Incident Log / Outbreak Tables (Operating effectiveness)	Risk
Notification of infections, mainly Norovirus, influenza and Diarrhea & Vomiting come directly from the affected areas, either by e-mail or telephone, and these are recorded in a log as they often result in the closure or partial closure of a ward and loss of beds. For each entry on the log an Incident & Outbreak Table is completed by the IP & C Team. This is updated daily and distributed to all relevant parties until the infection ends. Data from the log is used for reporting purposes. A random sample of 10 entries was selected from the log. These were checked to ensure that for each one an Incident & Outbreak Table had been properly completed at the time of the incident, and that the details on the log matched those on the outbreak table. Our testing identified instances of the end date of infections not being recorded on the incident log; the number of infected patients and staff and number of bed days lost being incorrectly recorded; duplicate Outbreak Tables for one incident showing different data for the same infection and one Outbreak Table for which there were no entry's on the log. This could lead to the reporting of incorrect or inaccurate infection data.	The UHB fails to prevent the spread of infection.
Recommendation	**Priority level**
Management should put checks in place to ensure that the data recorded in the Incident Log matches the details recorded in the Outbreak Tables.	**Medium**
Management Response	**Responsible Officer/ Deadline**
This will be reviewed routinely in the future	Senior IP&C Nurse

Finding 8 - Attendance at Clinical Board IPC and QS & E Meetings (Operating effectiveness)	Risk
The nurses within the Infection Prevention & Control (IP & C) team attend Clinical Board Quality, Safety & Experience (QS & E) meetings and will provide feedback and updates from the Trust Board IPC Group. They will also provide advice to the Clinical Board on IP & C issues. The minutes of the Clinical Board QS & E meetings are presented to the Health Board Q, S & E committee meetings. The minutes of the CB QS & E meetings presented to the UHB QS & E meetings held on the 17/09/19 and the 17/12/2019 were reviewed to assess the level of attendance at CB QS & E meetings by representatives from the IP & C Team. Of the 29 meetings reviewed, only 13 (45%) had been attended by a representative from the IP & C Team, and none of the six CD & T meetings had any IP & C representation. We were informed that the CD & T, Surgery and Specialist Services Clinical Boards also have their own IP & C meetings that are attended by a representative from the IP & C Team. However it was noted from the minutes reviewed that IP & C issues were discussed at all 6 CD & T CB Q,S & E meetings reviewed, and there was IP & C representation at two of the three Surgery meetings reviewed and three of the five Specialist Services meetings reviewed.	The UHB fails to prevent the spread of infection.
Recommendation	**Priority level**
A lead nurse from the IP & C team should be assigned to each Clinical Board IP & C group and Q, S & E group. Where possible the designated lead nurse or a	**Medium**

representative from the IP & C team should attend all Clinical Board IP & C and Q, S & E meetings.	
Management Response	**Responsible Officer/ Deadline**
There is an IP&C nurse assigned to each Clinical Board who attends the Clinical Board Q&S meetings where possible. In future if they cannot attend they will send a representative on their behalf.	Senior IP&C Nurse

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.

Management of Health Board Policies and Procedures

Final Internal Audit Report

Cardiff and Vale University Health Board

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Service

Contents **Page**

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Committee:	Audit Committee

Audit and Assurance Services conform to 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 management of Health Board policies and procedures was completed in line with the 2019/20 Internal Audit Plan for Cardiff and Vale University Health Board.

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

The UHB has over 393 policies, procedures and other written control documents, including a number of All Wales NHS documents and excluding any deemed as 'local written control documents'.

The UHB's Corporate Governance Department provide a central contact, maintain a record of policies and procedures through use of a register, monitor review dates and arrange publication of documents.

The register is used as the main tool of management.

Local written control documents; such as departmental procedures are managed locally by respective authors. These are not overseen by the UHB's Corporate Governance Department. No count of these documents were obtained and these fall outside the scope of this audit.

2. Scope and Objectives

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

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

- The Health Board has appropriate guidance in place for the management of policies and procedures;
- The Health Board has an appropriate process for identifying, consulting and approving new policies, and for updating, consulting and approving existing policies.
- There is an appropriate process in place to ensure that staff and stakeholders are notified of new, amended and exiting policies.

3. Associated Risks

The potential risks considered in this review were as follows:

- There is inadequate structure and process to follow when developing or reviewing policies.
- Policies are inappropriately developed without relevant input from key staff and stakeholders.
- Policies have not been properly approved to confirm that they are fit for purpose and authorise implementation within the Health Board.
- Inappropriate decisions or working practices are undertaken due to a lack of awareness about new policies, changes to existing policies and policies that are no longer active.

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 Management of Health Board Policies and Procedures is **Reasonable Assurance**.

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

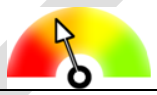
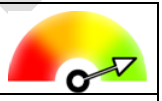
Overall, the UHB has controls in place to manage the risks identified in the audit scope, however the controls are not being consistently applied and operationally there are weaknesses.

The key issue identified relates to the significant number of out of date policies currently recorded on the register.

A number of additional issues were also identified including; non-compliances to the commitments set out in UHB 001, lack of register completeness and poor record keeping of communication for consultation and notifying staff of new, amended and exiting policies.

5. Assurance Summary

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

Assurance Summary					
1	The Health Board has appropriate guidance in place for the management of policies and procedures.		✓		
2	The Health Board has an appropriate process for identifying, consulting and approving new policies, and for updating, consulting and approving existing policies.			✓	
3	There is an appropriate process in place to ensure that staff and stakeholders are notified of new, amended and exiting policies.	n/a	n/a	n/a	n/a

** 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 management of policies.

Operation of System/Controls

The findings from the review have highlighted five (5) issues that are classified as weakness in the operation of the designed system/control for the management of policies.

6. Summary of Audit Findings

The key findings are reported in the section below with full details in the Management Action Plan under Appendix A.

Objective 1: The Health Board has appropriate guidance in place for the management of policies and procedures

The following areas of good practice were noted:

- The UHB has an up to date UHB001 Management of Policies, Procedures and Other Written Control Documents Policy which describes the UHB's "ways of working" regarding policies, procedures and other written control documents. This is supported by UHB 242 Written Control Documents - Development and Approval Procedure providing additional details on individual responsibilities for developing and reviewing written control documents.
- The UHB Corporate Governance Department maintains a register that records key information, including:
    - UHB reference number;
    - Title of Document;
    - Author;
    - Responsible owner / Executive Director;
    - Review date;
    - Approving group / committee;
- The UHB's Corporate Governance Department sends notifications to policy authors / owners of upcoming review dates. A separate tracker database is managed to view progress of the review process.
- Both UHB 001 and UHB 242 is in date and easily available through the UHB internet and or intranet sites.
- In comparing best practices across three Health Boards and two trusts, the following best practices were identified as present in Cardiff and Vale UHB:
    - A minimum of 28 days consultation period which is more than most organisations.
    - The UHB is committed to providing combined EHIA to all policies (and some procedures and written control documents).
    - Policies and procedures related to staff are reviewed by local negotiating committee as part of the approval process.
- A sample of forty (40) was selected based on the sampling selection process from the policy register.

- More than 98% were easily accessible from intranet and or internet sites.
- All were located corrected on the internet site.
- All had a document 'owner' and were approved by a committee or body.
- None of the older versions of the document remain accessible on the internet site.

The following significant findings were noted:

- Approximately 40% of the policies, procedures and written control documents maintained in the register appear to be currently out of date.
- The UHB's register may not be a complete record of policies, procedures and written control documents.
- There were notable non-compliances to commitments set out in UHB 001 Management of Policies, Procedures and Other Written Control Documents Policy.

Objective 2: The Health Board has an appropriate process for identifying, consulting and approving new policies, and for updating, consulting and approving existing policies.

The following areas of good practice were noted:

- A sample of two (2) recently created written control documents was selected based on the sampling selection process from the policy register.
  - All showed evidence that consultation took place and that they were approved by committee.
- A sample of four (4) recently reviewed written control document was selected based on the sampling selection process from the policy register.
  - All showed evidence of being sent to committee for approval or having been approved by committee.

The following finding was noted:

- For half of the sample of four (4) recently reviewed documents, no supporting documents could be located to confirm that consultation took place.

Objective 3: There is an appropriate process in place to ensure that staff and stakeholders are notified of new, amended and exiting policies.

Review of the process in place to ensure that staff and stakeholders are notified of new, amended and exiting policies could not be fully completed due to the COVID-19 outbreak.

We are therefore unable to provide assurance for this objective and the finding detailed below has not been taken into account when determining the overall assurance rating for the audit.

The following finding was noted:

- The current record keeping process is weak.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	**1**	**2**	**2**	**5**

Finding 1 – Out of date policies, procedures & written control documents (Operating Effectiveness)	Risk
The Health Board's guidance documents on the management of policies and procedures were in date and easily accessible through intranet and internet. A general review of the policy register identified that 41% of the policies, procedures and written control documents maintained in the register (393) appear to be currently out of date (161).	There is inadequate structure and process to follow when developing or reviewing policies.
Recommendation 1	**Priority level**
The UHB should ensure policies are reviewed and updated within appropriate timescales.	**High**
Management Response 1	**Responsible Officer/ Deadline**
A plan will be put in place to review all out of date policies and to contact document owners to update their policies. Due to activities which colleagues are dealing with in relation to COVID 19 the roll out of that plan will be delayed until Health Board staff have substantially returned to a business as usual position.	Head of Corporate Governance December 2020

Finding 2 – Completeness of the register of policies (Operating Effectiveness)	Risk
The Corporate Governance Department maintains a register of policies and other control documents and this is used as the main tool of management. But, testing indicates that the UHB register may not be a complete record of policies, procedures and written control documents. A general review of the '*A-Z*' of Policies located on the UHB intranet and '*policies and procedures*' five sections located on the UHB internet, indicate that there are approximately (1222) policies, procedures and written control documents available through intranet (824) and internet (398). Only 33% of these documents was identified on the policy register. The test result was derived based on matching the first 25 characters of the document title. Many of the policies, procedures and written control documents available through the intranet and or internet sites were not recorded in the register. However, it was not clear if any of the 67% of documents from the intranet and internet should actually be included in the register. Further review was undertaken of a sample of eighty (80) policies, procedures and written control document from the internet (398). Two (2) were not recorded in the policy register. One (1) was due for review, and it is not clear if this document is extant or has been made redundant.	There is inadequate structure and process to follow when developing or reviewing policies.

Recommendation 2	Priority level
1. Review the 'register' for completeness. Assess if all policies, procedures and other written control documents available on the intranet and internet are current and then ensure they are all recorded appropriately in the 'register'.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
A plan will be put in place to review the register for completeness and to consider that document alongside the written control documents available on the intranet and internet. It is assumed that not all documents available on the intranet and internet will fall to be monitored and maintained by the Corporate Governance team and plans will be put in place to correctly identify and collate those which are and those that will be monitored and maintained at a local level. Due to activities which colleagues are dealing with in relation to COVID 19 the roll out of that plan will be delayed until Health Board staff have substantially returned to a business as usual position.	Head of Corporate Governance December 2020

Finding 3 – Non-compliance with UHB 001 Management of Policies, Procedures and Written Control Document Policy. (Operating Effectiveness)	**Risk**
A sample of 40 (policies, procedures and written control document) was tested for compliance to the commitments set out in UHB 001 Management of Policies, Procedures and Other Written Control Documents Policy. UHB 001 is the primary policy for management of policies. The following non-compliance was identified: • *Our documents will be written in plain language* - Tested using StyleWriter software and NHS Digital Service Manual recommended SMOG analysis, 67% were non-compliant. • *Possible to find them easily on our internet and/or intranet sites* – Intranet - 25% of sample were located incorrectly according to type of document. • *Each document will have an "owner"* – All of the sample had an owner, but 33% (13 of 40) had a different owner to what was recorded in the register. • *A combined Equality and Health Impact Assessment (EHIA) will be completed for all policies* – Sample contained fourteen (14) policies and four (4) did not have a combined EHIA and no explanation provided – 29% non-compliant. More detailed testing of 40 sample identified incorrect information was recorded in the register, including: • 16 of 40 recorded an incorrect name compared to actual document title;	There is inadequate structure and process to follow when developing or reviewing policies

• 8 of 40 recorded an incorrect new review date; • 7 of 40 recorded an incorrect approving group / committee.	
Recommendation 3	**Priority level**
1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet. 2. Correct and improve accessibility of documents. Review publishing process to ensure documents are circulated through correct location in internet and/or intranet sites. 3. A combined EHIA should be completed for all policies or where a Health Impact Assessment is not required this should be clearly stated. 4. The Corporate Governance Department should ensure the integrity of the 'Register', by reviewing accuracy of all key information.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
Recommendations are noted and agreed. A plan will be put in place to action the recommendations and circulate appropriate messages to document owners to address the issues raised.	Head of Corporate Governance December 2020

Finding 4 – Non-compliance with the Development and Approval procedure. (Operating Effectiveness)	Risk
A total of 12 **existing policies**, procedures or written control document was reviewed during the period October 2019 to Feb 2020, of which four (4) were selected for detailed testing. Testing of the consultation and approval processes identified the following weakness: • No supporting documents could be located to corroborate that consultation took place for two (2) of the documents reviewed. It is also noted that evidence could not be located to confirm that the document was approved for one (1). The document was submitted for approval to appropriate committee in February 2020. However, no meeting minutes were available, possibly due to staff shortages and no subsequent meeting took place during COVID-19.	Policies are inappropriately developed without relevant input from key staff and stakeholders.
Recommendation 4	**Priority level**
Review of record keeping process for when a request is made to create **new** written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	**Low**

Management Response 4	Responsible Officer/ Deadline
Recommendations are noted and agreed. A plan will be put in place to action the recommendations and put in place appropriate processes.	Head of Corporate Governance December 2020

Finding 5 – Lack of evidence to support staff & stakeholder notification (Operating Effectiveness)	Risk
Review of the process in place to ensure that staff and stakeholders are notified of new, amended and exiting policies could not be fully completed. However, weaknesses were identified including: • Lack of record keeping. It was difficult to corroborate notification activity indeed took place. The Corporate Governance team does not keep a record of requests made to Communication Team. Supporting details from Communication Team could not be obtained due to COVID-19 circumstances.	Inappropriate decision or working practices are undertaken due to a lack of awareness about new policies, changes to existing policies, and policies that are no longer active.
Recommendation 5	**Priority level**
Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	**Low**

Management Response 5	Responsible Officer/ Deadline
Agree – Arrangements will be put in place to record when request are submitted to the communications team and when notifications are circulated.	Head of Corporate Governance December 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.

Pre–Employment Checks

Draft Internal Audit Report

Cardiff and Vale University Health Board

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Distribution: Martin Driscoll (Executive Director of Workforce, CVU)

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Sian Bryant (Recruitment Business Partner, NWSSP)

Nadia Bates (Recruitment, NWSSP)

Sandra Coles (Senior Nurse, Temporary Staffing Dept, CVU)

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

The review of the Pre-Employment Checks (PEC's) was completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board.

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

All NHS candidates must undergo and comply with NHS Wales Pre-Employment Checks as part of their on-boarding process. The Pre-Employment Checks process should form part of robust recruitment practices to ascertain a person's fitness and suitability for the role they have been conditionally offered, verifying they meet all preconditions of employment.

The Pre-Employment Checks process should comply with the NHS Employment Check Standards and all relevant regulatory requirements.

The Standards apply to all successful applicants including internal and external employees, and bank staff.

The Pre-Employment Checks for prospective Cardiff and Vale employees are carried out by the NHS Wales Shared Services Partnership (NWSSP) Recruitment Service, with the exception of medical and bank staff whose pre-employment checks are carried out by the Health Board itself. However, the Health Board retains responsibility for ensuring that staff do not commence employment without satisfactory completion of the checks.

Locum Doctors' pre-employment checks are not completed in-line with the six NHS Standards. Consequently, this area was not reviewed as part of this audit.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Pre-Employment Checks, in order to provide assurance to the Health Board Audit Committee that Pre-Employment Checks are completed in a correct and timely manner.

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

<u>Pre-Employment Checks</u>

- The Health Board and the NWSSP Recruitment Service has appropriate and up to date guidance in place for the completion of Pre-Employment Checks; and
- The six NHS Employment Checks Standards are fulfilled to verify an individual meets the preconditions for the role prior to commencing employment;

Timescales of Pre-Employment Checks

- Target timescales set in the Internal Fast Track Process are being met;
- Target timescales set for external applicants are being met; and
- Delays in the Pre-Employment Check Process are communicated effectively and common issues are identified and addressed appropriately.

3. Associated Risks

The potential risks considered in this review are as follows:

- Patient safety may be compromised if Pre-Employment Checks are not completed correctly;
- Target timescales are not met resulting in delays to the recruitment process and possible financial implications to the Health Board; and
- Non-compliance with the NHS employment Checks Standards.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Pre–Employment Checks process is **Reasonable Assurance**.

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

Overall, the controls in place to manage the risks associated with the systems and processes tested within the review are of a reasonable standard. However, we have identified a number of weaknesses in the areas reviewed.

We identified a number of issues concerning the Health Board and NWSSP's procedural guidance and process flow charts. Testing of pre-employment checks found some overall non-compliance with the six NHS Standards. We identified some weaknesses in communication between the Health Board and NWSSP concerning internal appointments.

The testing undertaken identified that pre-employment checks for both internal and external candidates are not always completed within the target timescales. It is however noted that the reasons for the delays generally relate to external issues that are outside the control of both NWSSP Recruitment and the Health Board.

One high priority issue was identified in this review concerning pre-employment checks undertaken for bank staff.

5. Assurance Summary

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

Assurance Summary					
1	Health Board & NWSSP Guidance			✓	
2	Completion of PECs prior to commencement			✓	
3	Timescales for Internal Fast Track Process			✓	
4	Timescales for External Candidates			✓	
5	Communication of Delays			✓	

** 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 six issues that are classified as weaknesses in the system control/design for Pre–Employment Checks.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system/control for Pre–Employment Checks.

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).

Pre-Employment Checks

Objective 1: The Health Board and the NWSSP Recruitment Service have appropriate and up to date guidance in place for the completion of Pre-Employment Checks

We note the following areas of good practice:

- NWSSP has up to date procedural guidance relating to the completion of Pre-Employment Checks and how to navigate the Trac system; and
- The Health Board has up to date procedural guidance for the recruitment of Medical Staff.

We identified the following significant findings:

- We found the Temporary Staffing Department do not have procedural guidance for bank staff recruitment.

Objective 2: The six NHS Employment Checks Standards are fulfilled to verify an individual meets the preconditions for the role prior to commencing employment

We note the following areas of good practice:

- All identification and supporting documentation is checked, signed and dated by the NWSSP recruitment team during the face to face pre-employment checks meeting to verify it's validity before being photocopied/scanned and uploaded to the central Trac system;
- Trac has a 'communications' section which logs all communications over the course of the pre-employment checks process, providing a comprehensive audit trail;
- All healthcare practitioners registrations/nursing PINs are checked online by NWSSP and Medical Work Force to verify their validity; and

- Before the unconditional letter is sent out, an ECO ('employment check O.K.') check is completed by NWSSP to ensure all PEC's have been completed accordingly.

We identified the following significant findings:

- We highlighted several non-compliances with the NHS Checks Standards whilst undertaking testing on temporary staffing recruitment which included: invalid documentation accepted as proof of identification and right to work in the UK, documentation not signed and dated as proof of validity by the individual undertaking the check and references did not cover a sufficient period of consecutive employment.

Timescale of PECs

Objective 3: Target timescales set in the Internal Fast Track Process are being met

We note the following areas of good practice:

- An E-bulk online electronic service is used for DBS referrals which speeds up the process when submitting multiple referrals;
- The Home Office 'Right to Work' online portal is used, where appropriate, to speed up the process in determining whether a non-UK individual has the right to work in the UK;
- Referees are sent four automatic reminder emails via Trac. NWSSP will manually chase outstanding references following this, where necessary. The Trac system sends automatic emails to managers when references require approval; and
- A file review is completed by NWSSP 5 days after the conditional offer letter is sent out. Progress is then checked on a daily basis.

We noted the following issue under this objective:

- Four of ten on-boarding times tested did not meet the target timescale; however, delays were due to issues outside of NWSSP control such as: delays with DBS applications and Occupational Health clearance and applicants awaiting exam results/professional registrations. Consequently no recommendation has been made for this objective.

Objective 4: Target timescales set for external applicants are being met

We note the following areas of good practice:

- Please see areas of good practice detailed in Objective 3 'Target timescales set for Internal Fast Track applicants are being met'

We noted the following issue under this objective:

- Seven of ten on-boarding times tested did not meet target timescale; however, delays were due to issues outside of NWSSP control such as: delays with DBS applications and Occupational Health clearance, postal verification being utilised as opposed to the face to face PEC meeting and invalid documentation being provided by the applicant. Consequently no recommendation has been made for this objective

Objective 5: Delays in the Pre-Employment Check Process are communicated effectively and common issues are identified and addressed appropriately

We note the following areas of good practice

- NWSSP send monthly 'Managers Updates - Outstanding Actions' reports to the Health Board notifying recruiting managers of any delays in the pre-employment checks process. Managers are expected to take relevant action to speed up any pre-employment checks relating to their applications;
- Recruiting managers are sent automatic weekly reports via Trac to update them of any open applications or vacancies; and
- On-boarding statistics for non-medical Health Board recruitment show an annual average compliance with the 27 day on-boarding target.

We identified the following findings:

- Pre-Employment Checks are not always completed prior to an internal candidate commencing employment. There appears to be a lack of communication between the Health Board and NWSSP regarding the completion of PECs and the confirmation of start dates.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**3**	**6**	**10**

Finding 1 - Procedures in place for bank recruitment pre-employment checks require review (Operating effectiveness)	Risk
We highlighted numerous non-compliances with the NHS Employment Checks Standards whilst undertaking testing on temporary staffing recruitment pre-employment checks. The non-compliances highlighted are as follows: • We found that Identification, Right to Work and Qualification documentation are not signed and dated as evidence of validity by the individual undertaking the pre-employment checks; • We found that downloaded bank statements had been accepted as valid proof of address; • We found that a downloaded E-P60 had been accepted as proof of right to work in the UK; • We found that references did not cover a consecutive two year period of employment/education prior to the applicant commencing post; • We found that dates detailed on references differed to the corresponding dates detailed on Trac; and • We found that Qualification Certificates/Proof of Registration are not uploaded to Trac.	Patient safety may be compromised if pre-employment checks are not undertaken appropriately

Recommendation	Priority level
Temporary Staffing Management should revise their current pre-employment checks procedures. The following highlighted areas should be considered for revision: • All original Identification, Right to Work and Qualification documents should be brought to enrolment and photocopied by the Temporary Staffing Department. All copies should be signed and dated and then uploaded to Trac as evidence of proof of validity by the individual undertaking the checks. Online/downloaded documentation should not be accepted as proof of identification or right to work in the UK • References should cover the consecutive two year period of employment/education prior to the commencement of post. Reference dates should correctly correspond to the dates detailed on Trac; • Original Qualification Certificates/Proof of Registration (i.e. screenshot of nursing PIN) should be uploaded to Trac to evidence the individual meets the criteria of the role conditionally offered; and • Management should inquire if 'Qualification Check' can be added to the Temporary Staffing Trac list of required pre-employment checks.	**High**
Management Response	**Responsible Officer/ Deadline**

Finding 2 - Internal applicants commencing post before PECs are completed (Operating effectiveness)	Risk
We tested the 10 individuals who had been on the December 2019 escalation report the longest. We found that 2 individuals were still listed on December 2019's report despite having start dates of February 2019 and October 2019, respectively. NWSSP confirmed that pre-employment checks had not been completed for either individual until January 2020. NWSSP were unable to confirm why these individuals had been able to commence employment without their PECs being completed. We contacted the recruiting managers to query these appointments and found that one individual had commenced and ended their secondment before their PECs were completed (no formal reason could be given for this). Similarly, the other individual had also started their secondment before PECs were completed due to their manager believing the checks had been fully undertaken.	Patient safety may be compromised if Pre-Employment Checks are not completed appropriately.
Recommendation	**Priority level**
Health Board managers should be reminded that internal applicants cannot commence in post prior to pre-employment checks being fully completed. Managers should also be reminded to take notice of the weekly Trac update emails and the monthly escalation reports sent to them and regularly check on the progress of their applicants' pre-employment checks and take action as required to speed up the process. Managers should be encouraged to use Trac to keep up to date with progress of applications. The 'Managers Tips to Reduce Time to Hire' guidance should be circulated throughout the Health Board via email.	**Medium**

Management Response	Responsible Officer/ Deadline

Finding 3 - Procedural guidance required for bank recruitment (Control design)	Risk
We found the Temporary Staffing Department do not currently have any procedural guidance documents in place for bank staff recruitment.	Patient safety may be compromised if pre-employment checks are not completed appropriately.
Recommendation	**Priority level**
Temporary Staffing Department management to familiarise themselves with the NHS Employment Checks Standards and implement appropriate procedural guidance, ensuring it satisfies all requirements/criteria of the Standards.	**Medium**
Management Response	**Responsible Officer/ Deadline**

Finding 4 - Reference Checks for Consultants (Operating effectiveness)	Risk
During the course of the audit we tested five consultants' references. As per the Medics Recruitment guidance, a minimum of 3 references should be sought for consultants before the post can be confirmed. The 'Medical/Dental Workforce Department - Recruitment and Selection Guidance for Hospital Doctors and Dentists' reads; *'For Consultant appointments, a minimum of three references are sought - at least one of which must be from the current or most recent employer. All instances where the applicant has been employed by more than one employer in the last three years, references are sought from at least two employers within that period including one from the current or most recent employer. Additionally for Consultant posts, if the applicant's current or most recent employment has been in a substantive Consultant post or in a Locum Consultant post for a period exceeding 12 months then a fourth reference is sought from the relevant Medical Director.'* We found only two references were obtained for 4 of the 5 consultants prior to the post being confirmed.	Patient safety may be compromised if Pre-Employment Checks are not completed appropriately.
Recommendation	**Priority level**
Management to review the process for Consultant reference checks to ensure it adheres to the relevant guidance.	**Medium**
Management Response	**Responsible Officer/ Deadline**

Finding 5 - SLA to be reviewed (Control design)	Risk
The NWSPP SLA highlights the on-boarding process. It specifies the responsibilities of NWSPP and the Health Board during the PEC process. The current SLA covers the period 2017-18. We found no evidence to suggest this has been reviewed since its completion in November 2017.	Patient safety may be compromised if Pre-Employment Checks guidance is not correct and up to date.
Recommendation	**Priority level**
Management to review the Employment Services SLA.	**Low**
Management Response	**Responsible Officer/ Deadline**

Finding 6 - Recruitment Process Flowcharts to be reviewed (Control design)	Risk
We found there are Fast Track and External flowcharts that specify target timescales for the on boarding of non-medical staff. We found the Internal Fast Track Process flowchart does not identify a completion or review date so we were unable to ascertain when this was last reviewed. Testing showed that several fast track processes could not be utilised due to limitations in NWSSP document accessibility and DBS checks lasting a limited period. These limitations often result in fast track recruitment exceeding the 5-14 day target. The External Recruitment flowchart detailed a completion date of November 2016. We found there was no evidence of this flowchart being reviewed since its completion.	Patient safety may be compromised if Pre-Employment Checks guidance is not correct and up to date.
Recommendation	**Priority level**
Management to review Internal and External Recruitment Process Flowcharts and determine if their content is relevant.	**Low**
Management Response	**Responsible Officer/ Deadline**

Finding 7 - Reference guidance to be reviewed (Control design)	Risk
When examining procedural guidance relating to reference checks we noticed some contradicting information between the NHS Standard and Shared Services Reference Guidance. The NHS Employment History and Reference Checks Standard details the following, '*For new appointments from outside of the NHS, employers should seek the necessary references to validate a period of* ***three consecutive years*** *of* ***continuous employment*** *or training immediately prior to the application being made*', whist the Shared Services Reference Guidance details, '*Recruitment will request two written references covering the* ***last two years*** *of employment and/or education history... Where an appointee has been with the same employer for over two years one reference is sufficient. Should an applicant have more than two employers within the last two years references should cover a sufficient period of time i.e. 12-18 months, a pragmatic approach should be taken to the number of references requested i.e. not exceed three references'.*	Patient safety may be compromised if Pre-Employment Checks guidance is not correct and up to date.
Recommendation	**Priority level**
Management to review the apparent contradicting information found in the NHS Reference Standard and the NWSSP Reference Guidance and determine which is more relevant. Management should consider updating the guidance if necessary.	**Low**
Management Response	**Responsible Officer/ Deadline**

Finding 8 - Reference Checks for Non-Medical Staff (Operating effectiveness)	Risk
When undertaking the non-medical staff testing we highlighted the following issue pertaining to one individual's reference checks: Two references were obtained for one employee covering a total period of June 18 - Jan 2020. Reference 1 was detailed as covering period June 2018 - January 2020 on the application form however the reference itself detailed covering period June 2019 - December 2019. Following a failed reference attempt of obtaining a second reference, NWSSP requested a third referee's details. The applicant's sister, a supervisor at a restaurant, submitted this reference (which covered period June 2018 - January 2020). At no point did the applicant detail this restaurant as a place of work on their application form. We feel this may be a potential validity issue.	Patient safety may be compromised if Pre-Employment Checks are not completed correctly. Non-compliance with the NHS employment Checks Standards.
Recommendation	**Priority level**
NWSSP Recruitment and Health Board recruiting managers to be reminded of the importance of considering validity of references when undertaking and approving pre-employment checks.	**Low**
Management Response	**Responsible Officer/ Deadline**

Finding 9 - CVU Guidance to be reviewed/updated (Control design)	Risk
We reviewed the CVU policies/procedures listed in the CVU Recruitment Policy. We found that numerous policies/procedures are overdue review. We highlight the following potential issues: • Testing showed secondment recruitment breached the pre-employment checks standards. There is currently no information pertaining to pre-employment checks in the Secondment Policy. The policy has not been reviewed since March 2016. • We found the following detailed within the Recruitment of Locum Doctors and Dentist Policy, '*the CRB check procedure should be carried out'.* The Locum Recruitment Policy has not been reviewed since July 2015.	Patent safety may be compromised if pre-employment checks are not completed appropriately.
Recommendation	**Priority level**
Management should review all supporting policies/procedures listed in the CVU Recruitment Policy. Management should review and consider updating the Secondment Policy to include the requirement for pre-employment checks to be completed before an employee can commence in a secondment post. Management should review the Recruitment of Locum Doctors and Dentists Policy, ensuring all terminology is relevant.	**Low**
Management Response	**Responsible Officer/ Deadline**

Finding 10 - Letter sent to successful bank applicants requires updating (Control design)	**Risk**
We highlighted a concern regarding the standard letter sent out with the conditional offer of appointment of successful bank applicants; it informs the applicants of what identification documents they need to provide in order to satisfy the identity pre-employment check. The letter details the following, '*We require a total of 3 forms of ID consisting of utility bill, bank or Credit Card statement, Council Tax information or HMRC Tax details, no more than 3 months old, Passport or Driving Licence*'. This requirement does not match that of the NHS ID Check Standard which specifies the following: *'Prospective employees will need to provide one of the following combinations: – Two forms of photographic personal identification from List 1, and one document confirming their current residing address from List 2. – One form of photographic personal identification from List 1, and two documents confirming their current residing address from List 2.'*	Patient safety may be compromised if pre-employment checks are not completed appropriately.
Recommendation	**Priority level**
Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.	**Low**
Management Response	**Responsible Officer/ Deadline**

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.

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 **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.

Strategic Planning / IMTP

Draft Internal Audit Report

2019/20

Cardiff and Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Abigail Harris, Executive Director of Planning
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Committee:	Audit Committee

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1. Introduction and Background

The review of the Cardiff and Vale University Health Board (the UHB or the 'Health Board') Strategic Planning / Integrated Medium Term Plan (IMTP) processes was completed in line with the 2019/2020 Internal Audit Plan.

The UHB has a statutory duty to operate within the bounds of a Welsh Government approved IMTP. Reviewed annually, the NHS Planning Framework sets out the core content expected within the IMTP.

The IMTP is the key planning document for the UHB and sets out the milestones and actions they are taking and the expected outcomes, in order to progress implementation of Shaping Our Future Wellbeing, the UHB's ten year strategy.

The UHB 2019-22 IMTP was formally approved by Welsh Government. This is the first occasion that the Health Board has had its IMTP approved, having previously been subject to an annual planning process as it was unable to submit a balanced IMTP.

The processes for developing and implementing the UHB's IMTP have been covered as part of previous Internal Audit reviews. The current review will therefore focus on the processes for the development, review and approval of business cases (BCs) for key service developments included within the Health Board and individual Clinical Board IMTPs.

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

2. Scope and Objectives

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

The scope of the audit was to establish if robust processes are in place for the development, evaluation and approval of business cases to ensure that appropriate key developments included within IMTPs are progressed.

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

- The Health Board has appropriate and up to date business case procedures and standard documentation in place;
- Clinical Boards undertake a robust process for the development of business cases, in accordance with any Health Board procedures and utilising any standard documentation;
- The Health Board has a robust process for evaluating and approving submitted business cases; and

- Approved business cases are subject to on-going monitoring / review of outcome measures to determine if the service changes are delivering the anticipated objectives.

In order to assess the robustness of the system, the following 2 business cases were selected for review:

- **Diabetes Enhanced Service BC**: This is a Welsh Government allocation for 2019/20 - A Healthier Wales, in response to the long term plan for Wales. The development of the business case and specification for the service was dictated by Welsh Government. There was a requirement for the health board to perform a quality and assurance review rather than the usual approval as required of a typical business case.
- **Overseas Nurse Recruitment BC**: This was led corporately, however owned by staff in the Medicine and Surgery Clinical Boards. As the two major clinical boards with the highest level of vacancies they were required to provide business cases which were integrated into one business case. The recruitment of the overseas nurse's scheme came up as a part of the objectives of the Project 95 group. This was developed over three years ago for the continual recruitment of band 5 staff. Some of the group's objectives involved the recruitment, retention and constant monitoring of nursing staff numbers.

3. Associated Risks

- Business cases are not developed in a consistent format and / or to the required standard;
- Inappropriate service changes / developments are implemented; and
- Service changes do not achieve the anticipated objectives.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Strategic Planning / IMTP is **Reasonable Assurance.**

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

The current review has identified that there are generally good processes and controls in place for managing the risks associated with the development, evaluation approval and implementation of business cases.

There is a Health Board Business Case flow chart in place, however this needs to be updated to reflect the current practices of the system.

There was evidence that Clinical Boards and key staff responsible for the preparation of the business cases were being adequately supported by the corporate planning team.

The two sampled business cases had relevant backing and supporting documentation which explained the basis and need to fund the project. Although the selected copy of the business case documents were either not signed or only partly signed by key staff, they were found to be comprehensive having relevant fields to ease review and enable the Business Case Approval Group (BCAG) to reach an appropriate decision.

Adequate processes are in place for monitoring the on-going delivery of the developments and service changes that have been approved and funded through the business case process.

5. Assurance Summary

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

Assurance Summary					
1	Appropriate Procedures			✓	
2	Robust development of Business Case			✓	
3	Robust Evaluation Process of Business Case			✓	
4	Clinical Board On-going Monitoring				✓

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

Design of Systems/Controls

The findings from the review have highlighted 1 issue that is classified as weakness in the system control/design for Strategic Planning / IMTP.

Operation of System/Controls

The findings from the review have highlighted 3 issues that are classified as weaknesses in the operation of the designed system/control for Strategic Planning / IMTP.

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: The Health Board has appropriate and up to date business case procedures and standard documentation in place

The following area of good practice was noted:

- There is a Health Board Business Case flowchart in place which provides guidance on the stages and standard documents to be used for the production and approval of business cases.

The following significant finding was noted for this objective:

- On review of the Business Case flowchart, it was observed that it required updating and improved positioning for easy accessibility on the intranet.

Objective 2: Clinical Boards undertake a robust process for the development of business cases, in accordance with any Health Board procedures and utilising any standard documentation

The following areas of good practice were noted:

- The sampled business cases have been appropriately developed having backing documents to support why the business cases should be approved. Key persons were engaged and supported within relevant Clinical Boards. Input from (and not limited to) the following staff were used in the compilation of the business cases.
  - GPs;
  - Clinicians;
  - Finance; and
  - Procurement.
- Each business case has key leads. The Diabetes Enhanced Service BC was led by a key staff member in the Primary, Community and Intermediate Care (PCIC) Clinical Board while the Overseas Nurse Recruitment BC was led corporately, however owned by staff in the Medicine and Surgery Clinical Boards.
- IMTP Workshops are usually held and localities were asked for their input. In relation to 2019/20, there were two main types of IMTP session/ workshops held in the PCIC Clinical Board.
  - IMTP Development Sessions for the IMTP 2020-2023; and
  - IMTP Progress Sessions for the IMTP 2019/20 Priorities.
- The following actions were undertaken to help inform the production of a business case for overseas nursing staff:
  - There was a review of the position of the nurse staffing levels against the expected forecast at the corporate level. An update was presented to the Management Executive Team, the outcome from the review showed that all areas except the Medicine and Surgery Clinical Boards had exceeded the substantive filling of the band 5 posts.
  - A check was also done on the level of staff retention on the last round of recruitment where it was found that there was a higher level of retention rate of Nurses from Non EU Nurses.

The following significant finding was noted for this objective:

- On review of the business cases it was observed that they had not been appropriately signed off.

Objective 3: The Health Board has a robust process for evaluating and approving submitted business cases.

The following areas of good practice were noted:

- A standard process is followed, however, this is usually based on the nature and type of business case as some are initiated corporately/ at the Clinical board level while some schemes are externally funded;
- The Corporate Planning team meets with the Clinical Boards and Executive leads where they work through the IMTP priority list;
- There is a Business Case Approval Group (BCAG) which meets monthly. The group is made up of members of staff representing the relevant areas with the required level of specialisation. They come together to scrutinise business cases and they also undertake assurance reviews particularly relating to external funding;
- The Corporate Strategic Planning lead sends emails out to the Clinical Boards with a list of business cases and key events with deadlines;
- The BCAG works using an action plan document, all business cases (both approved and unapproved) are stated within this document. It summarises the business cases to be reviewed for the period indicating the dates these reviews should take place, dates they have taken place (if already undertaken) and states the cost implication; and
- A BCAG decision report is prepared and presented at the Management Executive meeting.

The following significant finding was noted for this objective:

- The decision report was not used to document the position of one of the two business cases reviewed.

Objective 4: Approved business cases are subject to on-going monitoring / review of outcome measures to determine if the service changes are delivering the anticipated objectives.

The following area of good practice was noted:

- There are reasonable measures in place regarding the monitoring of the outcome of the approved business cases in relation to the nature and level of completion of the two selected business cases.

There was no significant finding noted 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**	**2**	**2**	**4**

Finding 1 - Update of Business Case Guidance document (Control design)	Risk
The available business case guidance document is in a flow chart format. The flow chart was noted to have been produced in April 2016 showing the various stages and documents used for the preparation of a business case which feeds into the IMTP. The flow chart was reviewed to establish its relevance to the current system in operation. Below are some of the findings: • The 'Health System's responsibility' stated within the flow chart should actually be the 'Management Executive responsibility' • The development of PODs was still included as one of the documents to be completed during the process. This document has been taken out of the current process as it is seen as a duplication of the business case. • The BCAG decision report was not referenced within the flowchart. Also, at the documentation of the system / process stage, a '1 page pro forma' document was mentioned during discussion with the Corporate Strategic Planning Lead as being essential. However, this was not used as a part of the process during the period under review, although it was said to be used previously and going forward. Use of this pro forma was also not stated within the flow chart, indicating that further update of the guidance/ flowchart is required. It was observed that the flowchart guidance document can be found in the following locations:	Business cases are not developed in a consistent format and / or to the required standard

• On the intranet, where it is located as an appendix within the BCAG Terms of Reference (ToR). • Within a shared drive which is only accessible to the BCAG, Finance and the Planning team. These locations do not ensure that the guidance document is easily accessible to all staff.	
Recommendation 1	**Priority level**
Management should ensure that the business case procedural document (flowchart) is up to date and reflects the current system in place regarding the processing of projects/ schemes from the point of inception down to the stage of approval. Each stage/ document/ process within the flow chart should be individually reviewed for relevance and where required elements should be added or removed. Management should also ensure that the business case flowchart is made available in a location easily assessable to other members of staff.	**Medium**
Management Response	**Responsible Officer/ Deadline**

Finding 2 - Business Case (Operating effectiveness)	Risk
In order to ensure that the business cases go through a robust process during development in accordance with the Health Board procedures and utilising any standard documentation, two business cases which had been approved for funding were selected for review. The business case document has a section which requires an approval sign off from the Clinical / Service Board Director or Departmental Director and Chair of the BCAG. Below are the findings of the business cases which were selected for review to ensure that they were adequately signed off as required: • **Diabetes Enhanced Service BC** was led by the PCIC Clinical Board. The business case form was not signed by BCAG chair. • **Overseas Nurse Recruitment BC** which was led corporately by Workforce but owned by Medicine and Surgery Clinical board. The business case form was not signed by the required signatories.	Business cases are not developed in a consistent format and / or to the required standard
Recommendation 2	**Priority level**
Management should ensure that all key staff required to sign the business case complete and evidence sign off at the required stage.	**Medium**
Management Response	**Responsible Officer/ Deadline**

Finding 3 - BCAG Decision Report (Operating effectiveness)	Risk
The BCAG meet monthly to review the business cases as outlined in the already agreed action plan for the period. The outcome from the decisions made regarding the business cases are documented within the BCAG decision report. This states if the business case has been approved (or not) with any added note for the decision made. A Business Case Approval Group decision report is prepared for presentation at the Management Executive meeting. On request of the BCAG decision report for the 2 selected business cases, it was observed that one (Corporate - Overseas nurse recruitment) which was approved by the Chair's action was not captured within the BCAG decision report as required.	Inappropriate service changes / developments are implemented.
Recommendation 3	**Priority level**
Management should ensure that the due process and documentation required to document decisions of business cases are adhered to.	**Medium**
Management Response	**Responsible Officer/ Deadline**

Finding 4 - BCAG Terms of Reference (Operating effectiveness)	Risk
The Business Case Approval Group is responsible for the scrutiny and management of revenue based business cases and ensuring they are robust. They have ToR which govern the Group. The BCAG ToR was last reviewed in March 2017. It was stated within the ToR that they would be reviewed on an annual basis to ensure they remain relevant and up to date.	Inappropriate service changes / developments are implemented
Recommendation 4	**Priority level**
Management should ensure the ToR are reviewed and updated as required.	**Low**
Management Response	**Responsible Officer/ Deadline**

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.

Report Title:	**Good Governance during COVID 19**								
Meeting:	Audit Committee						**Meeting Date:**	28th May 2020	
Status:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Interim Chair of the Board**								
Report Author (Title):	**Director of Corporate Governance**								

1.0 Background

It is important that during the COVID 19 period good governance is maintained. However, systems and processes will need to be quicker and more efficient to enable decisions to be made at speed whilst still maintaining good governance and a clear audit trail.

This paper sets out the approach to be taken to ensure good governance, to ensure the Board can maintain its scrutiny and oversight and that decisions are made in the right place at the right time.

The paper also requests the Board to approve a temporary variation from our Standing Orders which provides the legal framework we are required to work within.

2.0 Current Situation

2.1 Governance Principles

The Board Secretaries Group has framed a number of governance principles that are designed to help focus consideration of governance matters over coming weeks and months.
These are:

• **Public interest and patient safety** - We will always act in the best interests of the population of Wales and will ensure every decision we take sits in this context taking into account the national public health emergency that (COVID-19) presents.
• **Staff wellbeing and deployment** – we will protect and support our staff in the best ways we can. We will deploy our knowledge and assets where there are identified greatest needs.
• **Good governance and risk management** – we will maintain the principles of good governance and risk management ensuring decisions and actions are taken in the best interest of the public, our staff and stakeholders ensuring risk and impact is appropriately considered.
• **Delegation and escalation** – any changes to our delegation and escalation frameworks will be made using these principles, will be documented for future record and will be continually reviewed as the situation unfolds. Boards and other governing fora will retain appropriate oversight, acknowledging different arrangements may need to be in place for designated officers, deputies and decisions.
• **Departures** - where it is necessary to depart from existing standards, policies or practices to make rapid but effective decisions - these decisions will be documented appropriately. Departures are likely, but not exclusively, to occur in areas such as standing orders (for example in how the Board operates), Board and executive scheme of delegation, consultations, recruitment, training and procurement, audit and revalidation.
• **One Wales** – we will act in the best interest of all of Wales ensuring where possible resources and partnerships are maximised and consistency is achieved where it is appropriate to do so.

We will support our own organisation and the wider NHS to recover as quickly as possible from the national public health emergency that COVID-19 presents returning to business as usual as early as is safe to do so.

• **Communication and transparency** - we will communicate openly and transparently always with the public interest in mind accepting our normal arrangements may need to be adapted, for example Board and Board Committee meetings being held in public.

2.2 Governance Structure

Attached at the appendix 1 is the Governance Structure which was approved by the COVID 19 Board Governance Group and circulated to the Board. The Structure has been developed to reflect Gold Command despite the organisation not strictly operating under a Gold Command and Control structure.

The Chief Executive, as Accountable Officer, has delegated authority by the Board to make decisions with regard to the management of the health board. Executive Directors have been delegated certain responsibilities and decision making powers through the Board's Scheme of Reservation and Delegation of Powers. These arrangements will remain in place with regard to the ongoing functioning of the organisation. In respect of COVID-19, the Chief Executive will deploy decision making through the established COVID 19 Strategic Group.

2.3 COVID 19 Board Governance Group

The COVID 19 Board Governance Group has been set up to ensure that there is appropriate scrutiny and governance over the decision making process during the COVID 19 period and to provide assurance to the Board that this is taking place. The Board Governance Group will also be able to sign off Chairs actions plus other significant decisions (which would normally be presented to the Board) on a weekly basis which would normally require the Chair, CEO and consultation with 2 IMs to take place. All actions approved by this Group will also be ratified by the Board in line with the normal process for Chairs actions.

The COVID 19 Board Governance Group will meet on a weekly basis and the minutes, resultant actions and the decision log of that meeting will also be shared with the whole Board.

The Group comprises the Interim Chair, Interim Vice Chair, Chair of Audit Committee, CEO plus a relevant Executive Director. The Director of Corporate Governance will also be in attendance.

In principle, the current Board scheme of delegation and specifically the matters the Board reserves for its own decision (schedule 1 of the Standing Orders) will remain. However, a number of changes, set out at appendix 3, are required to the Standing Orders during COVID 19 which require the approval of the Board.

2.4 COVID 19 Strategic Group

The COVID 19 Strategic Group meets twice weekly on a Monday and Thursday. It is Chaired by the Chief Executive with the Vice Chair being the Medical Director. The meeting also comprises all Executive Directors, Director of Transformation and Information, Director of Corporate Governance and the Director of Communications. The Group makes decisions about strategic matters. The minutes, action log and a decision log is kept of each meeting. The decision log from the Strategic Group is presented to the COVD 19 Board Governance Group for decisions, which the Strategic Group does not have the authority to authorise, to be approved.

2.5 Operational Group

The Operational Group meets daily, 7 days a week and is Chaired by the Chief Operating Officer. It is attended by the Triumvirate from the Clinical Boards plus other Executive Directors. It reports into the

Strategic Group and brings decisions to the Group which require the authority of the CEO and the Executive Directors.

2.6 Operational Structure

The Operational Structure has moved away from the Clinical Board Structure (although these will still remain in place) to a site based structure each led by a Local Co-ordination Centre which is open 7 days a week from 8am – 8pm. The four areas are:

- University Hospital for Wales
- University Hospital for Llandough
- Surge Hospital
- Community

Each site has a triumvirate in place which is led by the Clinical Board Director.

2.7 Board & Committee Meetings during COVID 19

The Board will continue to meet on a bi monthly basis however it will meet on a quorum basis only and draft minutes from the Board on decisions made will be published within 7 days of the Board meeting. Decisions from the COVID 19 Board Governance Group will be ratified by the Board in line with the Chair's actions process.

The arrangements set out at appendix 2 have been put in place in relation to the Committees of the Board. The meetings will all be held at Woodlands House with Skype facilities. Those who attend in person will be required to adhere to social distancing requirements. These arrangements have been previously circulated to the Board and are in line with what the All Wales Board Secretaries Group have agreed with Welsh Government.

The agenda's for the Board and for the Committees of the Board will be kept to a minimum and they will be agreed between the Chair and Executive Lead as per normal arrangements. The Board will not be meeting in person therefore Members of the Public will be unable to attend or observe. Details of how transparency and openness will be achieved are set out in appendix 3 of the report and included as changes required to Standing Orders.

2.8 Financial Governance

Welsh Government has issued financial guidance to NHS Wales organisations given the immediate challenges presented by the COVID-19 pandemic, recognising that routine financial arrangements and disciplines are disrupted and need to adapt on an interim basis. The guidance has been developed to support organisations and provide clarity on expectations for this disrupted period and until organisations return to business as usual arrangements.

A review of the guidance has been undertaken by the Director of Finance and the following agreed by the COVID 19 Strategic Group:

As we are currently bound by the scheme of delegation that is currently in place, the Director of Finance has recommended the following (to exclude the field hospital)

Delegation of Revenue authorisation

- UHB Operational Group (Chief operating Officer) delegated to make individual spending commitments up to £125k each
- Anything above this, and all novel and contentious items to be referred to UHB Strategic Group for a decision where the CEO has a delegation up to £0.5m

- All items above £0.5m to be referred to the Board via COVID 19 Board Governance Group or Chairs Action
- All expenditure approved by UHB Operational Group to be reported to UHB Strategic Group for information (along with justification).
- UHB Strategic Group to record all authorised expenditure (including justification) from UHB Operational Group, UHB Strategic Group and the Board.
- This is to cover all revenue expenditure (excluding the field hospital) including equipment, workforce, supplies and services, estates, external contracts and all other revenue expenditure

Delegation of Capital authorisation

- UHB Operational Group (Chief operating Officer) delegated to make individual spending commitments up to £125k each
- Anything above this, and all novel and contentious items to be referred to UHB Strategic Group for a decision where the CEO has a delegation up to £1.0m
- All items above £1.0m to be referred to the Board via COVID 19 Board Governance Group or chairs action
- All expenditure approved by UHB Operational Group to be reported to UHB Strategic Group for information (along with justification).
- UHB Strategic Group to record all authorised expenditure (including justification) from UHB Operational Group, UHB Strategic Group and the Board.
- This is to cover all capital expenditure (excluding the field hospital) that falls within this definition including works, IT equipment & medical equipment and all other capital expenditure

It was recommended to the Strategic Group that this authorisation framework be put in place immediately and that it be included within the Governance and delivery documentation so that these arrangements are integrated and visible.

We will of course attempt to recover revenue and capital funding from WG, as appropriate in the new finance regime that will be put in place for 20/21. This cannot however be guaranteed. Notwithstanding this we need to have robust and documented systems in place to evidence the required governance around this and record and justify the decisions made. It is likely that we will get audited on this once this crisis is over.

2.9 Risk Management Arrangements

During the COVID 19 period the four sites will maintain an operational risk register of the risks they are managing within their site. The template registers which have been developed need ot be able to deal with risks in a quick and efficient manner e.g. what is the risk, what is the action to manage or mitigate the risk who will be doing and by when. The registers will need to be dynamic to deal with a fast moving situation. The registers will be reviewed and updated on a weekly basis and reported into the COVID 19 Strategic Group. A Strategic Risk Register will also be developed which detail strategic risks to the Health Board during the COVID 19 Period. The Strategic Risk Register will be reviewed less frequently but likely to contain such risk as impact upon CIP, delivery of key targets, delivery of IMTP.

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

It is essential that Good Governance is maintained during COVID 19 so that a clear audit trail of decisions which have been made, both financial and none financial, can be demonstrated.

The Health Board still needs to demonstrate its compliance with Standings Orders and Schemes of Delegations so no Group or Director is acting ultra vires but the arrangements set out in this report allow for more flexibility and the efficiency which is required in a fast moving and evolving situation.

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

The arrangements set out in the report provide the Health Board with robust governance arrangements during COVID 19. Risk registers will be kept for the site hubs and a Strategic Risk Register will be developed for the issues the Health Board is dealing with.

5.0 Recommendation:

The Audit Committee is asked to:

(a) Note the report setting out the Governance Structure and arrangements during COVID19
(b) Note arrangements to the Board and Committees set out at paragraph 2.7 and appendix 2.
(c) Note the changes to Standing Orders set out in Appendix 3 of the report.

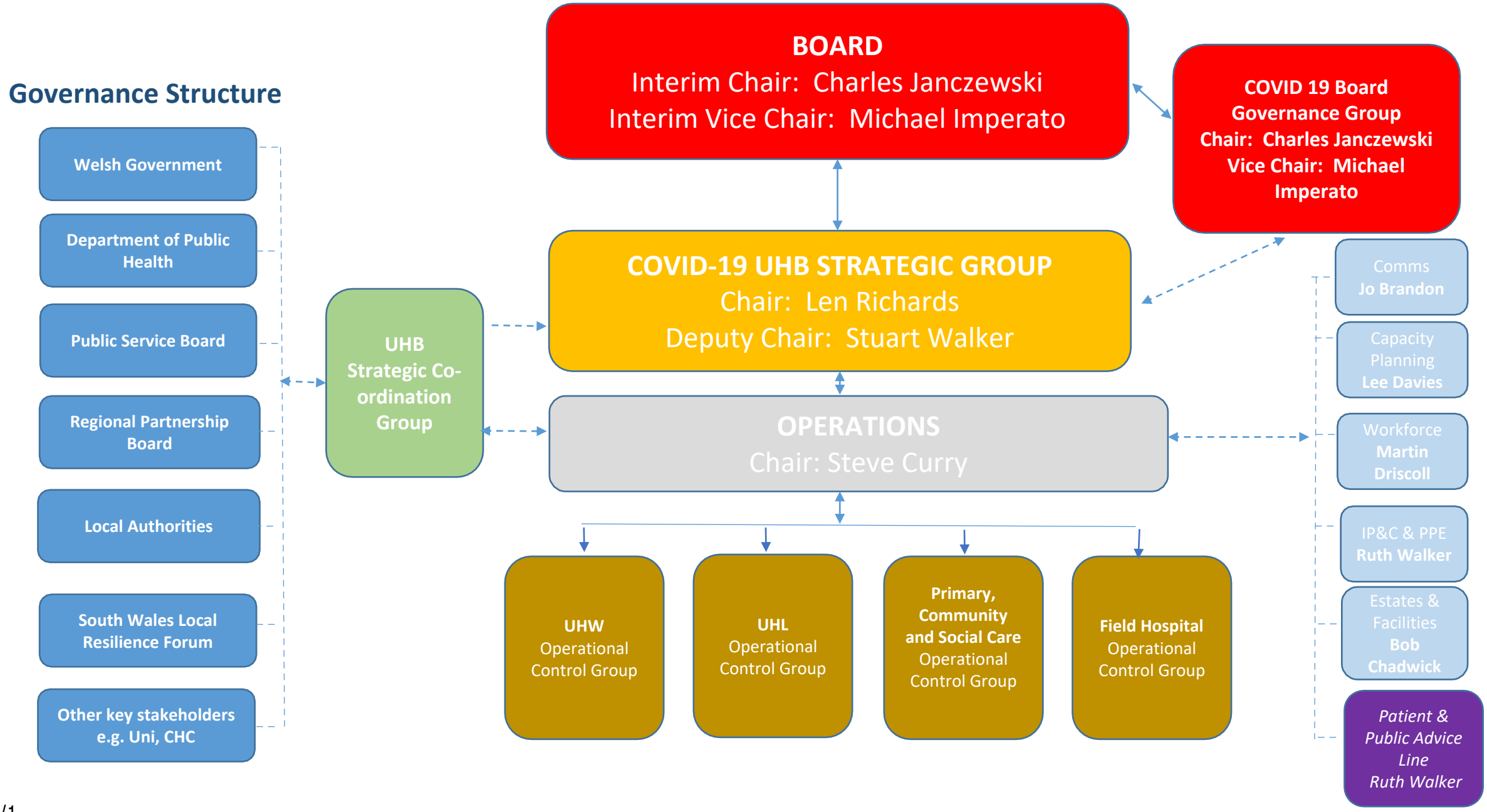
Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver 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.*

UHB GOVERNANCE AND DELIVERY ARRANGEMENTS FOR THE MANAGEMENT OF COVID – 19

Governance Structure



Committee	Dates of Meetings (March to August)	Actions
Board	26th March 28th May 30th July (AGM)	The Board Meeting on the 26th March 2020 will go ahead as planned. Further decisions will be made with regard to the May and July meetings in due course.
Board Development	30th April 25th June 27th August	Board Development and Briefing Sessions will stay in the diary, but are likely to be used as general briefing sessions for April, June and August, to cover areas such as COVID-19, workforce considerations, safety and quality issues and system governance.
Audit	21st April, 19 May, 28 May	Audit Committee will continue for its April and May Meetings to review the annual accounts, public disclosure statements and assurance for the audit opinion. Where possible the agenda will be reduced and items deferred. These meetings might need to take place virtually.
QSE	14th April 16th June 18th August	The Quality and Patient Safety Committee will take place on the 14th April, but with a shorter agenda. We may need to consider a virtual meeting. June and August dates will be kept in diaries and reviewed
Charitable Funds	17th March 5th May 4th August	Charitable Funds Committee on 17th March will proceed. The 5th May meeting will be cancelled. If Charitable Funds bids are received during the period they will go through the Executive Team as usual and virtual approval will be sought from the Committee as appropriate
DHIC	9th June	The June meeting will be cancelled
Finance	25th March 29th April 27th May 24th June 29th July 26th August	The Finance Committee on 25th March will proceed. April May and June meetings will be held and may need to be on a virtual basis. July and August meetings will be reviewed and remain in diaries at present

Health and Safety	7th April 30th June	April and June meetings will be cancelled. Reports relating to significant HSE cases or developments will be circulated to committee members for scrutiny
MHCLC	7TH July	To be reviewed and will remain in diaries at present
Strategy and Delivery	12th May 14th July	May meeting will be cancelled. July date will be kept in diaries and reviewed.

Standing Order	Heading	Proposed Variation for COVID 19
7.1	Putting Citizens First	Variation – The Board is unlikely to meet in person for foreseeable future and so will meet through electronic/telephony means. As a result of this, members of the public will be unable to attend or observe. To facilitate as much transparency and openness as possible at this extraordinary time, the Health Board will undertake to: •Publish agendas as far in advance as possible – ideally 7 days •Publish reports as far in advance as possible – recognising that some may be tabled and therefore published after the event. We will also increase our use of verbal reporting which will be captured in the meeting minutes •Produce a written summary of the key components of the meeting to be made
7.2	Board Plan of Business	Suspended for the foreseeable future
7.2.5	AGM Meeting	Welsh Government have confirmed that AGM are required to be held by end of November 2020.
7.4.3	Notifying and equipping Board Members	We will try our best to publish agendas 7 days in advance. We are unlikely to be able to publish papers at the same time, we will also be making greater use of verbal reporting which will be captured in the meeting minutes.
7.5	Conducting Board meetings Admission of the public, the press and other observers	Variation – The Board is unlikely to meet in person for foreseeable future and so will meet through electronic/telephony means. As a result of this, members of the public will be unable to attend or observe. To facilitate as much transparency and openness as possible at this extraordinary time, the Health Board will undertake to: • Publish agendas as far in advance as possible – ideally 7 days

		• Publish reports as far in advance as possible – recognising that some may be tabled and therefore published after the event. We will also increase our use of verbal reporting which will be captured in the meeting minutes • Produce a written summary of the key components of the meeting to be made