Bundle Audit Committee 4 December 2018

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8.3 To note the date of the next Committee meeting: 26th February 2019 at 9am, Corporate Meeting Room, HQ, UHW

9 Items to be Deferred to Board / Other Committee

10 Any Other Urgent Business

DECEMBER AUDIT COMMITTEE
9am on 4th December 2018
Corporate Meeting Room, HQ, UHW

AGENDA

1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Audit Committee meeting held on 25th September	Chair
5	Action Log	Oral Chair
6.0	**Items for Approval / Ratification**	
6.1	Board Assurance Framework	Director of Corporate Governance
6.2	Audit Committee Terms of Reference	Director of Corporate Governance
6.3	Audit Committee Work Plan 2019/20	Director of Corporate Governance
7.0	**Items for Review and Assurance**	
7.1	Internal Audit Progress Report Including Reports with **Limited Assurance**: (i) Mental Health Clinical Board Sickness Management (ii) Standards of Business Conduct (DoI and GH&S)	Head of Internal Audit
7.2	Wales Audit Office Report on Medical Equipment Management Response and Action Plan Update	Director of Therapies and Health Sciences
7.3	Tracking Reports	Director of Corporate Governance

7.4	Business Continuity Progress Report	Executive Director of Strategic Planning
7.5	Losses and Special Payments	Director of Finance
8.0	**Items for Noting and Information**	
8.1 8.1.1 8.1.2 8.1.3 8.1.4 8.1.5 8.1.6 8.1.7	Internal Audit Reports: **Substantial Assurance** Neurosciences IT System Follow Up Cost Improvement Programme **Reasonable Assurance** Shaping Future Wellbeing Capital Scheme Cleaning Standards Follow Up Carbon Reduction Commitment PCIC District Nursing Rotas Mental Health Section 17 Leave	Head of Internal Audit
8.2	Clinical Negligence Claims	Oral Executive Nurse Director
8.3	To note the date of the next Committee meeting: **26th February 2019 at 9am** Corporate Meeting Room, HQ, UHW	
9.0	**Items to be Deferred to Board / Other Committee**	Oral Chair
10.0	**Any Other Urgent Business**	Oral

Adjournment to Discuss Matters of a Confidential Nature

UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE
HELD ON 25 SEPTEMBER 2018
IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

John Antoniazzi	Independent Member and Chair, Audit Committee
Charles Janczewski	UHB Vice Chair
Dawn Ward	Independent Member, Trade Union

In Attendance:

Carol Evans	Assistant Director of Patient Safety & Quality
Craig Greenstock	Counter Fraud Manager
Christopher Lewis	Deputy Director of Finance
Ian Virgil	Deputy Head of Internal Audit
James Johns	Head of Internal Audit
Kimberley Rowe	Internal Audit
Mark Jones	Wales Audit Office
Mike Usher	Wales Audit Office
Nathan Couch	Wales Audit Office
Peter Welsh	Former Director of Corporate Governance
Rachel Burton (part)	Director of Operations, Children and Women
Sara Jeremiah (part)	Post Payment Verification
Simon Cookson	Internal Audit
Tom Haslam	Wales Audit Office
Paula Davies (part)	Lead Nurse in Community Child Health
Cath Heath (part)	Nurse Director, Children and Women Clinical Board

Secretariat	Julia Harper

Apologies:

John Union	Independent Member – Finance (Vice Chair – Audit)
Maria Battle	UHB Chair
Graham Shortland	Medical Director
Martin Driscoll	Executive Director of Workforce and Organisational Development
Nicola Foreman	Director of Corporate Governance
Robert Chadwick	Director of Finance
Steve Curry	Chief Operating Officer

AC: 18/046 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting. He also expressed his disappointment that no Executive Directors were in attendance.

AC: 18/047 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 18/048 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. Mr Charles Janczewski declared that he was Chair of the WHSSC Quality and Patient Safety Committee.

AC: 18/049 UNCONFIRMED MINUTES OF THE MEETING HELD ON 31 MAY AND THE SPECIAL AUDIT COMMITTEE ALSO HELD ON 31 MAY 2018

The Committee **RECEIVED** and **APPROVED** the minutes of the meetings held on 31 May 2018 and the Special Meeting held on the same day.

AC: 18/050 ACTION LOG FROM MEETING OF 31 MAY 2018

The Committee **RECEIVED** and **NOTED** the Action Log from the meeting of 31 May 2018.

Business Continuity Plan AC:18/022 – With no timescale identified for completion, it was agreed to ask the Lead Executive, the Director of Planning, for a written update for the December meeting.
Action – Mrs Abigail Harris

It was noted that Internal Audit would be following up this area of work in December.

It was **AGREED** that the Chair would remind Executive Directors that they could be called to the Audit Committee at any time.
Action – Mr John Antoniazzi

AC: 18/051 INTERNAL AUDIT PROGRESS REPORT

Mr James Johns provided the Committee with an update on the delivery of the agreed audit plan. He identified some areas of slippage and these would be brought to the December meeting.

Asked why some work resting with the Chief operating Officer had slipped, Mr Johns was unable to provide the reason, and Committee agreed that the reasons for delays had to be justified. It was agreed to follow this up outside the meeting.
Action – Secretariat

Eight audits had been finalized during the year and this presented a largely positive picture. Mr Johns advised that the result of the Charitable Funds audit had been revised to substantial assurance.

Mr Johns also referred to the delivery of the Audit Plan and the reasons for delays / changes to the Plan. It was noted that Management Executive received Internal Audit Reports but the Committee felt it was not getting the same assurances that action was being taken. Mr Johns advised that following receipt of the reports, the Director of Corporate Governance provided him with an update. Members felt that the Committee needed to receive better tracking and assurance and to be in a better position to chase areas where there was slippage.

Overall Mr Johns reported a positive picture and commented that high priority areas would be the key in follow-up audits. In terms of the status schedule of assignments, again it was felt that UHB tracking was vital in order to deal with issues before they were presented by Internal Audit.

Members highlighted paediatric/adult transition plans and expressed concern at the delays. As this was currently a very sensitive area within the UHB, it was agreed to ask the Chief Operating Officer to attend Committee to explain the findings.
Action – Secretariat

In terms of the completion of follow-up audits, Mr Johns reported that the 8 audits were fairly positive and that an updated timescale had been received for one low priority action to be implemented. A further 5 follow-ups were in progress, but there were some delays in management responses.

Concern was expressed about the limited and no assurance reports that had been discussed at Committee previously. It was hoped that in future, the Head of Internal Audit would discuss the reasonableness of timescales with the Audit Committee Chair.
Action – Mr James Johns

The Committee noted that the Audit Plan was changed in year in response to changing circumstances / priorities and the emergence of new risks. It was suggested that the Director of Corporate Governance could advise on how new risks were included on the risk register. It was reported that Management Executive received a quarterly report that looked back as well as forward at the different areas of work. In addition, the Chief Executive held an allocation of audit days to be used for current concerns not already included in the Plan. Wales Audit Office was mindful that risk registers were not as strong as they could be in Wales and that they needed to be linked to a comprehensive Board Assurance Framework.

Internal Audit reported that one of the follow-ups was overdue and had not yet commenced. It was delayed due to the volume of work of the IT specialist auditor.

Asked about the impact of limited and no assurance reports on the UHB's overall standing, it was noted that 8 domains had been agreed externally and with NHS Wales Board Secretaries, each with their own rules. Roughly, if 3 of the domains were assessed as limited assurance, it was likely that the overall opinion would be limited assurance although professional judgement was also used. In addition, all limited assurance reports were referred to Welsh Government to consider whether

intervention was required. It was therefore important for Members of the Committee to discuss with Internal Audit before the year end submission. It was noted that the biggest challenge would be where follow up audits did not demonstrate improvement.

The Committee **CONSIDERED** and **NOTED** the Progress Report against Plan.

AC: 18/052 CONSULTANT JOB PLANNING – REVIEW OF PROGRESS AGAINST RECOMMENDATIONS AND REVIEW OF ACTION PLAN

In the absence of the Medical Director, Committee considered the update provided and were dissatisfied as there were no milestones or trajectories that were considered fundamental for enabling the measurement of progress. It was vital, therefore, that a reasonable deliverable timescale was developed as a matter of urgency.

Options were discussed and it was agreed that the Medical Director be given the opportunity to deliver a specific plan. In support, it was suggested that the Medical Director may find it helpful to discuss with other heath boards how they tackled issues of culture. It was agreed that Mrs Carol Evans would feedback to the Medical Director so that he could prepare a report and provide assurance.
Action – Mrs Carol Evans
In the meantime, a separate meeting with the Medical Director and both Independent Members (Messrs Antoniazzi and Union) and Mrs Nicola Foreman had been arranged for 30th October.

AC: 18/053 CONTINUING HEALTHCARE FOLLOW-UP: REVIEW OF ACTION PLAN AND TIMESCALES

Ms Rachel Burton, Mrs Cath Heath and Ms Paula Davies attended the meeting for this item. Ms Davies advised the Committee that the only outstanding action was the production of an operational policy that was a very large piece of work. An expert had been commissioned to undertake scoping work and found there to be increasing differences of professional opinion from a variety of agencies. However, a draft joint operational policy had been produced in conjunction with the Cardiff and Vale of Glamorgan Local Authorities. A task and finish group had been established and milestones produced. A number of areas had been considered including finance, risk of capacity and gaps in mental health monitoring and assessment. Ms Davies assured the Committee that work was on track and that the joint policy would be agreed by the end of March, with all parties committed to this timescale. This work was complex and new to Wales.

Asked whether aspirations for joint commissioning were realistic, it was noted that funding needed to be explored further and this would form part of the next stage of the work. In the interim, written guidelines were in place.

It was agreed that in this particular instance, the follow-up timescale was unrealistic and therefore the second follow-up would be pushed back.

Action – Mr James Johns

The Committee **NOTED** progress which was inter-agency dependent.

AC: 18/054 WALES AUDIT OFFICE UPDATE REPORT AND MEDICAL EQUIPMENT UPDATE

Mr Mark Jones updated Committee on work in progress and highlighted that the audit of the Charitable Funds Accounts had been brought forward and would be considered at the meeting of the Trustees on 13th December. In addition, work was underway to start planning for the 2018/19 audit.

Mr Jones drew attention to the national and thematic reviews into Welsh Primary Care that were due at Committee in December. In addition, the Structured Assessment was underway covering governance and use of resources. A draft should be expected in November for comment. A review of clinical coding (follow-up from 2015) was also being undertaken.

A report into Welsh Primary Care Out of Hours had been published. This concluded that the UHB performed worst in Wales against the 1 and 6 hour clinical assessment targets. However, the UHB was the cheapest service in Wales. It was hoped that the fact that Cardiff was the fastest growing city could also be reflected in the report.

Mr Haslam advised Committee that a national report was being prepared into language and communication barriers, whilst local work included follow ups in theatres and outstanding IT related recommendations.

In relation to the Primary Care work the Committee was reminded that Healthier Wales Strategy had been launched and the follow up was not auditing against this new standard, rather against recommendations made against a different framework in 2014. The new Strategy changed everything and needed to be reflected and embraced as part of the upcoming review. On balance, it was considered that a good baseline was required before moving forward with the new structure in order to measure the benefits of the new Strategy.

Mr Tom Haslam explained that work undertaken last year on medical equipment was based on the recommendations made originally in 2013. In conclusion there had been some progress but only one recommendation had been implemented with 6 still in progress. A new single group had been established but its effectiveness and engagement was queried and the new role established had not provided the impact expected. Overall there was still a lack of clarity and a lack of Clinical Board engagement. No risks had been identified in the Clinical Board risk registers and there was no single inventory of medical equipment costing less than £5k. In addition, Clinical Boards did not have revenue funding to purchase such items.
Questions were asked about whether any serious incidents had been linked to issues of medical equipment as patient safety overrode finance and it was noted that the Quality Safety and Experience Committee received comprehensive information on

serious incidents. However, the impact on staff sickness and morale should not be overlooked. The recent bed replacement programme had not consulted staff and resulted in waste when the equipment purchased was not fit for purpose. Poor equipment affected productivity, efficiency and morale as staff felt undervalued when they could not access relatively cheap new equipment. It was queried whether this issue should be addressed by the Board.

It was agreed to discuss the management response in detail at the next Committee and if Members were not assured, then Executive Leads would be asked to give an account. In the meantime three Independent Members (Messrs Antoniazzi, Union and Ms Ward) would meet the Lead Executive(s) (Chief Operating Officer and Director of Therapies and Health Sciences) together with Mr Nathan Couch of WAO.
Action – Ms Dawn Ward

The Committee **NOTED** the update report.

AC: 18/055 WALES AUDIT OFFICE: FINANCIAL STATEMENT REPORT – RECOMMENDATIONS ADDENDUM

Mr Mark Jones from Wales Audit Office reported that reasonably good progress had been made against the feedback from the annual accounts and follow-up reports. Four had been actioned and 2 remained outstanding – asset management and identification. Finance processes were found to be fit for purpose but were not applied with sufficient consistency. This year's recommendations covered 10 areas and good engagement with officers was reported.

In response it was noted that progress had been made and action against some of the recommendations was not in the UHB's gift as dependent on Shared Services, but a commitment was given to try to resolve.

The Committee **NOTED** the Financial Statement Report.

AC: 18/056 TRACKING REPORT ON WALES AUDIT OFFICE RECOMMENDATIONS

The former Director of Corporate Governance, Mr Peter Welsh referred back to the number of comments already made by the Committee about good tracking. This format was under review and certainly required greater ownership and better quality information.

It was agreed that this should be a standing item at Committee and that an update on progress be provided at the next meeting.
Action – Secretariat and Mrs Nicola Foreman

In terms of feeding information back to Committees it was reported that a Protocol had been agreed at Management Executive. WAO reports would continue to be received

at the Audit Committee and the Chair of the Committee had authority to refer reports to Chairs of Board Committees if further information/assurance was required.

The Committee **NOTED** the Tracking Report.

AC: 18/057 STRUCTURED ASSESSMENT REPORT 2017 – 6 MONTH REVIEW OF PROGRESS AGAINST RECOMMENDATIONS

The former Director of Corporate Governance, Mr Peter Welsh reminded Committee that the Structured Assessment was received in April when a 6 month progress report was requested. Mr Welsh gave assurance that each recommendation had been allocated to a Lead Executive and Committee. Whilst there had been some progress, there was more to be done and a further update would be provided in 6 months – February 2019.
Action Mrs Nicola Foreman

The Committee **NOTED** the Structured Assessment Report 2017.

AC: 18/058 POST PAYMENT VERIFICATION PROGRESS REPORT

Ms Sara Jeremiah attended for this item and reported that a training pilot was being progressed with Aneurin Bevan Health Board with a view to rolling out across Wales. Practices were being reminded of the need for accuracy in their returns, but a problem of using untrained staff in larger practices was identified as an issue and this meant more time to check returns was needed. Staff had been into the larger practices to stress the requirement for training and had provided templates for completion in an attempt to reduce admin costs and ensure clinically safe processes were used.

In terms of the low recovery rate it was explained that this was due to the preventative work undertaken beforehand and claims were no longer paid if they were not completed properly.

Members felt the report lacked comparison, did not sufficiently demonstrate improvement and some graphs did not make sense without explanation. It was hoped that this would be addressed in future reports.
Action – Sara Jeremiah

The Committee **NOTED** the Post Payment Verification Progress Report.

AC: 18/059 REGULATORY AND REVIEW BODIES TRACKING REPORT

The former Director of Corporate Governance, Mr Peter Welsh presented the report that monitored external reviews / inspections and advised that the format required review. In addition, it was noted that not all reports came through HQ and instead went straight to the respective Clinical Board and it was possible that some were not

captured. Therefore, there was more work to be done with the Chief Operating Officer.

The Committee **NOTED** the Regulatory and Review Bodies Tracking Report.

AC: 18/060 ANNUAL REPORT OF THE HOSPITALITY REGISTER AND REGISTER OF DECLARATIONS OF INTEREST

The former Director of Corporate Governance, Mr Peter Welsh advised that this report was brought to Committee twice a year and that Clinical Boards also held their own registers.

The Committee **NOTED** the reports.

AC: 18/061 PATIENT SAFETY

The Assistant Director Patient Safety and Quality gave an oral update on 2 current items:

1. **Paediatric Surgery**
   The Board would receive a report later in the week that would attract media interest. Mrs Evans assured Committee of robust Executive oversight.

2. **Blood Inquiry**
   This was launched recently and the UHB had submitted its evidence and response although there had been difficulty locating records from the 1970s and 80s. The 7 folders of information had also been shared with Haemophilia Wales. This Inquiry was expected to last many years and would be damaging to the UHB's reputation. It was noted that families had to request that records be submitted to the Inquiry.

AC: 18/062 ITEMS FOR INFORMATION

Items for Information were **NOTED:**

- Losses and Special Payments – this related to clinical negligence claims and it was noted that a report was received at the Quality Safety and Experience Committee in September. It was agreed to invite Mrs Angela Hughes to the next meeting to provide detail on the clinical negligence claims.
  Action – Secretariat
- WAO Report – Collaborative Arrangements for Managing Local Public Health Resources
- Costing Review (17/18) Internal Audit Report
- RTT Performance Reporting (17/18) Internal Audit Report
- Annual Quality Statement Internal Audit Report

- Ombudsman Reports Internal Audit Report
- Environmental Sustainability Internal Audit Report
- Electronic Staff Record Internal Audit Report
- Management of the Disciplinary Process Internal Audit Report
- Dental Nurse Provision Internal Audit Report
- Dental Theatre Sessions Internal Audit Report
- Charitable Funds Internal Audit Report

AC: 18/063 REVIEW OF MEETING

There were no items to be reviewed. However, comments were made about the display of information on the ibabs system. This was not user-friendly and the formatting suffered in several reports.

AC: 18/064 URGENT BUSINESS

There was no urgent business.

AC: 18/065 DATE OF NEXT MEETING

The next Audit Committee meeting would be held at **9.00am** on **Tuesday, 4 December 2018** in the Corporate Meeting Room, Headquarters, UHW.

AUDIT COMMITTEE ACTION LOG FOLLOWING SEPTEMBER 2018 MEETING

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS	
					OUTSTANDING	DATE FOR COMPLETION
AC: 18/022	31.05.18	Internal Audit Progress Report: Business Continuity Plan	To ask Lead Executive to ensure the Business Continuity Plan is delivered during the course of the year.	Executive Director of Strategic Planning / Chief Operating Officer	To ensure Clinical Boards are undertaking the task to populate the Business Continuity Template and this is delivered during course of the year.	Clinical Boards are continuing to develop their business continuity planning and further work is being done to review the corporate overview arrangements.
AC: 18/050	25.9.18		Request written update for December meeting as no timescales identified.	Executive Director of Strategic Planning		Written update for **December 2018**
AC: 18/022	31.05.18	Consultant Job Planning: Limited Assurance	Medical Director to be invited to next meeting to review progress made and for there to be a complete update in six months' time.	Medical Director / Chair	The Committee will be updated at the February meeting. Clinical Boards will be informed that they will be under scrutiny and that	On September agenda. This item has been moved for an update in **February 2019**.

					timescales will be put into the action plan.	
AC: 18/052	25.9.18	Consultant Job Plans	Ask Medical Director to provide more detailed report with trajectories and milestones.	Assistant Director Patient Safety and Quality		This item has been moved to the **February 2019** meeting.
AC: 18/062	25.9.18	Losses and Special Payments Panel	Need to invite Angela Hughes next meeting to discuss detail of clinical negligence claims.	Secretariat	30 October - Angela Hughes invited to attend Audit December meeting.	**Audit December 2018**
AC: 18/051	25.9.18	Internal Audit Report	Ask COO why there had been delays in responses to Neuro IT and Renal IT systems. The audits had to be rescheduled and was not available for September Committee. Ask COO to attend meeting to explain findings of paediatric/adult transition plans as sensitive issue. Discuss reasonableness of Audit timescales with the Committee Chair.	Secretariat Secretariat Head of Internal Audit	There have been a number of reports where Clinical Boards have contested the findings and there has been further discussion between the Audit Team the COO and the CB to clarify the position while moving forward with the actions. This is related to a small number of	**Audit December 2018**

					reports. The Operations Team have been reminded to ensure there is timely response to reports going forward.	
AC: 18/053	25.9.18	Continuing Healthcare Follow up	Agreed to push back the timescale for further follow up.	Head of Internal Audit		
AC: 18/054	25.9.18	WAO Report on Medical Equipment	Management response to be considered in detail at next meeting.	D Ward		**Audit December 2018**
AC: 18/056	25.9.18	Tracking Report on WAO Reports	Update on progress at next meeting.	Director of Corporate Governance		**Audit December 2018**
AC: 18/057	25.9.18	Structured Assessment 2017	Further update report to be received in 6 months.	Director of Corporate Governance		**February 2019**
AC: 18/058	25.9.18	Post Payment Verification	Future reports to provide more detail, explanation and comparison.	PPV Manager		**Audit April 2019**
ACTIONS TO BE BROUGHT FORWARD ON ANOTHER AGENDA						

ACTIONS COMPLETED SINCE LAST COMMITTEE						
AC: 18/050	25.9.18	Internal Audit Progress Report: Business Continuity Plan	Write to Executives to remind them they could be called to Committee any time	Chair		**COMPLETE** 31 October 2018
AC: 18/022	31.05.18	Consultant Job Planning: Limited Assurance	Audit Committee to have sight of action plan and for timescales to be reviewed	Medical Director / Chair		**COMPLETE** A special meeting was held on 30 October 2018 to discuss
AC: 18/023	31.05.18	Losses and Special Payments Panel	A breakdown of clinical negligence claims to be brought to next meeting	Assistant Director Patient Safety and Quality		**COMPLETE** Annual report on Putting Things Right presented at September meeting
AC: 18/054	25.9.18	WAO Report on Medical Equipment	Arrange for 3 IMs to meet Lead Executives and WAO to discuss	D Ward		**COMPLETE** Meeting held in November 2018
AC: 18/056	25.9.18	Tracking Report on WAO Reports	Make this a standing item at Committee	Secretariat		**COMPLETE** Already a standing item

Report Title:	Board Assurance Framework								
Meeting:	Audit Committee						**Meeting Date:**	4.12.18	
Status:	**For Discussion**	x	**For Assurance**	x	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

The purpose of the report is to advise Members of the Audit Committee, of the newly developed Board Assurance Framework which details the principle risks to the achievement of strategic objectives.

REPORT

BACKGROUND

The Wales Audit Office Structured Assessment 2017 stated the following recommendations in relation to Cardiff and Vale UHB's Management of Risk:

The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by:

- Mapping risks to the Health Board's strategic objectives;
- Reviewing the required assurances;
- Improving clarity of risk descriptors; and
- Clarifying to the reader the date when risks are updated and/or added.

The required outcome was to ensure the UHB has a robust risk management system and Board Assurance Framework.

The Board does not currently have a means by which it can easily understand the principle risks to the delivery of its strategic objectives. The last time the Board received a report on risk was November 2017 when the Corporate Risk and Assurance Framework (CRAF) was presented with some 90+ risks within it.

The Board's main focus is strategic. Board Members must be able to understand the business objectives and be able to identify the principle risks that may threaten achievement of these objectives.

The Board's role is to focus on those risks and events which may compromise the achievement of strategic objectives, and to support the creation of a culture which allows Cardiff and Vale UHB to anticipate and respond to adverse events, unwelcome trends and signficant business and clinical opporutunities.

The Board Assurance Framework provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important objectives, to map out the key controls to managing or mitigating those risks and to confirm the assurance about the effectiveness of those controls.

The benefits of a working Board Assurance Framework are :

- A simple and comprehensive method for managing risks to achievement of objectives
- It provides evidence to support the Annual Governance Statement
- It helps to simplify Board reporting and prioritisation which allows more effective performance management
- It provides assurances about where risks are being managed effectively and objectives delivered
- It allows the Board to determine where to make efficient use of resources
- It allows the identification of priorities for Board to provide confidence that the organisation is able to understand capacity to deliver.

ASSESSMENT

The attached Board Assurance Framework has been developed by the Director of Corporate Governance and Executive Directors after discussion at Management Executive Team where the following risks were agreed as the main risks to the achievement of Cardiff and Vale's Objectives:

1. Workforce
2. Financial Sustainability
3. Sustainable Primary and Community Care
4. Safety and Regulatory Compliance
5. Sustainable Culture Change
6. Capital Assets (including Estates, IT and Medical Equipment)

The Board Assurance Framework should include the following:

- Strategic Objectives
- Principle risks that threaten the achievement of objectives
- Controls in place to manage/mitigate the principle risks
- Assurances on the controls in place
- Gaps in control
- Gaps in assurance
- Actions to address the gaps in control and assurance to enable objectives to be delivered

In addition to the above the Head of Corporate Governance has been working over the last 12 months with Clinical Boards to develop and progress their risk registers to ensure consistency in the way risks are described, controls which are in place and assurance on those controls evidenced. This work should be completed within the next 6 months at which point the highest risks (Corporately and from the Clinical Boards) will also be reported to the Board. This will enable the Board to not only see the principle risks to the achievement of strategic objectives but to also have oversight of key operational risks.

The Board Assurance Framework was presented to the Board on 29th November 2018 and it was agreed that next steps in ensuring that the organisation has robust risk management arrangements in place are to:

1. Ensure that the work on the Corporate and Clinical Board Risk Registers is completed within a timely manner and then reported to the Board alongside the Board Assurance Framework.
2. Assess the organisation's 'Risk Appetite' - this will be undertaken with the Management Executive and then presented to the Board by the end of the financial year.

3. Report the new process to the Audit Committee so the Committee can provide assurance to the Board.
4. Report individual risks upon the Board Assurance Framework to the relevant Committees of the Board to allow the Committees to undertake a more detailed review and then provide assurance to the Board.
5. Continue to develop and then update the Board Assurance Framework with Executive Directors to ensure it remains a dynamic and live document.

ASSURANCE is provided by:

- Discussion with individual Executive Directors and Management Executive Team.

RECOMMENDATION

The Audit Committee is asked to:

- **DISCUSS AND NOTE** the report and Board Assurance Framework.

Shaping our Future Wellbeing Strategic Objectives			
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											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

BOARD ASSURANCE FRAMEWORK 2018/19

It is essential that Cardiff and Vale University Health Board is aware of the major risks which could impact upon the delivery of Strategic Objectives as set out in Shaping Our Future Wellbeing.

Strategic Objectives

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

Principle Risks

Risk	Gross Risk	Net Risk	Target Risk	Context	Executive Lead	Committee
1. Workforce	**25**	**15**	**10**	Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff. Staff costs represent the largest expense for the NHS in Wales. The pay bill has continued to increase year on year, with a significant increase over the last three years.	Executive Director of Workforce and OD	Strategy and Delivery Committee
2. Financial Sustainability	**25**	**15**	**10**	Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing prudent healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future.	Executive Director of Finance	Finance Committee

3. Sustainable Primary and Community Care	**20**	**15**	**10**	The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.	Chief Operating Officer	Strategy and Delivery Committee
4. Safety and Regulatory Compliance	**16**	**12**	**8**	Patient safety and compliance with regulatory standards should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.	Executive Nurse Director	Quality, Safety and Experience
5. Sustainable Culture Change	**16**	**12**	**8**	In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which is building upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.	Executive Director of Workforce and OD	Strategy and Delivery Committee
6. Capital Assets (Estates, IT Infrastructure, Medical Devices)	**25**	**20**	**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.	Executive Director of Strategic Planning, Deputy Chief Executive, Executive Director of Therapies and Health Science	Strategy and Delivery Committee, IG & T Committee, Quality, Safety and Experience Committee

1. Workforce

Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff.

Risk **Date added:** 12.11.2018	There is a risk that the organisation will not be able to recruit and retain a clinical workforce to deliver high quality care for the population of Cardiff and the Vale		
Cause	Increased vacancies in substantive clinical workforce Requirements of the Nurse Staffing Act and BAPM Standards Ageing workforce Insufficient supply of Nurses at UK national level High nurse turnover in some specialties Insufficient supply of Doctors in certain specialties at UK national level (e.g., A&E, Adult Psychiatry, Anaesthetics, General Medicine, Histopathology, Neurosurgery, Paediatric Surgery) Changes to Junior Doctor Training Rotations (Deanery)		
Impact	Increase in agency and locum usage Increase in costs of using agency and locum Impact on quality of care provided to the population Rates above Welsh Government Cap (Medical staff) Low Staff moral Poor attendance at statutory and mandatory Training Potentially inadequate levels of staffing		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	Project 95% Nurse Recruitment and Retention Programme Medical international recruitment strategies (including MTI) Recruitment campaign through social media with strong branding Job of the week Staff engagement with recruitment drive Programme of talent management and succession planning Values based recruitment		
Current Assurances	Workforce metrics reported to Strategy and Delivery Committee High conversion rates from media campaign and Open Day Highest percentage of students in Wales applied to Cardiff and Vale UHB (23.2%) Nurse monitoring at Nurse Productivity Group (NPG) Medical monitoring at Medical Workforce Advisory Group (MWAG)		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	Continuation of Open days uncertain Plan for recruitment of overseas staff		
Gap in Assurances	Trajectory showing net vacancies in nursing		

Actions			Lead	By when
	1. Trajectory to be developed showing recruitment and when numbers arrive plus leavers providing a net effect		RW/MD	31/12/2018
	2. Plan for overseas recruitment of nursing staff to be developed		MD	31/03/2019
	3. Plan to be developed for continuation of social media campaign and open day		MD/JB	31/03/2019
Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (High)**	

2. Financial Sustainability

Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing Prudent Healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future.

Risk **Date added:** 12.11.2018	There is a risk that the organisation will not be able to deliver its ambition within the financial resources available		
Cause	Budgets overspent (five Clinical Boards currently in escalation) Cost Improvement Programme not yet met in all areas Increasing spend on agency nursing Reduction in income received		
Impact	Unable to deliver balanced plan No £10m recurrent funding from Welsh Government Reputational Loss Remain in Targeted Intervention or Special Measures Turnaround		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	Full savings programme and financial improvement plan in place Finance Committee meets monthly and formally reports into the Board Performance Meetings held monthly with Clinical Boards Financial performance is a standing agenda item on Management Executives Meeting Standing Financial Instructions in place with clear delegations of authority		
Current Assurances	Performance Meeting outcomes reported monthly to Management Executives Clinical Boards placed in escalation where not meeting budget and CIP target and no assurance to demonstrate recovery (currently 5 Clinical Boards) Finance report presented to every Board Meeting demonstrating progress and reporting variances		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	Recovery plans from overspending Clinical Boards		

Actions	**Lead**	**By when**
1. Set a balanced deliverable plan for 2019/20	RC	31/01/2019
2. Overspending Clinical Boards to provide robust recovery plans	SC	31/12/2018
3. Identification of further opportunities to eliminate underlying deficit – transformation, efficiency framework, clinical variation and waste, value based healthcare.	Exec Directors	31/01/2019

Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

3. Sustainable Primary and Community Care

The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.

Risk **Date added:** 12.11.2018	The risk of losing resilience in the existing service and not building the capacity or the capability of service provision in the Primary or Community care setting to provide the necessary preventative and responsive services.		
Cause	Not enough GP capacity to respond to and provide support to complex patients with multiple co-morbidities and typically in the over 75Years age bracket. GP's being drawn into seeing patients that could otherwise be seen by other members of the Multi-disciplinary Team. Co-ordination of Health and Social Care across the communities so that a joined up response is provided and that the patient gets the right care. Poor consistency in referral pathways, and in care in the community leading to significant variation in practice. Practice closures and satellite practice closures reducing access for patients. Lack of development of a multidisciplinary response to Primary Care need.		
Impact	Long waiting times for patients to access a GP Referrals to hospital because there are no other options Patients turning up in ED because they cannot get the care they need in Primary or Community care. Poor morale of Primary and Community staff leading to poor uptake of innovative solutions Stand offs between Clinical Board and Primary care about what can be safely done in the community Impact reinforces cause by effecting ability to recruit		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (red)**
Current Controls	Me, My Home , My Community Signals from Noise to create a joined up system across Primary, Community, Secondary and Social Care. Development of Primary Care Support Team Contractual negotiations allowing GP Practices to close to new patients		
Current Assurances	Improved access and response to GP out of hours service Sustainability and assurance summary developed to RAG rate practices and inform action Three workshops held to develop way forward with engagement of wider GP body in developing future models		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (red)**
Gap in Controls	Actively scale up multidisciplinary teams to ensure capacity Achieving scale in developing joint Primary/Secondary Care patient pathways Recruitment strategies to sustain and improve GP availability and develop multidisciplinary solutions		
Gap in Assurances	No gaps currently identified.		

Actions		Lead	By when
	1. Health Pathways – to create a protocol driven of what should and can be done in Primary care/Community care.	SH	31/03/2019
	2. Roll out of Mental Health and MSK MDT's to reduce the primary care burden on GP's	SC	Commencing by 31/01/2019
	3. Roll out digital solutions for smart working (join up system – Vision 360 degree)	SH	31/03/2020
	4. Development of recruitment strategies for GP and non GP service solutions	MD	Ongoing
	5. Develop Health and Social Care Strategies to allow seamless solutions for patients with health and or social needs	SH	30/09/2019

Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

4. Safety and Regulatory Compliance

Patient safety and compliance with regulatory standards should be above all else for the Cardiff and Vale University Health Board.
Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and feedback. Undertaking a high quality level of investigation to identify the root causes. Implementing solutions to minimise/mitigate the risk of them recurring.

Risk **Date added:** 12.11.2018	There is a risk that systems of safety and regulatory compliance are potentially not as robust as they could be and this has been demonstrated by the HTA Review, poor decontamination systems and the commissioning of services outside the Health Board which were not of a high quality.		
Cause	Non-compliance with regulatory or statutory requirements Non-compliance with effective decontamination processes to support the delivery of high quality patient care Appointment of contractor without required quality checks being in place to ensure service delivered was of a high standard		
Impact	Harm and distress caused to patients and their families Reputational damage to the Health Board Increase in clinical claims Financial consequences		
Impact Score: 4	Likelihood Score:4	Gross Risk Score:	**16 (Extreme)**
Current Controls	Human Tissue Act HTA Licencing Standards Statutory Designated Individual in post Clinical Board QSE arrangements; CD&T – regulatory compliance group Quality, Safety and Experience Committee in place supported by robust governance and reporting structure Office of Professional Leadership shares responsibility for Quality Agenda (Medical Director, Executive Nurse Director, Executive Director of Therapies and Health Science) Quality and Safety Team Patient Experience Team Health and Care Standards Decontamination and reusable devices procedure in place Decontamination Group Weekly Executive led concerns/claims and serious incidents meeting Monitoring of ongoing investigations Quality control system that triangulates areas of concern		
Current Assurances	Annual Report to Quality, Safety and Effectiveness Committee on key quality and safety areas External accreditation processes Monitoring of incident trends, noise in the system or any concerns arising from inspections Heath and Care Standard Self-Assessment undertaken on key areas and reported into the Quality , Safety and Experience Committee Internal Audit reviews on quality and safety		
Impact Score: 4	Likelihood Score:3	Net Risk Score:	**12 (High)**

Gap in Controls	Lack of central decontamination Unit Lack of robust QSE criteria/monitoring in procurement and commissioning processes Capacity of the Patient Safety and Patient Experience team to enable more proactive approach to quality improvement and data analysis			
Gap in Assurances	Robust ongoing monitoring and assurance reporting on historical areas of concern Internal audit programme needs to be more closely aligned to areas of greatest risk			
Actions			Lead	By when
	1. Discuss and agree a way forward in relation to central decontamination unit		RW / FJ	31/12/2018
	2. Review of procurement and commissioning processes to be undertaken to ensure that robust quality, safety and experience criteria and included		RW/ RC	31/03/2019
	3. Review of capacity of Patient Safety and Patient Experience Team to be undertaken		RW	31/03/2018
Impact Score: 4	Likelihood Score:2	Target Risk Score:	**8 (High)**	

5. Leading Sustainable Culture Change

In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which is building upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.

Risk	There is a risk that the cultural change required will not be implemented in a sustainable way		
Cause	Current climate within the organisation is high in bureaucracy and low in trust. Staff reluctant to engage with the case for change as unaware of the UHB strategy and the future ambition. Staff not understanding the part their role plays for the case for change due to lack of communication filtering through all levels of the UHB.		
Impact	Staff morale may decrease Increase in absenteeism Difficulty in retaining staff Transformation of services may not happen due to staff reluctance to drive the change through improvement work. Patient experience ultimately affected.		
Impact Score: 4	Likelihood Score: 4	Gross Risk Score:	**16 (Extreme)**
Current Controls	Values and behaviours Framework in place Task and Finish Group weekly meeting Cardiff and Vale Transformation story and narrative Leadership and Management Development Programme Programme of talent management and succession planning Values based recruitment Staff survey results and actions taken – led by an Executive (WOD) Patient experience score cards CEO sponsorship for the Values and behaviours (culture) enabler. Executive Director of WOD highly engaged with this enabler		
Current Assurances	Transformation activity reported to monthly to Management Executives, HSMB and Strategy and Delivery and Board. Engagement of staff side through the Local partnership Forum (LPF)		
Impact Score: 4	Likelihood Score: 3	Net Risk Score:	**12 (High)**
Gap in Controls	Lack of resources allocated to the culture change agenda.		
Gap in Assurances	Outcomes to measure culture are not explicit due to other factors influencing this enabler.		

Actions			Lead	By when
	1. An experiential leadership suite of programmes to be launched in 2019		MD / RG	31/05/2019
	2. Tier 1, 2 and 3 leaders within the UHB to undertake a leadership programme looking at styles and the climate we work in.		MD/RG	To commence by 31/03/2019
	3. A staff survey task and finish group established (led by Executive Director of WOD) with representation of staff and staff side to action a delivery plan in response to the survey.		MD	30/11/2018
Impact Score: 4	Likelihood Score: 2	Target Risk Score:	**8 (High)**	

6. Capital Assets (Estates, IT Infrastructure, Medical Devices)

The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.

Risk **Date added:** 12.11.2018	The condition and suitability of the estate, IT and Medical Equipment impacts on the delivery of safe, effective and prudent health care.		
Cause	Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B. Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. Lack of investment in IT also means that opportunities to provide services in new ways are not always possible and core infrastructure upgrading is behind schedule. Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement		
Impact	The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. Service provision is regularly interrupted by estates issues and failures. Patient experience is sometimes adversely impacted. IT infrastructure not upgraded as timely as required increasing operational continuity and increasing cyber security risk Medical equipment replaced in a risk priority where possible, insufficient resource for new equipment or timely replacement		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. IT SOP sets out priorities for next 5 years, to be reviewed in early 2019 Medical equipment WAO audit action plan to ensure clinical boards manage medical equipment risks The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP, with regular oversight of the programme of discretionary and major capital programmes.		
Current Assurances	The estates and capital team has a number of business cases in development to secure the necessary capital to address the major short/medium term service estates issues. Work is starting on the business case to secure funding to enable a UHW replacement to be build. The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised. The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks.		

	IT risk register regularly updated and shared with NWIS. Health Care Standard completed annually Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group, health care standard completed annually.		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the 3 services. In year requirements further impact and require the annual capital programme to be funded by capital to be re-prioritised regularly.		
Gap in Assurances	The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year		

Actions	**Lead**	**By when**
1. Progress implementation on the estates strategic plan	AH	Ongoing
2. Separate discussion with WG Director of Strategy to ensure shared understanding of risks and plans	AH	31/12/2018
3. Regular reporting on capital programme and risks to Capital Management, Management Executive and Strategy and Delivery Committee	AH	Ongoing
4. Review of IT SOP to be undertaken	SH	31/03/2019

Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

Report Title:	Terms of Reference – Audit Committee								
Meeting:	Audit Committee						**Meeting Date:**	4.12.18	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

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

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

REPORT

BACKGROUND

The Terms of Reference for the Audit Committee were last reviewed in September 2016.

ASSESSMENT

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

RECOMMENDATION

The Audit Committee is asked to:

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

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

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

Audit Committee

Terms of Reference ~~and Operating Arrangements~~

Updated ~~September 2016~~November 2018

AUDIT COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

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

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

2. PURPOSE

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

- the organisations ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards and other directions and requirements set by the Assembly Government and others;

- the reliability, integrity, safety and security of the information collected and used by the organisation;

- the efficiency, effectiveness and economic use of resources; and

- the extent to which the organisation safeguards and protects all its assets, including its people

- the adequacy of the arrangements for declaring, registering and handling interests at least annually

- the adequacy of the arrangements for dealing with offers of gifts or hospitality

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

- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- the Schedule of Losses and Compensation;

- the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- the adequacy of executive and managements response to issues identified by audit, inspection and other assurance activity;

- (where appropriate) proposals for tendering for Internal Audit services or for purchase of non-audit services from contractors who provide audit services;

- proposals for the appointment of the external auditor made by the Auditor General for Wales

- anti-fraud policies, whistle-blowing processes and arrangements for special investigations; and

- any particular matter or issue upon which the Board or the Accountable Officer may seek advice

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

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

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

- considering and approving policies as determined by the Board.

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

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

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

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

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

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

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;.
- the systems for financial reporting to the Board, including those of budgetary control, are effective; and that

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

Authority

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

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

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

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

Access

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

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

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

Sub Committees

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

- Finance Task and Finish Group
- Resource Allocation Group.

4. MEMBERSHIP

Members

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

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

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

Attendees

4.2 In attendance

Chief Executive
Director of Finance (Lead Executive)
~~Director of Workforce and Organisational Development~~
Director of Corporate Governance/Board Secretary
~~Assistant Director of Patient Safety and Quality~~
Head of Internal Audit
Local Counter Fraud Specialist
Representative of External Auditor
Other Executive Directors will attend as required by the Committee Chair

4.3 By invitation — The Committee Chair may invite:

- any other UHB officials; and/or
- any others from within or outside the organisation

- to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 Secretary - As determined by the Director of Corporate Governance / Board Secretary

Member Appointments

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

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

Support to Committee Members

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

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

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of Individuals in Attendance

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- quorum (set within individual Terms of Reference)

9. REVIEW

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

Audit Committee Work Plan 2019 - 20									
A -Approval D- discussion I - Information	Exec Lead	26-Feb	23-Apr	21-May	30-May	24-Sep	03-Dec	25-Feb	21-Apr
Agenda Item									
Governance									
Review the system of assurance	NF	D				D			D
Review the risk management system	NF	D							D
Note the business of other Committees and review inter-relationships	NF	D				D	D	D	D
Review Draft AGS	NF		D		A				
Review Draft Quality Statement	RW		D		A				
Review other sources of Assurance	NF	D				D	D	D	D
Review the UHB Annual Report	NF		D		A				
Review of Standing Orders	NF	D						D	
Report on Declarations of Interest and Gifts and Hospitality	NF		D				A		
Receive reports from Regulatory Bodies	NF	D	D			D	D	D	D
Receive tracking report from recommendations from Regulatory Bodies	NF								
Financial Focus									
Agree final accounts timetable and plans	RC						A		
Review of annual accounts progress	RC	D						D	
Review of audited annual accounts and financial statements	RC		D						D
Review risks and controls around financial management	RC					D			
Review changes to SFIs and changes to accounting policies	RC/NF	D						D	
Review losses and special payments	RC	D	D			D	D	D	D
Internal Audit									
Review and approve annual internal audit plan	IA	A						A	
Review and approve internal audit Terms of Reference	IA	A						A	
Review the effectiveness of internal audit	IA						D		
Review of internal audit progress reports	IA	D	D			D	D	D	D
Receive annual internal audit report and associated opinions (HoIA)	IA		D		A				
Receive Tracking Report on internal audit recommendations		D	D			D	D	D	D
External Audit									

Agree Auditor General's Audit Plan	WAO	A						A	
Review the effectivenes of external audit	WAO						D		
Review External Audit Progress Reports	WAO	D	D			D	D	D	
Receive the Auditors report to those charged with governance	WAO				A				
Receive the Auditors Annual Audit Report	WAO						A		
Receive Annual Structured Assessment Report	WAO	D						D	
Clinical Audit									
Review annual Clinical Audit Plan	RW	D						D	
Review Clinical Audit Terms of Reference	RW	D						D	
Review effectiveness of Clinical Audit	RW						D		
Review Clinical Audit Progress Reports	RW	D	D			D	D	D	D
Counter Fraud									
Review and approve annual counter fraud plan		D							
Review counter fraud progress reports		D	D			D	D	D	D
Review the effectiveness of Counter Fraud Specialist							D		
Receive counter fraud annual report			D		A				
Audit Committee									
Annual Work Plan	NF	A						A	
Self assessment of effectiveness	NF						D		
Review Terms of Reference	NF	A						A	
Produce annual Audit Committee Annual Report	NF	A						A	
Private discusison with internal and external auditor	NF	D	D			D	D	D	D
Minutes of Audit Committee Meeting	NF	A	A			A	A	A	A
Action log of Audit Committee Meeting	NF	D	D			D	D	D	D

Report Title:	Internal Audit Progress Report								
Meeting:	Audit Committee						**Meeting Date:**	4.12.18	
Status:	**For Discussion**		**For Assurance**	x	**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Internal Audit								

SITUATION

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

- Detail relating to outcomes, key findings and conclusions from the finalised Internal Audit assignments;
- Specific detail relating to progress against the audit plan and any updates that have occurred within the plan.

REPORT

BACKGROUND

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

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

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

The progress report highlights the conclusion and assurance ratings for audits finalised in that period.

Reports that are given Reasonable Assurance are summarised in the progress report with the reports given Limited Assurance included in full. There are two reports that have been given a Limited Assurance rating.

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

ASSESSMENT

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

RECOMMENDATION

The Audit Committee is asked to:

- **CONSIDER** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports and
- **CONSIDER** and **APPROVE** updates to the Internal Audit Plan.

Shaping our Future Wellbeing Strategic Objectives			
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	

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five 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

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

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

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee December 2018

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

1. INTRODUCTION

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

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

1.3. The plan for 2018/19 was agreed by the Audit Committee in April 2018 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. ASSIGNMENTS WITH DELAYED DELIVERY

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

Audits planned for Audit Committee but not finalised			
Estates time recording	Draft	Limited	Mgt responses not received
Renal IT System	Draft	Reasonable	Delay in sign off of brief
PCIC Interface incidents	Draft	Limited	Awaiting management responses
Surgery CB – Medical Staff Financial Governance	Draft	Limited	Delay in accessing key staff
Corporate Regulatory Compliance	wip		Work taken longer to deliver
Medicine CB absence Mgt.	wip		Work taken longer to deliver
CD&T CB	wip		Work taken longer to deliver
Data quality. (Non RTT / key targets)	wip		Work taken longer to deliver

3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

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

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

FINALISED AUDIT REPORT	ASSURANCE RATING	
Neurosciences IT System Follow up	Substantial	
Cost Improvement Programme		
Shaping Future Wellbeing Capital Scheme	Reasonable	
Cleaning Standards follow up		
Carbon Reduction Commitment		
PCIC District Nursing Rotas		
Mental Health Section17		
Mental Health Sickness Management	Limited	
Standards of Behaviour		

4. DELIVERY OF INTERNAL AUDIT PLAN

4.1. Delivery of audit work - From the table in section three above it can be seen that nine audits have been finalised since the Committee met last. In addition to that, there are four audits that have reached draft report stage.

To date two final reports have been given Limited assurance as well as a further three audits at draft stage and there is one audit currently in progress where it is anticipated to be limited assurance. The increasing number of Limited assurance reports could have an impact on the overall year end opinion.

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

4.2. Two follow up audits have been undertaken for audits (Cleaning Standards and Neurosciences IT System) that were given Limited assurance ratings in the previous year. Both of these have seen improvements with assurance rating increasing to reasonable and substantial respectively.

Appendix C shows the assurance summary by domain.

4.3. *A* number of routine follow up audits have been undertaken in the period and these are summarised in Appendix B. From the follow ups undertaken it can be seen that overall reasonable progress has been made with the implementation of agreed actions with the majority actioned or partially actioned.

4.4. Progress with the Delivery of the Plan and Changes to the agreed plan.

Following discussions at the previous meeting of the Audit Committee and a separate meeting with the Audit Committee chair, it has been agreed that the follow up audits of Consultants job Planning and Continuing Healthcare, both of which were originally given Limited assurance are to be deferred until the next audit year. Consideration will be taken as to what any potential impact these have on the overall opinion.

Further follow up audits may be required in year for reports with Limited Assurance. Some other minor changes have been made around timing of audits. The Audit Committee is ask to acknowledge the updates to the plan.

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

5. FINAL REPORT SUMMARIES

5.1 Neurosciences IT System Follow up

The follow up review concluded that, based upon discussions with relevant management, review of the evidence provided and the results of re-testing where appropriate, progress has been made.

A contract is now in place for the provision and maintenance of the system, the system has been moved to new servers and the database updated. In addition data entry controls are in place and the user group is to factor these into their discussions.

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

The management actions completed to date can be summarised as follows:

- The system moved to new server to provide better assurance.
- The database has been upgraded to a new, more secure version.
- A formal contract / SLA is now in place for for the maintenance and support of the system.
- A user group is in existence for the system.
- Data entry controls are in place.
- There is a process to identify further entry controls via the user group.
- The logon process has been enhanced with the use of Nadex being enforced.
- The Directorate has established a more robust process to ensure that leavers are deactivated.
- A business continuity document relating to Patientcare has been developed for the service.

The main issue highlighted through the follow up review can be summarised as follows:

- Although backups are taken and log files reviewed, there is no process in place for testing the backups.

5.2 Cost Improvement Programme

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Cost Improvement Programme 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 Health Board has robust processes in place for developing, monitoring and delivering the CIP. At the time of our audit the Health Board was on target to meet the agreed year-end deficit of £9.9m.

Each Clinical Board has been given savings targets and asked to develop savings plans to achieve those targets. These are recorded in the 'Savings Tracker' using a traffic light system and are initially recorded on the tracker as red. Savings schemes are then assessed and those that can evidence some key mandatory elements of the savings scheme are upgraded to amber. Savings schemes are not classified as Green until there is sufficient evidence that all mandatory elements of the scheme have been met and savings identified are 'guaranteed'.

The achievement of savings is monitored monthly through the production of financial performance reports which are submitted to each Clinical Board's Cost Reduction Board.

Our audit has confirmed that the CIP is making a significant contribution to the achievement of savings and the financial outturn target. However it was identified through review of a sample of the 'Top 20' savings schemes that the CIP could be further improved by enhancing the quality of supporting documentation underpinning saving schemes through the completion of Impact Statements and ensuring all fields within the savings tracker are accurately completed.

5.3 Shaping Our Future Wellbeing (Capital Projects)

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the 'Shaping Our Future Wellbeing – proposed programme and associated capital projects 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 primary reasons for this level of assurance are:
• the established project structure and report arrangements through to the Board were appropriate for the current stage of the Programme, but there was also a need to further develop the roles and responsibilities of groups within the structure;

• although progress had been made in compiling the required business cases, there had been slippage in the timetable for delivery of the overall Programme Business Case (originally targeted for December 2016, but submitted to Welsh Government in July 2018) and work was still required to deliver the project business cases by the target date of December 2018;
• Arrangements were in place for progress reporting on the Programme and the first tranche of projects.

5.4 Carbon Reduction Commitment

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the CRC Energy Efficiency Scheme 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.

Good processes were in place across the areas reviewed including, for the assessment and management of the purchase of allowances, the adequacy of the evidence pack was comprehensive and was retained in accordance with CRC requirements. Overall annual report data continued to improve, with only a small number of errors were identified in the data preparation and reporting process and these did not have a material effect on the reportable totals.

5.5 Cleaning Standards follow up

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.

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 Health Board has made Reasonable progress against the agreed actions for five of the six recommendations from the original review.

However, one of the high priority recommendations made in the original audit has not been fully achieved. This relates to the continued lack of ward sign-off of technical audits. Further work is also required around the finalisation and introduction of the combined 'Cleaning Strategy and Operational Plan' and the establishment of an appropriate multi-disciplinary Standards of Cleaning Group.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with National Standards for Cleaning in NHS Wales has improved to **Reasonable Assurance**. Management will however need to ensure that the

outstanding actions are fully implemented in line with the revised planned timescales.

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

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

Priority rating	No of management responses to be implemented	Fully actioned	Partially actioned	Not actioned
High	2	1	1	-
Medium	4	2	1	1
Low	-	-	-	-
Total	**6**	**3**	**2**	**1**

5.6 PCIC CB – District Nursing Rotas

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with PCIC CB – District Nursing Rotas 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.

Currently, the Health Board's District nursing teams are using the Health Board's Rostering Procedure for Nurses and Midwives to guide their process for rostering. Whilst this provides a good foundation, there are elements of the current system which need enhancing to ensure full

compliance with the recently published Welsh Government (WG) interim District Nurse Guiding Staffing Principles.

Rotas are managed locally by each of the District Nursing Team Sisters; the approach taken is inconsistent across the teams, even within the same locality. The main variation is the level of use of the Rosterpro system. However, despite this, rotas were found to be well prepared with appropriate consideration of skill mix and staff experience.

Each team reports their escalation levels weekly and a monthly performance report for each locality is provided to PCIC management. This ensures there is good oversight and review of compliance with KPIs, challenges faced and any capacity issues.

5.7 Mental Health Clinical Board Section 17

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Mental Health Clinical Board Section 17 Leave 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 findings from the review have identified that Section 17 leave is being adequately managed within the Clinical Board with a few issues being identified.

Section 17 Leave of Absence forms were available in the patient's notes within PARIS for all reviewed instances of leave granted and all had been authorised by a responsible clinician and detailed any conditions relating to the leave. In addition, there were letters available from the Ministry of Justice approving Section 17 leave for restricted patients.

The Section 17 leave is reviewed as part of the weekly or fortnightly ward rounds which involves the multi-disciplinary team and they will agree the type of leave that should be granted.

In cases where patients' section 17 leave had been revoked there were forms in place detailing the reason these had been signed by the responsible clinician.

The Health Board has produced a Guideline for Section 17 Leave of Absence which is generally in line with the Mental Health Act 1983 Code of Practice for Wales Revised 2016. However, it has yet to be formally approved.

In addition, the guideline refers to patients having up to date risk assessments and intervention plans in place relating specifically to the section 17 leave. The review confirmed that whilst up to date assessments and plans are in place they do not relate specifically to the section 17 leave. However, this requirement is not in line with the Mental Health Act and the Ward staff also confirmed that it would be too onerous to undertake these on each occasion of leave. The Health Board therefore needs to clarify the requirements to be followed and ensure they are correctly stated in the guidelines.

Assignment Status Schedule — Appendix A

CARDIFF AND VALE UHB INTERNAL AUDIT PLAN AND POGRESS 2018/19

Cardiff and Value UHB Internal Audit Plan 2018/19 -Planned output.	No	CRAF	Outline Scope	Exec Lead				Audit Cttee
~~Public Health Targets~~	~~8~~	~~1.2~~	~~Review delivery and achievement of PH targets for Obesity in relation to physical activity targets. Health Board has introduced internal standards around healthy options.~~	~~DoPH~~	~~Q1~~	~~Deferred at request of DoPH 19/20.~~	~~n/a~~	~~n/a~~
~~C&W CB – Paeds & Adults Transition Plans~~	~~33~~		~~Transition plans between Paediatrics and Adults.~~	~~COO/Clinical Board~~	~~Q1~~	~~Work to be deferred. Despite many requests to management, scope not signed off.~~	~~n/a~~	~~n/a.~~
Annual Quality Statement	18	5.1	To provide an opinion on the process that has been adopted and if the evidence recorded supports the self-assessment.	Nursing	Q1	Final	Substantial	Sept
Electronic Staff Record	42		Use, roll out, hierarchy set up.	Workforce	Q1	Final	Reasonable	Sept
Sustainability Reporting	43	6.4	To provide an opinion that the Health Board has robust systems in place to record and report minimum sustainability requirements as required by the Welsh Government.	Director Planning	Q1	Final	Reasonable	Sept
Management of the Disciplinary process.	41		Review adequacy of arrangements for effective and timely management of the disciplinary process.	Workforce	Q1	Final	Reasonable	Sept
Charitable Funds	15		Review governance	Director	Q1/2	Final report	Substantial	Sept

Cardiff and Value UHB Internal Audit Plan 2018/19 -Planned output.	No	CR AF	Outline Scope	Exec Lead				Audit Cttee
			arrangements, including the management of expenditure and donations, including spend activity within Medicine Clinical Board.	of Finance				
Dental CB – Theatre Cancellations	38		Theatre cancellations – rationale used for prioritising which lists and patients are cancelled over others and who makes the decision as we are not confident there is any clinician input.	COO/Clinical Board	Q1/2	Final. reasonable. Responses received 22/8	Reasonable	Sept
Dental CB – Dental Nurse Provision	39		Are the current levels of dental nurse staffing enough to provide full cover to compliment both education and service requirements, and are they aligned to the booking of clinical sessions and student timetabling.	COO/Clinical Board	Q1/2	Final reasonable - Responses received 22/8	Reasonable	Sept
Ombudsman Reports	20	5.6	Review arrangements as to how the Health Board deals with Ombudsman report.	Director Nursing	Q1/2	Final	Substantial	Sept
Estates Time recording / KRONOS system	**46**	**6.4**	**Review operation of new system to establish whether it has delivered the control improvements and benefits.**	**Director Planning**	**Q1**	**Draft issued august.**	**Limited**	**Dec**
IT system follow up – Neuroscience It System	**23**	**6.8**	**Follow up review to ensure agreed actions have been implemented.**	**COO**	**Q1/2**	**Final**	**Substantial**	**Dec**

Cardiff and Value UHB Internal Audit Plan 2018/19 -Planned output.	No	CR AF	Outline Scope	Exec Lead				Audit Cttee
Carbon Reduction Commitment				Director Planning	Q1/2	Final	Reasonable	Dec
Cleaning Standards – Follow up	44	6.4.8	Follow up to Limited assurance report.	Director Planning	Q1/2	Final	Reasonable	Dec
Departmental IT System - Renal It System	24	6.8	Review controls in place to manage the system, including security, data, contingency planning and operations.	COO	Q1/2	Draft Report	Reasonable	Dec
PCIC CB – District Nursing Rotas	30		District Nursing Rotas being managed in-line with the new rostering policy.	COO/Clinical Board	Q1/2	Final	Reasonable	Dec
Surgery CB – Medical Finance Governance	31		Medical finance governance (e.g. locum spend)	COO/Clinical Board	Q1/2	Delay in initially accessing key staff. Draft Report	Reasonable	Dec
MH CB – Section 17 Leave	34	6.2.1	Use of Section 17 leave in the context of the risk management of patients.	COO/Clinical Board	Q1/2	FINAL	Reasonable	Dec
MH CB – Sickness Management	35	6.2.1	Sickness management and support offered to Staff.	COO/Clinical Board	Q1/2	FINAL	Limited	Dec
PCIC CB – PCIC Incident Reporting	29		PCIC Incident Reporting (deferred 17/18) Review process for managing incidents that are cross cutting over multiple areas	COO/Clinical Board	Q1/2	draft	Limited	Dec
Medicine CB – Absence Management / Training	32		To review absence management and training	COO/Clinical	Q1/2	Plan – now focusing on		Dec

Cardiff and Value UHB Internal Audit Plan 2018/19 -Planned output.	No	CR AF	Outline Scope	Exec Lead				Audit Cttee
Compliance			**compliance within a directorate.**	**Board**		**absence mgt only. Brief signed off 16/8/18.**		
Cost Improvement Programme	**16**	**6. 7**	**Review the development, delivery and reporting of progress of the financial improvement plans.**	**Director of Finance**	**Q2**	**Final**	**substantial**	**Dec**
CD&T CB – Bank, Agency & Overtime Spend	**36**		**Governance around bank, agency and overtime spend.**	**COO/Clinical Board**	**Q1/2**	**wip**		**Dec**
Contract Compliance	48		**Review of compliance with Rules around awarding of commercial contracts.**	**Director of Finance**	**Q2**	**Planning /wip**		**Dec**
Performance Reporting – data quality. (Non RTT / key targets) reporting dashboard	**10**	**5. 3**	**Review adequacy and appropriateness of performance reporting covering other / non RTT targets.**	**DoPH**	**Q2**	**Wip**		**Dec**
Legislative / Regulatory Compliance	**4**	**8**	**To review the corporate arrangements for monitoring and managing compliance requirements.**	**Corporate Governance**	**Q2/3**	**wip**		**Feb**
Standards of behaviour (DoI & G&H)	5	8.2	To review compliance with the updated policy requirements.	Corporate Governance	Q3	wip		Feb
Private and Overseas patients	17		Review Organisational arrangements for the management of private and overseas patients including income collection.	Medical Director	Q2/3	Further discussion requited with Executive Director.		Feb

Cardiff and Value UHB Internal Audit Plan 2018/19 -Planned output.	No	CR AF	Outline Scope	Exec Lead				Audit Cttee
UHB Core Financial Systems	14	6.7	Review a selection of controls in place to manage key risk areas across the range of the main financial systems.	Director of Finance	Q2/3	wip		Feb
Commissioning	11	2.1	Assurance over whether HB has effective commissioning framework / process in place and is it fit for purpose.	DoPH	Q2/3	planning		Feb
GDPR	25	8.1 .5	Review UHB arrangements for compliance	DoPH	Q2/3	Brief prepared		Feb
e-advice	26	6.8	Review controls in place to manage key risk areas within the process.	Director Therapies	Q2/3	Brief prepared		Feb
Strategic Planning/IMTP	7	5	Review on going delivery and monitoring of the plans. Review quality of information as part of PODs to support decision making.	Director of Planning	Q3			Feb
Performance Reporting Data Quality RTT	9	5.3	Review adequacy and appropriateness of performance reporting covering sample of key RTT targets.	DoPH	Q3			Feb
Delayed Transfers of Care	13		Compliance with DTOC Reporting	COO	Q3	Brief prepared		Feb
Claims Reimbursement	2	---	Review compliance with Welsh Risk Pool Standard requirements for claims reimbursement.	Director Nursing	Q3	Wip, fieldwork complete		Feb
Ward Nurse Staffing Levels	21	6.2	Review of this area looking at actions implemented to ensure compliance.	Director Nursing	Q3	Brief prepared		Feb

Cardiff and Value UHB Internal Audit Plan 2018/19 -Planned output.	No	CRAF	Outline Scope	Exec Lead				Audit Cttee
MHRA Compliance	22	8	Review arrangements for compliance with regulatory requirements	COO	Q3			Feb
Health and Care Standards	1	5.1 .6	Review utilisation of standards within the Health Board and processes for assessing performance against them.	Director Nursing	Q2-4			Apr
e IT learning	28	6.8	Coverage to be agree with management.	Director Therapies	Q2/3			Feb
~~Continuing Healthcare - Follow up~~	~~6~~	~~5.1 .13~~	~~Follow up of 2017/18 Limited Assurance Report. (This follow up and subsequent report with be split between the Child and Adult service)~~	~~COO~~	~~Q3/4~~	~~Deferred until next audit year as per audit committee discussions.~~		
DOLS Follow-up	19	8.1 .3	Follow up of agreed actions form previous Limited assurance report, possible re-audit)	Medical director	Q4	Timing of review to be discussed further.		April
~~Consultant Job Planning Follow-up~~	~~40~~	~~6.2~~	~~Follow up (subject to finalisation of current report)~~	~~Medical~~	~~Q3~~	~~Deferred until next audit year as meet discussion with audit committee chair.~~		
Commercial Outlets (Deferred1718)	45	6.4	Review arrangements for commercial outlets	Director Planning	Q3			Feb
Risk Management / CRAF development /Risk registers	3	8.2	To review the enhanced corporate risk and assurance arrangements currently being developed.	Corporate Governance	Q3/4			April
UHB Transformation Process	12	10	Review the progress with the UHB transformation process.	DoPH	Q3/4			April
Cyber Security (TBA)	27	6.8	The delivery of this audit will	Director	Q3/4			Feb/A

Cardiff and Value UHB Internal Audit Plan 2018/19 -Planned output.	No	CR AF	Outline Scope	Exec Lead				Audit Cttee
			depend on the outcome of report of the external review.	Therapies				pr tba
Estates Service Improvement Team	47	6.4	Review the establishment and working of new team. Phased review.	Director Planning	Q1 - Q4			
Specialist CB	37		Review specific serious of risk as agreed with the Clinical Boards.	COO/Clinical Board		Scope agreed with Clinical Board.		

Follow-up Summary Report **Appendix B**

Follow-up Summary Report

1. Introduction

This report provides the Audit Committee with a summary of the current progress against the implementation of the agreed management actions from previously finalised Internal Audit reports.

The approach taken to verifying the level of progress made with the implementation of the agreed management actions varies depending on the overall assurance rating of the original report.

For 'Reasonable' or 'Substantial' assurance reports the level of progress is initially established via an Email request to the relevant managers. They are requested to provide information on the current position for each of the agreed management actions from the original report along with any relevant evidence to support the level of progress. Following review of the initial response / evidence Internal Audit will obtain any required additional evidence or carry out follow-up testing as deemed appropriate to verify the stated level of progress.

For 'Limited' or 'No' assurance reports a detailed follow-up review will be undertaken in order to establish the level of progress made and determine the up-dated level of assurance that can be provided. The outcome of these detailed follow-up reviews will be reported to the Audit Committee via the production of separate, individual follow-up reports.

2. Summary of Findings

The current follow-up position for each of the individual reports that have been finalised since April 2017 is summarised within Appendix A below.

The outcomes for those follow-ups that have been completed since the last meeting of the Audit Committee are as follows:

CUHB1718.19 – MTED Deployment

The report was finalised in November 2017 with a rating of **Substantial** assurance. All agreed actions were planned to be implemented by April 2018.

As at 09/10/2018 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	-	-	-	-
MEDIUM	2	2	-	-
LOW	-	-	-	-

TOTAL	**2**	**2**	**-**	**-**

CUHB1718.11 – Welsh Patient Referral System

The report was finalised in November 2017 with a rating of **Substantial** assurance. All agreed actions were planned to be implemented by April 2018.

As at 09/10/2018 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	-	-	-	-
MEDIUM	2	2	-	-
LOW	-	-	-	-
TOTAL	**2**	**2**	**-**	**-**

CUHB1718.23 – Surgery CB Anaesthetist Rota Management

The report was finalised in February 2018 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by March 2018.

As at 17/10/2018 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	1	1	-	-
MEDIUM	-	-	-	-
LOW	-	-	-	-
TOTAL	**1**	**1**	**-**	**-**

CUHB1718.24 – Children & Women CB Medical Staff Rotas and Study

The report was finalised in September 2017 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by April 2018.

As at 09/07/2018 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	1	-	-	1
MEDIUM	5	5	-	-
LOW	1	-	1	-
TOTAL	**7**	**5**	**1**	**1**

The incomplete action relates to the introduction of a monthly review of study leave as part of the Directorate Performance Review. This was delayed due to interim Clinical Director arrangements. A revised implementation date of November 18 has been provided so a further follow-up has been scheduled for December 18.

CUHB1718.26 – Mental Health CB Sickness Management and Rostering

The report was finalised in September 2017 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by June 2018.

As at 18/09/2018 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	2	-	1	1
MEDIUM	2	1	-	1
LOW	1	-	-	1
TOTAL	**5**	1	**1**	**3**

The 3 actions relating to the management of sickness absence have been recorded as not actioned due to the outcome of the recent Sickness Management audit within Mental Health. Updated actions have been agreed as part of the associated limited assurance report which is on the agenda as a separate item.

CUHB1718.26 – Action Plan on Deloittes Financial Management Review

The report was finalised in April 2018 with a rating of **Substantial** assurance. All agreed actions were planned to be implemented by May 2018.

As at 31/08/2018 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	-	-	-	-
MEDIUM	1	1	-	-
LOW	1	1	-	-
TOTAL	**2**	**2**	**-**	**-**

Follow ups in progress

In addition to the completed follow-ups detailed above, a further 10 follow-up schedules have been issued to date. Responses are currently being pursued from management for these.

						Audit Report Recommendations				High Recs Implemented			Medium Recs Implemented			Low Recs Implemented		
Job No	Audit	Assurance Rating	Report Issue	Follow-Up	Status of Follow-Up	Total	High	Med	Low	Full	Part	Not	Full	Part	Not	Full	Part	Not
1718.05	Business Continuity Follow-Up	Reasonable	May-18	Dec-18	Not Started	**2**	1	0	1									
1718.06	Research & Development	Reasonable	Oct-17	May-18	Complete	**6**	1	4	1	1		0	3	1		1		
1718.07	Wellbeing Objectives	Reasonable	Apr-18	Oct-18	1st Email Sent	**5**	0	5	0									
1718.08	Strategic Planning/IMTP	Reasonable	Apr-18	Jan-19	Not Started	**0**	0	2	0									
1718.10	UHB Core Financial Systems	Substantial	Feb-18	Dec-18	Not Started	**0**	1	0	0									
1718.11	Charitable Funds	Substantial	Aug-17	Aug-18	Complete	**4**	0	2	2				1	1		2		
1718.13	Costing	Reasonable	Aug-18	Apr-19	Not Started	**6**	2	4	0									
1718.14	AQS	Substantial	Aug-18	Apr-18	Complete	**1**	0	0	1	1								
1718.16	Serious Incidents Management	Reasonable	Nov-17	Jun-18	Complete	**5**	1	3	1	1			1	2			1	
1718.17	Mortality Reviews	Reasonable	May-18	Nov-18	1st Email Sent	**3**	1	2	0									
1718.19	MTED deployment	Substantial	Nov-17	May-18	Complete	**2**	0	2	0				2					
1718.20	Virtulisation	Reasonable	Apr-18	Nov-18	1st Email Sent	**5**	1	2	2									
1718.22	Welsh Patient Referral System	Substantial	Nov-17	May-18	Complete	**2**	0	2	0				2					

Job No	Audit	Assurance Rating	Report Issue	Follow-Up	Status of Follow-Up	Total	High	Med	Low	Full	Part	Not	Full	Part	Not	Full	Part	Not
1718.23	Surgery CB	Reasonable	Feb-18	Sep-18	Complete	**1**	1	0	0	1								
1718.24	Medicine CB	Limited	Nov-17	Jan-19	Not Started	**6**	3	2	1									
1718.25	Children & Women CB	Reasonable	Sep-17	May-18	Complete	**7**	1	5	1			1	5				1	
1718.26	Mental Health CB	Reasonable	Sep-17	Jul-18	Complete	**5**	2	2	1		1	1	1		1			1
1718.27	Residences	Reasonable	Feb-18	Jun-18	2nd Email Sent	**10**	1	4	5									
1718.28	WLI Follow-Up	Reasonable	Feb-18	Sep-18	1st Email Sent	**2**	1	0	1									
1718.31	Neuroradiology Additional Payments Follow-Up	Not Rated	Nov-17	Sep-18	1st Email Sent	**1**	1	0	0									
1718.34	Consultant Job Planning	Limited	May-18	Jan-19	Not Started	**6**	3	2	1									
1718.35	Nurse Revalidation	Reasonable	Nov-17	May-18	Complete	**3**	1	1	1		1		1			1		
1718.36	Organisational Values	Reasonable	Apr-18	Jan-19	Not Started	**3**	0	2	1									
1718.37	Sustainability Reporting	Reasonable	Sep-17	Apr-18	Complete	**3**	0	2	1				1	1			1	
1718.38	Model Ward	Reasonable	Mar-18	Sep-18	1st Email Sent	**5**	1	0	4									
1718.39	Cleaning Standards	Limited	Nov-17	Jun-18	Complete	**6**	3	2	1	1	1		2	1	1			
1718.41	EU 12 Hour Target	Reasonable	Apr-18	Jul-18	2nd Email Sent	**2**	0	2	0									

Job No	Audit	Assurance Rating	Report Issue	Follow-Up	Status of Follow-Up	Total	High	Med	Low	Full	Part	Not	Full	Part	Not	Full	Part	Not
1718.42	Action Plan on WAO Audit of RKC Associates	Substantial	Feb-18	Jun-18	Complete	**3**	0	1	2				1			2		
1718.43	Action Plan on Deloittes Financial Management Review	Substantial	Apr-18	Jul-18	Complete	**2**	0	1	1				1			1		
1718.44	RTT Performance Reporting	Reasonable	Jun-18	Jan-19	Not Started	**4**	0	3	1									
1718.45	HTA Findings	Substantial	Apr-18	Jun-18	Complete	**1**	0	0	1							1		

C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2018/19 Appendix C							
Assurance domain	**Audits**	**Overall rating**	**Not rated**	**No assurance**	**Limited assurance**	**Reasonable assurance**	**Substantial assurance**
Corporate Governance, Risk and Regulatory Compliance					● Standards of Behaviour		
Financial Governance and Management							● Charitable Funds ● Cost Improvement Programme (draft)
Clinical Governance, Quality and Safety							●Annual Quality Statement ● Ombudsman Reports
Strategic Planning, Performance Management and Reporting							
Information Governance and Security						● Neuroscience It System follow up ● *Renal It system (draft)*	
Operational Service and Functional Management					●*PCIC Interface Incidents (draft)* ● Mental Health CB - Sickness Mgt. ● Surgery CB Medical Staff Governance –	●Dental – Nurse Provision ●Dental – Theatre Sessions ● Mental Health CB – Section 17	

C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2018/19 Appendix C							
Assurance domain	**Audits**	**Overall rating**	**Not rated**	**No assurance**	**Limited assurance**	**Reasonable assurance**	**Substantial assurance**
					(draft)	●PCIC District Nursing rotas	
Workforce Management						●Electronic Staff Record ●Management of the Disciplinary Process	
Capital and Estates Management					● *Estates Time Recording System – Kronos (draft)*	● Capital Schemes – Future Wellbeing *(17/18)* (SSU) ● Environmental Sustainability Reporting ●Cleanliness Standards Follow up ●Carbon Reduction Commitment (SSU)	

Key to symbols:

● Audit undertaken within the annual Internal Audit plan
Italics Reports not yet finalised but have been issued in draft

INTERNAL AUDIT REPORT RESPONSE TIMES								**APPENDIX D**
Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off actual	Final issued	R/A/G	
Annual Quality Statement	Substantial	Final	13/6	4/7	2/7	2/7	G	1
Environmental Sustainability Reporting	Reasonable	Final	18/7	8/8	23/8	23/8	A	
Electronic Staff Record	Reasonable	Final	13/7	3/8	10/9	10/9	A	
Management of the Disciplinary Process	Reasonable	Final	13/7	3/8	10/9	10/9	A	
Dental CB – Dental Nurse Provision	Reasonable	Final	26/7	16/8	29/8	30/8	A	
Dental CB – Dental Theatre Sessions	Reasonable	Final	7/8	28/8	29/8	30/8	G	2
Estates Time Recording / KRONOS	Limited	draft	15/8/18	5/9/18			R	
Cleaning Standards Follow up -	Reasonable	Final	23/8/18	13/9/18	21/11/18		R	
Ombudsman Reports	Substantial	Final	23/8/18	13/9/18	24/8	24/8	G	3
Charitable Funds	Substantial	Final	31/8/18	21/9/18	10/9	10/9	G	4
PCIC Interfaces Incidents	Limited	Draft	26/9	25/10			A	
Mental Health Sickness Absence	Limited	Final	26/9	25/10	29/10	30/10	A	
PCIC district nursing rotas	Reasonable	Final	11/10	3/11	16/11	19/11	A	
Neuro IT System	Substantial	Final	21/10	3/10	4/10	4/10	G	5

Standards of behaviour	Limited	Final	31/10	21/11	15/11	15/11	G	6
Mental Health s17	Reasonable	Final	26/10	16/11	15/11	16/11	G	7
Renal IT System	Reasonable	Draft	7/11	28/11				
Surgery CB Medical Staff	Limited	Draft	12/11	4/12				
Cost Improvement Programmes	Substantial	Final	16/11	7/12	21/11		G	8

AUDIT & ASSURANCEKEY PERFORMANCE INDICATORS **APPENDIX E**

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2018/19	G	April 2018	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2018/19	A	83% 19 from 23	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	84% 16 from 19	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	47% 8 from 17	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 15 from 15	80%	v>20%	10%<v< 20%	v<10%

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Cardiff and Vale University Health Board

Mental Health Clinical Board – Sickness Management

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Final report issued:	30th October 2018
Auditor/s:	Lucy Jugessur, Principal Internal Auditor
	Sian George, Internal Auditor
Executive sign off:	Steve Curry, Chief Operating officer
Distribution:	Ian Wile, Director of Operations
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	Natalie Wraith, Clinical Board HR Manager
	Joanne Wilson, Directorate Manager
	Mark Jones, Directorate Manager
Committee:	Audit Committee

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

1. Introduction and Background

The review of Sickness Management within the Mental Health Clinical Board was completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board.

The Health Board relies on its workforce in order to provide a high quality service to its patients. Effective procedures for the management of staff sickness absence are essential to ensure that the required staff members are available when needed.

The management of sickness absence within the Mental Health Clinical Board was previously reviewed as part of the 'Sickness Management and Rostering' audit that was completed in September 2017. This identified a number of significant issues across the 4 wards that were reviewed.

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

2. Scope and Objectives

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

The purpose of the review was to establish if sickness absence is being effectively managed in order to minimise the rates of absence.

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

- There are appropriate sickness absence management policies and procedures in place and these are available to all staff;
- Sickness absence is appropriately recorded, monitored and managed in accordance with local procedures and the All Wales Sickness Management Policy; and
- Previous Internal Audit recommendations have been appropriately actioned.

The scope of the current review was limited to nursing staff and did not cover the management of Medical staff sickness absence.

As part of the review, detailed testing of the management of sickness absence was undertaken within the following 4 wards that were covered as part of the previous audit:

- Mental Health Services for Older People (MHSOP) - Ash Ward and Ward East 14.
- Adult Mental Health – Oak Ward and Cedar ward

In addition testing was also undertaken within the following new ward, as requested by Clinical Board management:

- Adult Mental Health - Alder Ward.

3. Associated Risks

The potential risks considered in this review were as follows:

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

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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 Mental Health Clinical Board Sickness Management is **Limited assurance**.

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

The findings from the current review have identified that Sickness absence within the Clinical Board is not being effectively managed.

Within Oak, Ash and Cedar wards the current testing identified that the All Wales Sickness Policy is not being consistently complied with. There were instances whereby self-certificates were not available or had been completed incorrectly and Return to Work forms had been completed inaccurately and there were delays in completing them. In addition,

sickness triggers were not being managed appropriately. Similar issues were identified within these 3 wards as part of the previous 'Sickness Management and Rostering' audit that was completed in September 2017. The current findings therefore illustrate that the previously agreed management actions have not been effectively implemented.

The current review also covered Alder ward, which had not been included in the previous review. Due to there being a number of changes in Ward Management, sickness absence is not currently being effectively recorded or managed. From the sample of 10 episodes of sickness reviewed, there was no documentation for seven and only partial documentation available for the other three cases. There was also no evidence of monitoring or management of sickness triggers.

It is however noted that the management of sickness absence in ward East 14, the fourth ward covered in the previous review, has improved considerably and the documentation was available to review and had been completed correctly.

5. Assurance Summary

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

Assurance Summary					
1	Appropriate sickness absence management policies and procedures			✓	
2	Sickness absence is appropriately recorded, monitored and managed		✓		
3	Previous internal audit recommendations have been actioned		✓		

** 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 MH CB – Sickness Management.

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 MH CB – Sickness Management.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: Appropriate sickness absence management policies and procedures in place.

The following areas of good practice were noted:

- From discussion with staff on the ward areas reviewed, they were all aware of the All Wales Sickness Policy.
- Copies of the All Wales policy and associated sickness absence flow charts were available to staff on the wards.

There were no significant findings noted.

Objective 2: Sickness absence is appropriately recorded, monitored and managed

The following areas of good practice were noted:

- It was identified from discussions with the selected wards that they have processes in place for reporting and recording sickness absence.
- From review of sickness management within the wards, it was evident that within East 14 the management of sickness had improved considerably.

The following significant findings were noted:

- Individual sickness episodes are not being consistently recorded and managed in accordance with the Sickness Absence Policy. Review of a sample of 50 nursing staff sickness episodes from across the 5 wards identified the following issues:
  - There was no sickness documentation present for seven employees;
  - Five self-certificates were not available;
  - For nine self-certificates there was no reason for sickness given on the form;
  - Six self-certificates were missing dates;
  - Two Return to Work (RTW) documents were not available;
  - Seven RTWs were completed on out of date versions of the forms and therefore the date the employee returned to work was not recorded;
  - Two RTWs forms had not been signed by the Manager and two RTWs had not been signed by the employee;
  - Eight RTWs forms had not been completed on a timely basis;

  - Seven episodes of sickness had days which were not authorised by a self-certificate form or a medical note;
- Sickness absence triggers are not being consistently monitored and the required informal / formal meetings are not always undertaken. The following issues were identified from the testing:
  - Seven employees had hit the triggers but there was no documentation to confirm that meetings had been held; and
  - There was no evidence that any monitoring of the triggers was being undertaken within Alder ward.

Objective 3: Previous internal audit recommendations have been actioned

The following significant findings were noted:

- From our testing, it is evident that the two recommendations from the previous audit have not been appropriately actioned. The management of sickness absence has not improved within 3 of the 4 wards previously reviewed, with similar findings being identified during the current review.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**0**	**2**	**4**

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

• 7 instances whereby an out of date version of the Return to Work form had been used and therefore the date the employee returned to work was not recorded on the form. • 3 instances whereby the RTW was not carried out within seven days of the return to work date. • 3 instances whereby the RTW had not been signed by either the employee or the manager. **Ash Ward** Review of the ten sampled staff identified the following issues: • 1 instance whereby no self-certification form was completed (the fit note did not start at the beginning of the sickness episode). • 5 instances whereby the self certs did not have a reason for the absence completed on them. • 3 instances whereby the self certs did not have fully completed dates of sickness. • 3 instances whereby a RTW was not carried out within 7 days of the staff member returning to work • 5 instances whereby sickness episodes had days which were not authorised by a self cert or med cert. **East 14** Review of the ten sampled staff identified the following issues: • 1 RTW had not been carried out within 7 days of the employee returning to work. **Alder Ward** The ward has had five new managers within seven months during the current	

year. Due to the frequent change of Managers and the pressures of the ward, sickness has not been managed appropriately. At the time of the review, a new Ward Manager had commenced on the ward and is aware that sickness absence needs to be managed more effectively. Review of the ten sampled staff identified the following issues: • 7 instances whereby there was no documentation to support the episodes of sickness. Of the three available: • 1 instance whereby a self cert was not available for the episode of sickness. • 2 instances whereby RTW forms were not available for the episodes of sickness. • 2 instances whereby sickness days had not been authorised.	
Recommendation	**Priority level**
Management should ensure that all sickness episodes are managed and documentation is completed in accordance with the All Wales Sickness Policy. Management should ensure that a self-certificate is completed correctly and a return to work interview is held with the employee including the completion of the return to work form. Clinical Board management should consider introducing periodic training on the sickness management process in order to increase awareness and compliance levels.	**High**

Management Response	Responsible Officer/ Deadline
• Directorates to send all managers a link to the sickness policy /NHS Wales Managing Attendance at Work Policy, reminding them of the importance of sending timely letters, conducting interviews and checking self-certification notes. • All Band 6 and 7 managers to attend refresher sickness training. • Further sickness surgeries have been scheduled and sickness rates have fallen.	Directorate Managers for Adult and MHSOP / May 2019

Finding - Monitoring of sickness episodes (Operating effectiveness)	Risk
The All Wales Sickness Policy confirms that "Managers are required to actively manage where an employee has demonstrated a pattern or frequency of absence" which includes employees attending informal discussions and formal sickness interviews as requested by the employees Manager. Audit reviewed sickness triggers to establish if they had been managed correctly and in compliance with the All Wales Sickness Policy. The following issues were identified across the 5 sampled wards: **Oak Ward** Two instances whereby sickness triggers were not managed appropriately. **Cedar Ward** One instance whereby a required informal discussion had not been undertaken.	Increased sickness absence levels.

Ash Ward Four instances whereby triggers had been hit but the required interviews had not been undertaken in accordance with the All Wales Sickness Policy. **Alder Ward** Due to the lack of sickness absence management documentation on the ward, there was no evidence that the triggers were being monitored for any of the ten sampled staff.	
Recommendation	**Priority level**
Management should ensure that the sickness triggers are being managed correctly with informal discussions and formal sickness interviews being carried out in accordance with the All Wales Sickness Policy.	**High**
Management Response	**Responsible Officer/ Deadline**
• Directorates to send "trigger table" out to all managers, reminding them to check with line managers if they have any doubt or queries with individual cases. • Senior Nurse Managers to conduct random sickness file checks as part of 1:1 with managers.	Directorate Managers for Adult and MHSOP / April 2019

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

Finding - Sickness dates (Operating effectiveness)	Risk
It was evidenced from our testing that there were a number of inconsistencies across all five wards with the recording of start and end sickness dates. There were different start and end sickness dates recorded on sickness documentation and ESR. The majority of differences were only 1 or 2 days which suggests that there is an issue with correctly and consistently recording the dates that sickness ends and the actual dates of return to work.	Increased sickness absence levels.
Recommendation	**Priority level**
Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR, and all sickness dates should be accurately and consistently recorded.	**Low**
Management Response	**Responsible Officer/ Deadline**
• All band 6 / 7 managers to attend refresher sickness training.	Directorate Managers for Adult and MHSOP / May 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings


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


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


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


No assurance - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

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

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

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

Cardiff and Vale University Health Board

Standards of Business Conduct (DoI & GH&S)

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	C&V-1819-05
Report status:	Final Internal Audit Report
Fieldwork commencement:	11th October 2018
Fieldwork completion:	29th October 2018
Draft report issued:	6th November 2018
Management response received:	13th November 2018
Final report issued:	15th November 2019
Auditor/s:	Elizabeth Vincent, Cara Vernon
Executive sign off:	Nicola Forman, Director of Governance
Distribution:	Nicola Forman, Director of Governance Sian Rowlands, Head of Corporate Risk & Governance
Committee:	Audit Committee

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

1. Introduction and Background

The review of the management of Standards of Behaviour has been completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board (UHB).

The Welsh Government's *Citizen-Centred Governance Principles* apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

All Health Boards should have a Standards of Behaviour Framework in place that sets out the arrangements for ensuring that all staff comply with the principles, including recording and declaring potential conflicts of interest and handling of gifts, hospitality and sponsorship.

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

2. Scope and Objectives

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

The purpose of the review was to establish if the Health Board has appropriate processes in place to ensure that all its employees and Independent Members practice the highest standards of conduct and behaviour.

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

- The Health Board has an appropriate and up to date Standards of Behaviour Framework Policy in place and this is widely available to all relevant parties;
- Effective processes are in place to ensure that all employees and Independent Members are aware of the requirements of the Standards of Behaviour Framework and have access to appropriate information, support and advice;
- Effective Arrangements are in place to ensure that specific groups of Employees and Independent Members complete a Declaration of Interest (DoI) Form on initial employment with the UHB and at periodic intervals thereafter;
- The Health Board has an up to date Register of Interests in place and the content is reported to the Audit Committee at agreed intervals;

- Effective processes are in place for ensuring that employees and Independent Members declare any offer of a gift, hospitality or sponsorship which requires recording; and
- A Register of all declared Gifts, Hospitality and Sponsorship (GH&S) whether, accepted or declined, is maintained and the content is reported to the Audit Committee at agreed intervals.

3. Associated Risks

The potential risks considered in the review were as follows:

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

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Standards of Business Conduct (DoI & GH&S) is **Limited Assurance**.

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

The findings from the current review have identified that the overall systems and controls in place for the management of Standards of Behaviour are inadequate. The policy is out of date, with the outcome of the audit indicating that awareness of the policy is insufficient. Weaknesses were identified across the systems in place for both Declarations of Interest and Gifts Hospitality & Sponsorship; from the completion of the forms, to the recording of the details in the register and the robustness of the reporting to Audit Committee.

Whist the Declarations of Interest process for Board Members is managed to a reasonable standard, the existing process does not ensure that the required declarations are received from the specific staff groups set out in the policy, with only a very limited number received.

The current level of declarations of Gifts, Hospitality & Sponsorship recorded would appear to be much lower than anticipated for an organisation of the size and nature of the UHB.

5. Assurance Summary

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

Assurance Summary					
1	Standards of Behaviour Framework Policy			✓	
2	Effective Processes are in place		✓		
3	Declaration of Interest Forms		✓		
4	Register of Interests		✓		
5	Gifts, Hospitality and Sponsorship		✓		
6	GHS Register		✓		

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

Design of Systems/Controls

The findings from the review have highlighted four issues that are classified as weakness in the system control/design for Standards of Business Conduct (DoI & GH&S).

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for Standards of Business Conduct (DoI & GH&S).

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: The Health Board has an appropriate and up to date Standards of Behaviour Framework Policy in place and this is widely available to all relevant parties.

The following areas of good practice were noted:

- The policy for the Standards of Behaviour Framework is available on the UHB intranet and internet sites for employees and independent members to access.
- The Corporate Risk and Governance page has a Standards of Behaviour tab that has links to the policy and the Standards of Behaviour Framework Quick Guide Booklet.

The following significant findings were noted:

- The Standards of Behaviour (SoB) Framework policy was published 15th January 2015. The review of this policy should be undertaken no later than three years after the date of approval and is therefore out of date.

Objective 2: Effective processes are in place to ensure that all employees and Independent Members are aware of the requirements of the Standards of Behaviour Framework and have access to appropriate information, support and advice.

The following significant findings were noted:

- The findings of the audit indicate that awareness of the Standards of Behaviour policy appears low. The SoB policy is not part of the induction or mandatory training process.
- The Corporate Governance team are not proactive in raising awareness of the policy and rely on individuals to complete DoI and Clinical Boards to remind staff of their responsibilities.
- The intranet page should be updated to allow staff easier access in finding the DoI forms.

- The Corporate Team does not maintain a comprehensive list of staff members that are required to complete a DoI. They only pursue Independent and Board Members.

Objective 3: Effective Arrangements are in place to ensure that specific groups of Employees and Independent Members complete a Declaration of Interest Form on initial employment with the UHB and at periodic intervals thereafter.

The following areas of good practice were noted:

- The majority of Board Members have completed a Declaration of Interest form.
- All 20 DoI forms that were sampled as part of the audit were available. Each form was signed and dated and the information provided matched with that recorded on the register.

The following significant findings were noted:

- Only 24 Non Board members have submitted a completed DoI and none of these were from any clinical board management team members or senior finance staff and only one was from senior medical staff, as per the requirement of the policy.
- From a review of a sample of twenty DoI forms, a number of matters were identified with regards to the robustness of the completion of the forms.

Objective 4: The Health Board has an up to date Register of Interests in place and the content is reported to the Audit Committee at agreed intervals.

The following areas of good practice were noted:

- The DoI Register for Board and Independent Members is available on CAV intranet.
- The DoI Register was presented at the September 2018 Audit committee, which is in line with the SoB policy.

The following significant findings were noted:

- Weaknesses were identified with the reporting of the DoI Register to the Audit committee.

Objective 5: Effective processes are in place for ensuring that employees and Independent Members declare any offer of a gift, hospitality or sponsorship which requires recording.

The following significant findings were noted:

- The level of reporting of gifts, hospitality and sponsorship appears low for the size and nature of the UHB.
- A review of a sample of completed forms identified a number of matters including; approval not being sought prior to the event and forms not being completed in full or authorised appropriately. The current format and completeness of the register was inadequate. A small number of entries that had been accepted were potentially inappropriate.

Objective 6: A Register of all declared Gifts, Hospitality and Sponsorship whether, accepted or declined, is maintained and the content is reported to the Audit Committee at agreed intervals.

The following areas of good practice were noted:

- The GH&S register was presented at the September 2018 Audit committee, which is in line with the SoB policy.

The following significant findings were noted:

- Weaknesses were identified with the reporting of the Declarations of GH&S register to the Audit committee.
- The GH&S register did not record the forms in date or in chronological order plus additional forms were recorded on a separate tab on the database but had not been transferred to the current register and vice versa. Therefore making the reliance on the current registers information uncertain.

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	**3**	**3**	**0**	**6**

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

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

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

Management Response	Responsible Officer/ Deadline
Recommendation Agreed – A review of the information available on the intranet will be undertaken to ensure that the information is easy to access. A programme of awareness raising will also be developed alongside the process detailed in recommendation 1 which will be continual and not a one off awareness raising programme.	Head of Corporate Governance 31st December 2018

Finding 3 - Gifts, Hospitality and Sponsorship Compliance (Control design)	Risk
Testing of a sample of entries recorded in the register identified : • Two entries that had been accepted were potentially inappropriate. • It was noted on one form that the gift was to be used as a raffle prize, but this was not recorded on the register and no further details provided. • 1 form was missing; • 2 forms had been provided for a member of staff but the register only recorded 1; • 4/12 forms did not state if the gift, hospitality or sponsorship had been declined or accepted; • 8/12 forms did not have approval from relevant director prior to the event; • 1 form had been signed before being submitted to the Governance Department; • 3/12 forms had not been signed by Governance Department;	Inappropriate acceptance of gifts, hospitality or sponsorship.

• None of the forms are recorded in date/chronological order on the register; • While testing was being undertaken it was found that there were forms recorded on the accepted tab that had not been transferred to the current register, and vice versa. Little reliance could be placed on how many forms had been received throughout 17/18 and to date as there was no consistency between these recordings. A separate sheet records entries that have been declined.	
Recommendation	**Priority level**
The Corporate Team should ensure that all forms are compliant with the SoB Policy and completed appropriately. The current format of the register needs to be reviewed, updated and amalgamated into a single register.	**High**
Management Response	**Responsible Officer/ Deadline**
Recommendation agreed – all submitted forms to be reviewed in line with the Policy to ensure compliance and appropriately completed. Register will be reviewed and updated and amalgamated into an appropriate format including recording in chronological order, whether the declaration has been accepted and also signed off.	Director or Corporate Governance – immediate and ongoing Head of Corporate Governance

Finding 4 - Out of date policy (Operating effectiveness)	Risk
The Standards of Behaviour Framework policy was published 15th January 2015. The review of this policy should be undertaken no later than three years after the date of approval and is therefore currently out of date.	Lack of awareness and / or application of the required standards of behavior.
Recommendation	**Priority level**
The directorate should ensure that the policy is reviewed and updated accordingly with the appropriate approval for changes sought where necessary.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Recommendation Agreed – policy to be reviewed and updated in line with best practice and up to date guidance.	Head of Corporate Governance - 31st December 2018

Finding 5 - Declaration of Forms (Operating effectiveness)	Risk
A sample of 10 DoI forms from both the Independent Board Member Register and Non Board Register was obtained. Testing was carried out to ensure all 20 DoIs were up to date and in place. The following was identified: • 3/20 forms showed they had been signed by a member after the date of return to the corporate governance section; • 2 members were on the register twice, however only one form was submitted for each;	Relevant interests are not declared which could lead to inappropriate decisions / actions.

• 1 DOI form was signed by member in September 2017, making their declarations out of date at the time of testing; • One form was not dated on return; • It was also noted at the time of testing that one Board Level Director did not have a completed DoI.	
Recommendation	**Priority level**
The Corporate Team should ensure that all forms are compliant with the SOB Policy and completed appropriately.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Recommendation Agreed – Forms will be reviewed for compliance with the new policy once reviewed and up until then forms will be reviewed for compliance with the current policy.	Head of Corporate Governance - immediate

Finding 6 - Audit Committee (Control design)	**Risk**
Although the DOI and GH&S registers were reported at the September 2018 Audit Committee, the information contained within the report was incomplete, due to the limited number of returns received. In addition the format and layout of the report was inadequate.	Relevant interests are not declared which could lead to inappropriate decisions / actions. Inappropriate acceptance of gifts, hospitality or sponsorship.

Recommendation	Priority level
The Corporate Governance department must ensure that the information provided to the Audit Committee contains a full picture of the level and nature of declarations received and information on declarations not received.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Recommendation Agreed – Future reporting to the Committee will ensure that the report is complete and in a suitable format to allow challenge and assurance of the registers.	Director of Corporate Governance – February 2019

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:	Wales Audit Office Report on Medical Equipment Re-audit 2018								
Meeting:	Audit Committee						**Meeting Date:**	4.12.18	
Status:	**For Discussion**		**For Assurance**	x	**For Approval**		**For Information**		
Lead Executive:	Director of Therapies and Health Sciences								
Report Author (Title):	Director of Therapies and Health Sciences								

SITUATION

The Wales Audit Office (WAO) re-audit has been received, the overall conclusion was that the Health Board has made progress in addressing recommendations made in the 2013 report, but more action is needed to improve the existing arrangements in place for managing medical equipment.

The Medical Equipment Group has considered the recommendations, reviewed its membership and developed an action plan.

BACKGROUND

The UHB has a Medical Equipment Group which has Executive Leadership and membership from the Clinical Boards and Corporate departments. The UHB does not have a medical equipment department; rather it is managed through Clinical Boards, with Executive oversight.

The WAO re-audit of medical equipment set out 8 recommendations for improvement. This followed on from a 2013 audit, which made 7 recommendations, 1 was fully completed and 6 in progress.

ASSESSMENT

See attached recommendations and action plan.

ASSURANCE is provided by:

Clinical Boards have been reminded of the need to support the Medical Devices Safety Officer role and ensure time to undertake the functions and attendance at the Medical Equipment Group.

Of the 8 actions, 3 are fully completed and 5 in progress.

RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the progress on the action plan.

Shaping our Future Wellbeing Strategic Objectives			
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											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	x	
Equality and Health Impact Assessment Completed:	Not Applicable										

WAO Medical Equipment Re-audit 2018

Cardiff and Vale UHB Management Response and Action Plan Update

Recommendation	Intended outcome/benefit	High priority (yes/no)	Agreed (yes/no)	AIB responsibility and actions	Completion date	Update Nov 18	Responsible officer
Medical Equipment Group R1 Review the effectiveness of the Medical Equipment Group, focusing on: • Membership of the group; • Attendance; • Executive Support; and • Reporting lines.	The Medical Equipment Group is effective in managing medical equipment and includes key representatives from all departments within the organisation.	Yes	Yes	Review and Refresh ToR based on recommendations of this report. Set out reporting mechanisms within UHB governance framework and reporting lines.	1st Sept 18	Completed ToR revised and agreed, including UHB governance and reporting lines	Director of Therapies and Health Science
Medical Device Safety Officer R2 Improve the effectiveness of the Medical Device Safety Officer role, by: • Providing clarity on the purpose of the role; • Ensuring attendance at Medical Equipment Group meetings; • Ensuring attendance at Clinical Board Quality,	The Medical Device Safety Officer role is effective and liaises with both the Medical Equipment Group and Clinical Board.	Yes	Yes	**Fully embed MDSO in CB QSE structures** Review MDSO role profile and resourcing and communicate requirements of the role with Clinical Boards. Develop MDSO dashboard to	31st March 19 30th Sept 18 1st Nov 18	Clinical Boards written to 30/10/18 asking for MDSO nominations. Responses outstanding and followed up 28 Nov 18 MDSO dashboard	Director of Therapies and Health Science

Recommendation	Intended outcome/benefit	High priority (yes/no)	Agreed (yes/no)	AIB responsibility and actions	Completion date	Update Nov 18	Responsible officer
Safety and Experience meetings; • Ensuring that MDSOs engage with their respective Clinical Board on medical equipment risks and issues; • Ensuring MDSOs have the necessary time and resources to perform the role; and • Giving MDSOs access to potential learning and development opportunities.				include: • Attendance at MEG & QSE meetings • QSE Med Equip reports, CB Datix reports, • CB med equipment risks Take learning from comprehensive specialist services CB Health and Care Standard 2.9 compliance audit to all CBs and audit as part of annual self-assessment process.	31st March 19	developed, to be communicated when MDSOs identified by clinical boards and by others who are appropriately trained, knowledgeable, experienced and sufficiently senior.	
Medical Equipment Risk Management R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach.	Medical equipment risk management arrangements are in place at the operational and strategic levels of the organisation.	Yes	Yes	Ensure CB's capture medical equipment risks as part of their risk management processes. These will be monitored via MEG, and escalated through relevant strategic committees e.g Strategy and Resources/Capital	1st April 19	Requirement of MDSOs when appointed	Deputy Director of Therapies and Health Science

Recommendation	Intended outcome/benefit	High priority (yes/no)	Agreed (yes/no)	AIB responsibility and actions	Completion date	Update Nov 18	Responsible officer
				Management/QSE/ Management Executive as required.			
Medical Equipment Inventory R4 The Health Board should consider alternative criteria for recording medical equipment items on an inventory such as those suggested in good practice guidance developed by the World Health Organisation.	There is a comprehensive medical equipment inventory in place to facilitate tracking of assets and to safeguard against loss.	No	No	The MEG will review the WHO good guidance and determine what is feasible to introduce, with resources available, to improve medical equipment inventory	1st April 19	On track	Deputy Director of Therapies and Health Science
Replacement of Medical Equipment below £5,000 R5 Develop an organisational approach for purchase and replacement of medical equipment below £5,000, in order to reduce clinical risk where services are unable to buy business critical equipment below this value.	Systems and funding are in place for the purchase or replacement of business critical equipment under £5,000.	No	No	Ensure MSDOs include key under £5K items on their risk log and escalate replacement needs within the CB	31 Jan 19	MDSOs to advise re feasibility of approach for revenue items	MSDOs

Recommendation	Intended outcome/benefit	High priority (yes/no)	Agreed (yes/no)	AIB responsibility and actions	Completion date	Update Nov 18	Responsible officer
				Ensure medical devices procurement officer scrutinises under £5K items to identify opportunities for standardisation and efficiency	31 Jan 19	Medical devices procurement officer appointed and fulfilling this objective	Medical devices procurement officer
Clinical Board Engagement R6 Ensure that Clinical Boards include the Medical Device Safety Officer report as a standing agenda item at the Quality, Safety and Experience meetings to discuss and address any medical equipment risks and incidents that arise.	Clinical Boards are fully aware of medical equipment risks/ incidents and can take suitable action where necessary	Yes	Yes	Develop MDSO metrics for reporting to their CB QSE meetings, and MEG reporting.	1st Nov 18	Requested of clinical boards in letter of 30/10/18, need MDSOs in place to develop metrics	Deputy Director of Therapies and Health Science
Integrated Working R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists.	An integrated approach will ensure prompt resolution of medical equipment issues, minimise patient risk and provide an effective service.	Yes	Yes	Monitor attendance and engagement of CB MSDOs and other members at MEG, escalate non-attendance or lack of engagement	30 Sept 18	Completed	Deputy Director of Therapies and Health Science

Recommendation	Intended outcome/benefit	High priority (yes/no)	Agreed (yes/no)	AIB responsibility and actions	Completion date	Update Nov 18	Responsible officer
				Monitor progress of action plan developed by Health and Safety Advisor following the Arjo Proact 2017 survey Health and Safety Committee 18/005 minute (25 January 2018)	30 Sept 18	Completed, Agenda item for MEG	Health and Safety Advisor
				Maintain hoists within the Clinical Engineering Department at the end of external supplier contract	1st Dec 18	Agreed to transfer this, date of commencement will be April 2019 to enable budget transfer for this	Head of Clinical Engineering

Recommendation	Intended outcome/benefit	High priority (yes/no)	Agreed (yes/no)	AIB responsibility and actions	Completion date	Update Nov 18	Responsible officer
				Ensure Clinical Engineering is represented at the Bed Management Group	1st Dec 18	Completed	Deputy Director of Therapies and Health Science
Pathology Services R8 Evaluate the medical equipment arrangements in place within Pathology Services (Laboratory Medicine).	The Health Board will receive assurance that there are effective medical equipment arrangements in place within this service area.	Yes	Yes	Agree Pathology MDSO role with CD&T with same CB functions at a directorate level reporting through to CB MDSO.	1st Nov 18	Completed	Deputy Director of Therapies and Health Science

Report Title:	Tracking Reports								
Meeting:	Audit Committee						**Meeting Date:**	4.12.18	
Status:	**For Discussion**		**For Assurance**	x	**For Approval**		**For Information**	x	
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Corporate Governance								

SITUATION

This report provides the Committee with the tracking log relating to Wales Audit Office (WAO) reviews and recommendations. It also sets out proposals for managing the tracking of progress following key reviews / inspections and accurately reporting the same to Committee.

REPORT

BACKGROUND

Tracking logs have been maintained by the Corporate Governance Department to capture recommendations made and improvement actions taken following WAO and other external body reviews of UHB services. These logs have been routinely provided to the Audit Committee in order to provide assurance that the necessary remedial action is being taken by the relevant areas.

ASSESSMENT

It was acknowledged at the Committee's September meeting that the tracking system requires review and strengthening and the quality of reporting to the Committee improving.

An initial review of the current tracking system illustrates that:

- we are not accurately capturing progress and closure of actions with the result that many historic items remain open;
- we have a number of separate tracking logs so the information is not captured in one place; internal audit reviews are also currently excluded from the tracking system;
- there is a risk that we are not capturing all reviews / inspections with some reports going straight to the respective Clinical Board and therefore bypassing corporate governance oversight;
- tracking of regulatory compliance requires development to ensure that we are clear on all our obligations and any gaps in compliance.

It is proposed that the Corporate Governance department conclude the tracking system review and provide the Committee with a revised tracking log and report at the February Committee meeting.

This review will include liaison with Executive Directors to consider outstanding actions and confirm where items are concluded and can be closed, consideration of other systems in use to capture and monitor regulatory compliance and working with Clinical Boards to ensure our tracking log includes all reviews / inspections.

ASSURANCE is provided by the review being undertaken with Executive Directors and the provision of tracking reports to the Audit Committee as a standing agenda item.

RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the Wales Audit Office Tracking Report and
- **AGREE** the approach proposed in this paper.

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

Five Ways of Working (Sustainable Development Principles) considered										
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration	x	Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable									

Date of Report	Title of Review	Summary of Findings / Recommendations (as reported to Audit Committee	Excutive Lead	Management Response to Date	Status (Ongoing / Completed)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Feb 2015	Orthopaedics (2012)	Orthopaedic services are generally coping with demand, which is consistently low, but MRI waits are long, the inpatient pathway needs to be improved to make better use of resources and although outcomes are generally positive, revision rates and missed follow-up appointments are some of the highest in Wales - Investment in primary care services is increasing and there is a consistently lower rate of GP referrals, although the impact of the Clinical Musculoskeletal Assessment and Treatment Service (CMATS) is unclear. - Outpatient and physiotherapy services are generally meeting demand, although a reduction in did not attend rates for outpatient appointments and the availability of direct access to physiotherapy could further improve waiting times. Access to MRI for GP referred patients is problematic. - More timely pre-operative assessment, increased day surgery rates, maximised bed occupancy and a reduction in prosthetic costs could improve the use of inpatient resources; and - Patients generally have positive outcomes with the exception of revision rates, which are some of the highest in Wales and not all patients are followed-up. **WAO informed of upcoming follow-up review for next financial year 2018/19**	Chief Operating Officer	Report received and action plan approved by PPP Committee in July 2015. Interim report received in January 2016 and a full report in 12 months February 2017) R&D 7.11.17 - A revised model of care was being piloted in CMATS and indicated a significant impact on outpatient demand. Substantial work had been undertaken to reduce the waiting list. This remained challenging as there were pockets with significant demand but was confident this would continue to improve which had been reflected in the RTT position over the last few quarters. In regard to prosthesis costs; the service with NWSSP had negotiated the lowest cost of knee replacement in Wales. The Planned Care Programme had been rolled out to spinal surgery and achieved an 84% response rate for this year. This had allowed only 5-6% of patients to require follow-up stating clinical outcomes were better than the UK average.	On-going	Resource and Delivery - Charles Janczewski	21/07/2015 (PPP) 18.01.16 (PPP) R&D 7.11.117
01 Jun 2015	Medicines Management (2014)	The work reviewed medicines management arrangements in the acute sector to assess scope for making improvements in relation to the quality and efficiency of services. The review concluded that there are strengths in the way the Health Board managed medicines but there were also issues associated with the strategic approach, storage facilities, transfer of medicines information and performance monitoring. - There was clear executive leadership, regular financial monitoring and improved clinical engagement but there was scope to raise pharmacy's profile, clarify accountabilities and strengthen the strategy. - Pharmacy staff costs per bed day were lower than the Welsh average and workload pressures were similar to the rest of Wales. There was scope to dedicate more resource to training and improve access to the pharmacy team outside normal hours. - Pharmacy facilities largely comply with key requirements although there were risks associated with storage of medicines, monitoring the temperature of ward fridges and infrequent audit of injectable medicine preparation on the ward. - There were some strengths to medicines management processes but there were risks related to information transfer between primary and secondary care, timeliness of reconciliations, non-medical prescribing and supporting patients to take their medicines properly. - There is scope to improve performance reporting, mixed evidence about the effectiveness of learning processes and a need to understand more about the root causes of the pharmacy team's safety interventions.	Medical Director	Report agreed and action plan developed. Action plan presented to and agreed by the PPP Committee in January 2016. Whilst the Committee did not agree when a follow-up would be received it will be added to the workplan for February 2017 by which time most actions will have been completed. Report to be presented to Committee, 7 November 2017 **The Nurse Executive Director** was pleased to see there was improvement and progress being made. This was endorsed by the Chair in light of looking at the action plan. It was agreed for further assurance that recommendations were being acted on, a report would be brought back to the Committee on an annual basis for an update on progress but would be monitored through the Medicines Management Group. **Executive Director of Strategic Planning:** Business Continuity Training has been provided to Clinical Boards and standard templates have been developed to support buisness continuity planning in Clinical Boards. The Chief Operating Officer holds a dedicted meeting each quarter to discuss business continuity, supported by the Head of Emergency Planning. The corporate arrangements for business continuity planning are being reviewed. We reviewed business continuity following the post winter adverse weather review.	On-going 7.11.18 12.09.18	Resource and Delivery - Charles Janczewski	18.01.16 (PPP) R&D 7.11.17
01/10/2017 **01/10/2015**	Review of Follow-up Outpatients - Assessment of Progress Management of follow-up of outpatient appointments (2014)	R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: a) covers a broader range of specialities; and b) clearly reports clinical risks associated with delayed follow-up appointments. R2 Identify clinical conditions across all specialties where patients could come to irreversible harm through delays in follow-up appointments. R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date. R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation. The WAO review concluded that from a difficult starting point, the Health Board was taking appropriate action to identify the volume of its outpatient follow-up need but too many patients are delayed, the trend is worsening and it needs to do a lot more to develop sustainable follow-up outpatient services. The reason for their conclusion was that: - The Health Board has taken a pragmatic approach to determining the volume of outpatient follow-up demand, but it needs to better understand clinical risks to patients. - While follow-up waiting lists are more accurate, too many patients are delayed, the trend is worsening, and scrutiny and assurance arrangements needs strengthening - The Health Board is improving the administration of follow-up waiting lists but needs to develop a planned approach to modernise outpatient services.	Chief Operating Officer	Presented to Audit 5.12.17 and forwarded to QSE for monitoring purposes. Action plan approved by the PPP Committee on 10 November 2015. The Committee received a further report regarding Outpatients Follow-ups in March 2016 where it was agreed to receive a report at every meeting. The Committee has been advised that further work is required regarding pathway redesign and the Committee will be kept appraised of this via the regular reports. To report to Private Session of Board 28 July 2016 Reported to QSE on 20 June 2017. Minute QSE 17/105	Ongoing	Resource and Delivery - Charles Janczewski	Audit 5.12.17 QSE - 13.02.18 10/11/2015 & 15/03/16 (PPP) 12.07.16 (PPP) QSE 20.06.17
26 Jan 2016	Review of Operating Theatres (Jan 2016)	1) The theatre improvement project is driving change through a clear focus on improving processes and performance management to improve efficiency 2) Theatre utilisation and productivity have improved but the Health Board has not clearly demonstrated that its investment has led to cashable financial savings. 3) Problems with staff engagement and workforce capacity mean there are risks to maintaining momentum 4) The focus on utilisation has not been matched by a strong enough focus on quality, although staff have positive views about surgical safety.	Chief Operating Officer	To be considered by the PPP Committee in May 2015 To report to PPP Committee January 2017 meeting. 10.01.17 - The report from WAO was responded to and an action plan developed, 86% of which was now green. This prompted the Theatre Strategy work and out of this five workstreams had been created. 16.05.17 - • Theatres had received £860k of replacement equipment but faced a backlog of £3m. • The metrics were looked at in relation to the utilization of theatres. This provided visibility to what was happening across the patch. They were able to predict what would happen with the ability to track all categories. • There were issues with a few of the theatres. These were currently addressed and a plan was in place. • An theatre estates plan was being developed to refurbish the wards at UHW and UHL. 7.11.17 - THEATRE UTILISATION • In order to strengthen areas key strategies were put in place such as; a workforce plan to improve staffing levels; to strengthen governance and accountability with the clinicians; to look at systems reviewing whole pathways around the surgical stream• The position has increased to 78-79% utilisation with a stretch target of 83% being the national standard. Bookings have reached 86% compliance; this was an 8% improvement. Improvements in CAVOC had shown 92% of theatre utilization. Work had commenced with the Children's Hospital predominantly to do with the use of theatres for elective and emergency surgery. There has also been improved trajectory for day units on both the UHL and UHW sites.	On-going	Resource and Delivery - Charles Janczewski	02.05.16 (PPP) 12.07.16 (PPP) 10.01.17 (PPP) 16.05.17 PPP 7.11.17 - R&D
01 Sep 2016	Consultant Contract: Follow-up of previous audit recommendations	1) Processes to review job plans annually 2) Guidance and training 3) Appropriate involvement 4) Information and outcome setting 5) Appraisal 6) Monitoring arrangements 7) Service improvement 8) Supporting processional activities 9) Wider benefits realisation	Medical Director	Draft being prepared. To go forward to PPP in May 2017	Ongoing	Resource and Delivery - Charles Janczewski	Audit 28.02.17
01 Nov 2016	Review Delayed Transfers of Care	1) Discharge Planning Audit - address the findings from the Delivery Units discharge planning audit either by: developing an action plan; or incorporating actions into existing service improvement action plans. 2) Imtermediate Care Fund (ICF) - Explore ways of mainstreaming services funded through the ICFG to ensure services remain resilient	Chief Operating Officer	Draft being prepared. To go forward to next QSE meeting in April 2017. Asked when it was anticipated that progress would be seen (the UHB had the third highest number of delayed transfers of care) in Wales, it was noted that Mrs Alice Casey was taking the lead on length of stay through the transformation work and this would be reported to the UHB Board through the Transformation Board.	Complete	Resource and Delivery - Charles Janczewski	Audit 28.02.17 18.04.17 - QSE
01 Jan 2017	Review of Estates	1) To ensure thte estates service is represented at board level, priortise recruiting an independent board member for estates. 2) Create a central log of estates related issues and actions resulting from Clinical Board meetings. 3) Develop a fully costed Estates Management Strategy. 4) Develop a zero based estates budget that makes provision for likely revenue costs arising from changes to the Health Board estate, such as new buildings. 5) Introduce a system to inspect a percentage of repairs each month. 6) Strengthen performance management by: extending the performance dashboard to include Key Performance Indicators (KPIs) for the other serices covered by the Service Board; and making greater use of the data captured through the Backtraq repairs maintenance system. 7) To ensure repairs are correctly priortised: run Backtraq refresher training for helpdesk staff; and review questions on call handlers' script	Director of Strategic Planning	1) An Independent Member with responsibility for Capital & Estates has been appointed. 2) This can be achieved by our Backtraq Maintenance System. All actions can be logged on this system. 3) Estate Strategy ready for launch. 4) Executive Team regularly reviewing estates priorities via Capital Management Group 5) Full KPI pack for Estates in place and being measured. 6) KPI's completed and communicated each month. Content covers all of Service Board responsibilities. 7) Refreshers completed and Backtraq has multi levels dedicated for prioritisation. Teams manage all tasks by priority on a daily basis. Levels 1 to 5. (Immediate to Planned Work within 28 days). **Executive Director of Strategic Planning:** Estates Strategy has been drafted and considered by the Board in September. Shared with Welsh Government.	Ongoing 12.09.18	Strategy and Delivery John Antoniazzi	Audit 28.02.17 Audit 5.12.17

Date of Report	Title of Review	Summary of Findings / Recommendations (as reported to Audit Committee	Excutive Lead	Management Response to Date	Status (Ongoing / Completed)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Jan 2017	Structured Assessment 2016	1) Financial Reporting - strengthen financial reporting arrangements: a dashboard summarising performance against against key financial performance indicators and the issues and detail of actions being taken to manage overspend and deliver necessary savings by clinical area 2) Development of Plans: clear connectivity between the medium term plan and its longer term strategy, as well as its other strategic plans 3) Monitoring and scrutiny of plans 4) Planning capacity 5) Board and assurance framework 6) Transparency of public reporting 7) Board membership, vacancies to be filled and support quorate running of committees 8) Scrutiny of performance: Establish new Resources and Delivery Committee as a matter of urgency to ensure robust scrutiny is given to HBs performance and ensure relevant information is provided to Committee including sharing of clinical board reviews to focus attention on areas which need greatest scrutiny. 9) Governance capacity: to undertake further evaluation. The views of IMs on what assurances are needed should be sought as part of evaluation 10) Tracking arrangements: Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee	Director of Corporate Governance	Draft being discussed by the Management Executive and presented to Audit Committee in February 2018	Ongoing	Audit - John Antoniazzi	28.02.17 24.04.17 27.02.18
01 Feb 2017	Radiology Services	1) Develop an action plan detailing how reporting backlogs will be managed sustanability. 2) Over the next year, increase appraisal rates for non-clinical radiology staff to at least the level of all other radiology staff. 3) Over the next year, increase mandatory training rates for all radiology to staff at least eh Health Board target of 85%. 4) Liaise with referring clinicians when developing and reviewing referral guidance. Ensure all referring clinicians know ehre to access up to date versions of guidance. 5) To develop a radiology strategy over the next 12 months. 6) Develop a workforce plan alongside the radiology strategy which identifies the baseline capacity needed to sustainably meet radiology demand in a timely and safe way. 7) By mid-way 2017 develop an equipment replacement plan. 8) Strengthen directorate performance management	Chief Operating Officer	On Audit agenda for 24 April 2017 but not discussed as no representation. To be reported at Resource and Delivery Committee 7 November 2017 the Radiology Strategy is a complex piece of work and in the main actions were being progressed as intended. • Would like to see an indication of the timeframe with milestones finalised and how this would fit in with the IMTP process. • Over the next few months this piece of work would continue, with more specific timelines as this will be a part of the IMTP document. Once this was complete it would be shared with the Committee. •To have a brief update presented to the Committee of what was being put in place in regard to the recommendation that had not been accepted	Ongoing	Resource and Delivery - Charles Janczewski	7.11.17 - R&D
01 Jul 2017	Contractual Relationships with RKC Associates Ltd and its Owner	1) Board members and senior officials with significant financial responsibility should be on the organisations payroll, unless there are exceptional circumstances - in which case the Accounting Officer should approve the arrangements - and such exceptions should exisit for no longer than six months. 2) Engagements of more than six months in duration for more than a daily rate of £220, should include contractual provisions that allow the department to seek assurance regarding the income tax and NICS obligations of the engagee - and to terminate the contract if that assurance is not provided; and 3) These measures should be implements within three months - and implementation will be monitored after one year, reporting back to hte Chief Secretary to the Treasury and the Minister for the Cabinet Office; and if it emerges that any departments have not abided by these rules, sanctions will apply - wiht departmental resource budgets reduced by up to five times the payment in question	Medical Director	Action plan to be presented at Audit Committee 26.09.17 and Board Meeting 28 September will be a standing agenda item for Audit Committee until all actions complete.	Ongoing	Audit - John Antoniazzi	Audit - 26.09.17 Board - 28.09.17
01 Nov 2017	Discharge Planning	R1: Health Board collates a comprehensive range of information about community health and social care services. a) develop a system where ward staff are able to access up-to-date information about community health and social care services b) review the rnage and frequency of data about community health and social care services. For example, waiting times for some services anfd the frequency data on services available through other NHS bodies and housing options is collated. R2: We found that recently revised discharge and transfer of care and choice of accommodation policies were part of partnershipa ction plans but we found no evidence that patients and carers were involved in the process. The HB should seek to involve patients and carers when the next policy revisions are due. R3: we found that ward staff were unaware of discharge policies and pathways. The HB should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in dishcarge planning understand how to use it. R4: We found that staff training on discharge planning is patchy and that the HB does not monitor compliance with training. Plans to improve training is included on the discharge improvement plans but staff told us taht a lack of capcaity on the wards is a barrier to attending training. The HB should: a) explore developing an e-learning course for discharge planning which ward staff may find more accessible. b) ensure that attendance at training is captured on the ESR, which will help to improve compliance and monitoring.	Chief Operating Officer	Presented to Audit 5.12.17 and forwarded to QSE for monitoring purposes.	Ongoing		Audit - 5.12.17 QSE - 13.02.18
01 Sep 2017	Review of GP Out of Hours Service	R1 the Health Board does not have a GP out-of-hours strategy or workforce plan. The HB should A) Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance; and b. develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service. R2 the Health Board has strengthened the way it monitors GP out-of-hours performance. Some weaknesses remain in clinical audit for GPs and learning from patient feedback. a. introduce processes for learning from patient feedback to improve GP out-of-hours services; b. prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards; and c. check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate. R3 Public messaging: a) improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the conditions and circumstances in which patients should use it. b. work has already been undertaken to try to ensure all GP practices have a standard answerphone message that provides appropriate information about the out-of-hours service. The Health Board now needs to ensure this is rolled out and implemented in all practices. c) as part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours. R4 Interface with other services: a. share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand; and b. identify and address the reasons that are preventing out-of-hours staff from accessing the GP record.	Chief Operating Officer	Presented to Audit 5.12.17 and forwarded to QSE for monitoring purposes.	Ongoing		Audit 5.12.17 QSE - 13.02.18
01 Oct 2017	Review of Follow-up Outpatients - Assessment of Progress	R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: a) covers a broader range of specialities; and b) clearly reports clinical risks associated with delayed follow-up appointments. R2 Identify clinical conditions across all specialties where patients could come to irreversible harm through delays in follow-up appointments. R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date. R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation.	Chief Operating Officer	Presented to Audit 5.12.17 and forwarded to QSE for monitoring purposes.	Ongoing		Audit 5.12.17 QSE - 13.02.18

Date of Report	Title of Review	Summary of Findings / Recommendations (as reported to Audit Committee	Excutive Lead	Management Response to Date	Status (Ongoing / Completed)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Oct 2017	Collaborative Arrangements for Managing Local Public Health Resources	R1 Collaborative arrangements for managing local public health resources do not work as effectively as they should do. The Wales Audit Office recognises, in part, that the problems identified in this report relate to matters that are the responsibilities of Welsh Government, Health Boards and Public Health Wales. R2 Continued working with Health Boards through the DsPH to agree the public health priorities that need to be delivered collectively, including identifying individual contributions to delivery and agreeing how outcomes will be measured collectively and monitored and reported locally and nationally. R3 Developing effective arrangements to demonstrate that PHW is securing value for money from the specialist public health resources allocated to LPHTs. R4 Clarifying the roles and responsibilities of the Trust's national and local teams in relation to developing and delivering health improvement programmes. R5 Progressing work to develop reliable methods for allocating specialist public health resources to LPHTs and other stakeholders that covers the breadth of public health practice including healthcare public health. R6 Agreeing appropriate mechanisms for communicating and sharing information between the Trust and LPHTs. R7 Agreeing a mechanism whereby workforce planning discussions take place on a more formal basis between the Trust and DsPH R8 Clarifying the requirements for career progression for staff working within LPHTs, including whether a post-graduate degree in public health is a pre-requisite R9 Clarifying expectations for staff working within LPHTs about voluntary registration with the UK Public Health Register and whether it is, or should be, a requirement to undertake particular roles.	Director of Public Health	Presented to Audit 5.12.17	Ongoing		
Mar-18	Structured Assessment 2017	R1 The Health Board needs to use intelligence such as benchmarking data to identify stretch targets on a case-by-case basis in areas where greater levels of savings could be made. R2 To ensure compliance with the NHS planning framework, the Health Boards needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the annual operating plan, and subsequent three year integrated medium term plans. R3 To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of papers presented is appropriate and manageable. R4 To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner. R5 The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by: mapping risks to the Health Board's strategic objectives; reviewing the required assurances; improving clarity of risk descriptors and clarifying to the reader the date when risks are updated and/or added. R6 The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulation, which comes into force in May 2018. This should include: updating information governance strategy; putting in place arrangements for monitoring compliance of the primary care information governance toolkit; developing and completing an Information Asset Register; ensuring that an identified data protection officer is in place and improving the uptake of information governance training. R7 The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to include a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee. R8 The Health Board needs to revisit its informatics Strategic Outline Plan in light of the financial resources available and seek Board approval of the revised strategic approach. R9 To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security.R10 To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents.	Director of Corporate Governance	Presented to Audit 25.09.18	Ongoing Outstanding actions for completion Dec 2018, closure report will come to Audit Feb 2019	Audit - John Union	Audit 25.09.18

Report Title:	Business Continuity Progress Report								
Meeting:	Audit Committee						**Meeting Date:**	4.12.18	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		x
Lead Executive:	Executive Director of Strategic Planning								
Report Author (Title):	Emergency Preparedness Manager								

SITUATION

Since October 2010, Cardiff and Vale University Health Board (UHB) has had a Business Continuity (BC) Policy and BC Planning Guidance, promoting a culture of business continuity management, to instill confidence in its stakeholders (staff, patients and customers) in its ability to effectively deal with and recover from disruptive challenges.

BACKGROUND

In November 2014, an internal BC audit was undertaken, and the report finalised in February 2015. This highlighted three issues which resulted in an overall rating of **Limited Assurance**. All three were addressed and recognised in the follow up visit.

ASSESSMENT

A subsequent report was produced in 2016, with a more detailed list of recommendations (see below).

RECOMMENDATION	ACTION	CURRENT STATUS
Responsibility for leading on BCP to lie with the Executive Director of Strategy and Planning.	Incorporated in revised BC Policy (Ref: UHB050) and BC Planning Guidance (Ref: UHB400). Approved by Board sub-committee in January 2018.	Complete
In light of the clinical board authorisation process, it is now appropriate that business continuity planning becomes a routine agenda item for both Governance and Audit meetings.	COO established quarterly BC forum to monitor development of Clinical Board BC plans.	Complete

At a strategic level, support for UHB wide plans will be via the Civil Contingency function. Local/operational plans will continue to be the responsibility of individual Clinical Boards, with a framework provided from the Planning Department.	Revised BC Policy (Ref: UHB050) and BC Planning Guidance (Ref: UHB400) produced by the EPRR team. Support provided to Clinical Boards and Corporate departments to advise on approach for development of their respective BC plans.	Complete
RECOMMENDATION	**ACTION**	**CURRENT STATUS**
With guidance from the Planning Department, Clinical Boards will set out formally their arrangements for business continuity planning. Clinical Board triumvirates are required to formally review all escalation/business continuity / recovery documents within their areas of responsibility.	BC awareness sessions provided by EPRR team for Clinical Boards, Directorate Managers and Service Leads to advise on developing their respective BC plans, to clarify the approach required in developing robust and resilient arrangements.* Clinical Boards and Corporate Departments are now developing BC plans.	Ongoing
A formal guidance document and business continuity plan template has been developed. This has been piloted within two areas and is now ready for further dissemination. The required roll out will occur on an incremental basis during 2015.	BC Planning Guidance (Ref: UHB400) produced by the EPRR team. This includes the 'template' Planning Assessment Tool and BC Plan This has been rolled out across all Clinical Boards and Corporate Departments.	Complete
There is risk in the current civil contingency model, with capacity limited by a single Civil Contingency Manager. The Executive Director of Strategy and Planning will review the Civil Contingency model for business continuity requirements.	The Civil Contingency model was reviewed, and a business case presented for 2 new posts. Approval was granted for 1 post, providing resilience for the EPRR function; but limiting opportunity to address BC.	Complete
*See Annex A for BC support provided by EPRR team.		

ASSURANCE is provided by:

A further internal BC audit was undertaken, and the report finalised in May 2018. On the basis of this follow up, the level of assurance that could be given as to the effectiveness of the system of internal control in place to manage the risks associated with BCP has increased to **Reasonable Assurance**.

RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the progress report.

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

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	✓	Long term		Integration		Collaboration		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

ANNEX A

Business Continuity Planning Exercises

- In November 2016, the EPRR Team supported Clinical Diagnostics and Therapies in the delivery of an exercise to consider the impacts, priorities in the event of a protracted power failure (26/11/16).
- In November 2017, the EPRR Team delivered a multi-agency table top exercise (EVAC Ark). Its aim was to prepare UHB staff (with key partner agencies) for a hospital evacuation and shelter response involving the Childrens Hospital for Wales (08/11/17).
- In spring 2018, the UHB were involved in a lessons learnt exercise from the severe weather.
- In October 2018, in collaboration with PCIC, the EPRR team delivered a Business Continuity Management Exercise. Its aim was to review local preparedness planning and enhance organisational resilience in case of disruption to their core critical functions.

Business Continuity Planning Awareness Sessions Delivered in 2018

- Clinical Board Specific
  - Primary, Community & Intermediate Care (PCIC) (09/02, 07/03 & 04/04)
  - Surgery (27/04/18)
  - Medicine (03/06/18)
  - Children and Women (03/07/18)
  - Dental (18/07/18)
  - Clinical Diagnostics and Therapeutics (23/08/18)
  - Specialist (25/09/18)
  - Mental Health (28/09/18)

- GP Practice Managers
  - Delivery date: (16/10/18)

- General
  - Provided on 11/04, 04/07 & 12/09

In total, 152 members of staff from the Clinical Boards, Directorates, Services and GP Practices with responsibility for the development of BC arrangements have attended.

Business Continuity Planning Awareness Session Feedback

- Average 92% approval rating, with comments including:
  - An interactive workshop where we go through one of our own Red priority groups with an instructor to ensure we are working through the correct pathway.
  - Standard templates are the way forward simple to use - user friendly - uniform.
  - Helpful session.
  - The template is a great help but it would also be really helpful to see completed plans by other services (if any out there!).
  - Much more straightforward than anticipated.
  - I felt the session content was set at an appropriate level for the audience and now feel empowered with the knowledge and skills to write the plan.
  - Good session a follow up session to review completed plans might be helpful.
  - I have had sporadic info but it was good to attend this session because it filled in the gaps.

Business Continuity Planning Awareness Sessions Planned 2018-19

- General
  - Delivery dates: (09/01/19, 11/04/19, 16/07/19 & 10/10/19)

- The EPRR team are also working closely with the Emergency Department and CD&T in order to deliver Business Continuity Management Exercises, scheduled for March 2019 and May 2019 respectively.

Both exercises aim to review local preparedness planning and enhance organisational resilience in case of disruption to their core critical functions.

Report Title:	Report of the Losses and Special Payments Panel								
Meeting:	Audit Committee						**Meeting Date:**	4.12.18	
Status:	**For Discussion**		**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Finance								
Report Author (Title):	Head of Finance (Financial Accounting and Services)								

SITUATION

As defined in the Standing Financial Instructions, the Audit 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 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 / Assistant Director of Finance). This panel meets twice yearly and is tasked with considering the circumstances around all such cases and making 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.

BACKGROUND

The Losses and Special Payments Panel last met on 21st November 2018 to consider the 6 month period 1st April 2018 to 30th September 2018. This report informs the Audit Committee of the items considered at this meeting and the recommendations made for formal Audit 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.

ASSESSMENT

For the six month to 30th September 2018, the following losses have been identified for write off:

- £53,607 in respect of bad debt write offs for the period 1 April 2018 to 30 September 2018;
- Clinical negligence claims of £11.776m and personal injury claims of £0.292m for the period 1st April 2018 to 30th September 2018. For noting the income and expenditure charge suffered by the UHB in respect of such incidents was £0.852m;
- Small Claims Panel Losses of £4,875 for the period 1st April 2018 to 30th March 2018;

- £36,975 in respect of Ex Gratia Payments made during the period 1st April 2018 to 30th September 2018;

- £51,000 settlement costs relating to Employment Tribunal cases for the period 1st April 2018 to 31st October 2018.

ASSURANCE is provided by:

- The review undertaken by the Losses and Special Payments Panel and its recommendations to the Audit Committee.

RECOMMENDATION

The Audit Committee is asked to:

- **APPROVE** the write off of the losses and special payments outlined in the assessment section of this report:
- **NOTE** the minutes of the 21st November 2018 meeting of the Losses and Special Payments Panel.

Shaping our Future Wellbeing Strategic Objectives			
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											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term	x	Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

Appendix 1

MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS PANEL HELD ON 30th NOVEMBER 2018.

PRESENT:

Mr R Mahoney (Acting Chair)
Mr A Crook
Mr S Monk
Mr A Williams
Mrs S Wicks
Mr R Hurton

APOLOGIES:

Mr C Greenstock
Mrs A Hughes
Mr C Lewis (Chair)
Mr R Cockayne

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.

Agenda Items

1. Clinical Negligence and Personal Injury Losses

Mr Monk presented the financial report on Clinical Negligence and Personal Injury losses for the Six Months ending 31st March 2018.

The income and expenditure effect for the period was described as shown below: For comparison, the figures for the same period in 2017/2018 were also discussed

SUMMARY OF LOSSES

	2018/2019 £'000	2017/2018 £'000
Clinical Negligence	(641)	77,794
Personal Injury	11	257
Total Loss	(630)	78,051
Less WRP Receipts Due	1,482	-77,017
Total Net Cost to the UHB	852	1,034

With respect to clinical negligence claims, Mr Monk advised that there had been a reduction in gross expenditure (before reimbursal from the Risk Pool) by £78.7m. This was a result of a number of factors. Firstly, the increase in quantums of existing cases had fallen by £68.7m in comparison to the previous year. This was largely due to the significant increase in the value of provisions that had occurred in 2017/18 because of the revised discount rate which the Lord Chancellor announced in February 2017. No such adjustment had yet been required in 2018/19, though Mr Hurton noted that the discount rate was due to change again after Christmas. The impact of this was not yet known. In addition Mr Monk informed the panel that during the period, one high value Obstetrics claim (£8.6m), which had been dormant for 2 years was re-assessed from certain to possible

The impact of all recorded Personal Injury claims had been a gross I&E charge of £0.011m. This was a relatively low figure primarily due to 2 cases where damages have ultimately settled significantly lower than previously quantified

Recommendation

The Panel recommended that the Audit 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 £0.852m for the six months ending 30th September 2018.

Finalised Clinical Negligence (including Redress) Claims

During the six months ending 30th September 2018, there were 54 claims (where liability had been conceded and settlements paid) which had concluded at a total settlement costs of £11.776m (which are treated as a loss). The UHB also incurred £0.411m in legal fees re these cases and was successful in recovering £11.309m from the Welsh Risk Pool and Welsh Government for these claims, resulting in a net cost to the UHB of £0.878m.

Finalised Personal Injury Claims

During the six months ending September 30th 2018, 23 claims where liability had been conceded and settlements paid have concluded at a total settlement cost of £0.292m (which are treated as a loss). The UHB had also incurred £0.060m in defence fees and was successful in recovering £0.111m from the WRP for these claims, resulting in a net cost to the UHB of £0.241m.

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

Recommendation

The Panel recommended that the Audit Committee approve the write off of the settlement costs of claims finalised in the period 1st April 2018 – 30th

September 2018. The value of these claims finalised was - Clinical Negligence - £11.776m. Personal Injury - £0.292m.

2. Debt Write Offs

Mr Williams presented a report on proposed invoice write offs for the period 1st April 2018 to 30th September 2018.

These were as follows

Category of Debt	Value	Number
Dental	289	8
Medical Records	200	18
Payroll	3,243	5
Accommodation	260	1
O/Seas Patients	6,809	6
Misc	42,806	480
Total	**53,607**	**518**

Mr Williams stated that Included in the overpayment of salary write offs was one invoice for £2,461.28, this write off was requested by the Deputy Director of Operations and Delivery, Medicine Clinical Board. Due to failings by a directorate manager who was no longer employed by the Board, the UHB had taken the decision to action the write off to avoid becoming involved in litigation.

The miscellaneous category included 460 invoices totalling £40k that related to a 20% deduction for Irish With-holding tax from invoices paid by Irish Hospitals. These invoices relate to services provided by WEQAS and our Pathology and Medical Genetics laboratories. In the past we have been able to reclaim the 20% Withholding Tax amount from the Irish Revenue Commissioners; but since November 2017 we have been unable to submit a claim because HMRC are no longer willing to authorise the paperwork required by the Commissioner's office to process the claims. The issue had been pursued both directly with HMRC by the Board and with the Irish Tax Authorities via Deloittes. As a result the affected departments had now increased their prices with Irish bodies to make up for this loss of income.

Included in the Overseas Patients write Offs were one invoice for £2k and one for £3k. The £3k invoice was referred to CCI Credit Management Services but they were unable to collect the amount due. The invoice for £2k was requested for write off by the Private & Overseas Patient Manager as all avenues of collection had been pursued without success.

The below gives a comparison to amounts written off in previous years.

	2014/15		2015/16		2016/17		2017/18		2018/19	
	Value	No	Value	No	Value	No	Value	No	Value	No
Accommodation	0	0	8	1	1,049	8	0	0	260	1

Dental	90	7	130	10	81	6	148	11	289	8
Medical Records	1,182	48	360	22	650	35	207	10	200	18
Payroll	15,229	18	2,004	7	20,025	53	6,857	11	3,243	5
Private Patients	4,573	18	4,578	32	24,325	28	13,976	23	0	0
O/Seas Patients	24,761	38	53,011	48	16,475	10	47,306	29	6,809	6
IVF Wales	0	0	0	0	31,026	24	0	0	0	0
Misc	122,466	68	17,787	50	78,685	61	22,835	25	42,806	480
	168,301	**197**	**77,877**	**170**	**172,315**	**225**	**91,330**	**109**	**53,607**	**518**

Recommendation

The Panel recommended that the Audit Committee approve the write off of £53,607 in respect of Bad Debts for the period 1st April 2018 to 30th September 2018.

3. Permanent Injury Losses

Mr Monk presented a report on permanent injury costs for the first six months of the financial year 2018-19. 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 were a total of 28 cases ongoing, which in expenditure terms had cost the UHB £0.127m. There were payments made in the same period of £0.060m.

As none of the cases had met the requisite criteria to be thought of as concluded in the period, there was no loss as such to consider.

Recommendation

The Panel recommended that the Audit Committee be asked to note the impact on expenditure of £59,888 (for the Six Months Ending 30th September 2018).

4. Employment Tribunal Costs

Mr Crook presented a paper outlining the claims and costs for the period 1st April 2018 to 31st October 2018.

During the period, Cardiff and Vale University Health Board had been involved with twenty three Employment Tribunal claims.

Fourteen of these cases were live as at October 31st 2018. Fourteen of the 23 cases had previously been reported to the Losses and Special Payments Panel, and the remaining nine cases had been submitted to the Employment Tribunal since 1st April 2018.

The UHB had won 2 cases during the period and there had been 3 cases settled where it was determined that the claimant was contractually entitled to the payments subsequently made (which are therefore not losses)

Finally: 4 cases have been settled for:

- £1,000 unfair dismissal – Clinical Diagnostics & Therapeutics
- £10,000 Unfair Dismissal, Disability Discrimination - Capital, Estates & Facilities
- £30,000 constructive dismissal/race discrimination – Children & Women
- £10,000 unfair dismissal/disability discrimination - Medicine

Recommendation

The Panel recommended that the Audit Committee approve the write off of £51,000 in respect of Employment Tribunal Settlements for the period 1st April 2018 to 31st October 2018

5. Ex Gratia Payments and Other Losses

Mr Monk presented a report on costs for the period 1 April 2018 to 30 September 2018. Mr Monk noted that there were 13 ex-gratia losses totalling £36,975 made in the six months under consideration.

Nine of the cases (£5,850) were the result of the independent review/ombudsman process. Three of the cases involved the receipt by UHB departments of counterfeit bank noes (£120). One incidence relates to an ex gratia payment to a householder who claimed compensation that the value of his property had been effected by increased noise and traffic flow caused by road alterations carried out by the UHB at the entrance to Llandough property. The Vale of Glamorgan council had acted for the UHB on the issue and under their advice a settlement of £31,005 was made

Recommendation

The Panel recommended that the Audit Committee approve the write off of the losses incurred in the period 1st April 2018 to 30th September 2018 amounting to £36,975

6. Small Claims Panel Losses

Mr Monk presented a report on costs for the period 1 April 2018 to 30 September 2018. During that period 16 claims had been settled at a total cost of £4,875.

The largest payments made were compensation for loss of a digital hearing aid (£1095) and compensation in respect a car which was damaged by one of the traffic control barriers in operation on the UHW site (£2047)

Recommendation

The Panel recommended that the Audit Committee approves the write off of the £4,875 in respect of compensation payments which had been paid during the first six months of the Financial Year 2018-19.

7. Voluntary Early Release Payments

Mr Crook reminded The Panel that payments under a Voluntary Early Release Scheme were classified as "ex-gratia" payments and were managed in accordance with the Losses and Special Payments procedure. All such payments would require the approval of the Remuneration and Terms of Service Committee.

Where any compensatory payments were over £50,000, under the terms of the scheme, the Welsh Assembly Government would be required to provide approval for such payments to be made.

The Panel was asked to note the total payments figure shown below. However no recommendation for approval was required, since these would be approved by the appropriate committee.

There had been 3 payments during the first 6 months of the year totalling £0.103m.

Recommendation

The Panel recommended that the Audit Committee note the £102,509 paid in Voluntary Early Release Payments made during the first 6 months of 2018/19.

8. Any Other Business

Mr Hurton stated that the group would usually have received reports from Mr Greenstock regarding instances of Fraud and from Mr Cockayne re Security Losses. Mr Greenstock was currently on long term sick and therefore would be asked to produce a report on the full year for the May meeting. It was unclear as to why Mr Cockayne had not produced the required report; but he also would be required to produce a report on the full year for the next meeting of the panel, which would be in May 2019.

Specialist Services
Follow up - Patientcare IT System

FINAL INTERNAL AUDIT REPORT
2018/19

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

Appendix A Assurance opinion and action plan risk rating

Review reference:	CUHB1819.23
Report status:	Final
Fieldwork commencement:	July 2018
Fieldwork completion:	10 September 2018
Draft report issued:	21 September 2018
Management response received:	3 October 2018
Final report issued:	4 October 2018
Auditors:	Martyn Lewis

Executive sign off:	Chief Operating Officer
Distribution:	S Lloyd, Directorate Manager, Neurosciences; P Goode, Director of Operations, Specialist Services
Committee:	Audit Committee

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

Please note:

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

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

1. EXECUTIVE SUMMARY

This follow up review of the Patientcare IT System used within the Neuro Department has been completed in line with the 2018/2019 Internal Audit Plan. The review seeks to provide the Health Board with assurance that agreed actions from the previous review of Patientcare have been implemented appropriately.

The initial internal audit report was finalised in April 2017 and highlighted a total of eight issues which resulted in an overall assurance rating of Limited Assurance.

The risks considered in the previous review was as follows:

I. Inappropriate access to system / data.

II. Inaccurate data held in system.

III. Loss of processing / data.

IV. The UHB is not maximising the benefits from the system.

Follow up work was undertaken to determine whether progress / full implementation had been made relating to the following actions from the agreed management responses:

- By the end of April 2017 any user logging on to Patientcare will be enforced to do so via NADEX. (Finding 1, High Priority)
- The Directorate Management team will implement a quarterly monitoring system for checking leavers to ensure the process is being applied correctly and will enable an auditable trail. (Finding 1, High Priority)
- A contract/SLA will be put in place to set out who is responsible for which elements of the system with regard to maintenance and software updates. (Finding 2, High Priority)
- A user group will be established with the supplier to discuss the changes required to the system to enable limits on data fields to be applied and give consideration to mandating certain fields (Finding 3, Medium Priority)
- The Directorate will develop a business continuity and disaster recovery plan for the Patientcare database. (Finding 4, Medium Priority)
- Neurosciences will liaise with the Cardiff & Vale UHB IT Department to produce a scheduling plan for undertaking backups and the testing of these backups are within CAV approved policies and procedures. (Finding 5, Medium Priority)

- The Directorate will seek advice from Peter Welsh with regard to concerns around Intellectual Property. (Finding 6, High Priority)
- Any future IT projects / service developments will follow the usual project control structure used by the IT department when implementing new systems. (Finding 7, Medium Priority)
- A user group will be established with the supplier to take forward the development of a 2 way interface. (Finding 8, Low Priority)

2. CONCLUSION AND FINDINGS

In summary, progress against the eight findings contained in the management responses that required implementation was as follows;

Priority Rating	No of Management Responses to be implemented	Fully Actioned	Partially Actioned	Not Actioned
HIGH	3	3	-	-
MEDIUM	4	3	1	-
LOW	1	1	-	-
TOTAL	**8**	**7**	**1**	**-**

The follow up review concluded that, based upon discussions with relevant management, review of the evidence provided and the results of re-testing where appropriate, progress has been made.

A contract is now in place for the provision and maintenance of the system, the system has been moved to new servers and the database updated. In addition data entry controls are in place and the user group is to factor these into their discussions.

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

The management actions completed to date can be summarised as follows:

- The system moved to new server to provide better assurance.
- The database has been upgraded to a new, more secure version.
- A formal contract / SLA is now in place for for the maintenance and support of the system.
- A user group is in existence for the system.

- Data entry controls are in place.
- There is a process to identify further entry controls via the user group.
- The logon process has been enhanced with the use of Nadex being enforced.
- The Directorate has established a more robust process to ensure that leavers are deactivated.
- A business continuity document relating to Patientcare has been developed for the service.

The main issue highlighted through the follow up review can be summarised as follows:

- Although backups are taken and log files reviewed, there is no process in place for testing the backups.

Finding 1 Testing of Backups– (Operating effectiveness)	Risk
Although backups are taken and log files reviewed, there is no process in place for testing the backups.	Loss of data
Recommendation	**Priority level**
A process should be established to periodically test the backups.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Discussions are underway with IM&T and a test of the backup is due to be scheduled and undertaken following these.	Directorate Manager, Neurosciences and ALAS November 2018

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Cardiff and Vale University Health Board

Cost Improvement Programme

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	C&V-1819-16
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Auditors:	Ken Hughes, Principal Auditor
	Ian Virgil, Deputy Head of Internal Audit
Executive sign off:	Bob Chadwick, Director of Finance
Distribution:	Chris Lewis, Deputy Director of Finance
	Andrew Gough, Assistant Director of Finance
Committee:	Audit Committee

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

1. Introduction and Background

The review of the implementation of the Cost Improvement Programme (CIP) within the UHB was completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board.

The Health Board is currently in deficit and is required to produce annual financial plans that are agreed by the Welsh Government, and this will continue until they are able to set a balanced budget. Included within the 2018/19 financial plan is a recurrent savings target of £25.335m (3% of annual budget) and a non-recurrent savings target of £8.445m (1% of the annual budget). These targets drive the Cost Improvement Programme and will need to be achieved to meet the agreed year-end deficit.

The relevant lead Executive Director for the assignment was the Director of Finance.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of the Cost Improvement Programme in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of systems objectives were being managed appropriately.

The purpose of the review was to establish if cost reduction targets were appropriately established, devolved through the organisation, that appropriate plans had been developed to meet these and that the plans were implemented and monitored.

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

- Cost reduction targets are established, agreed and devolved to appropriate management level;
- Plans are identified and developed to meet cost reduction targets;
- CIP savings are implemented and delivered; and
- Robust monitoring and reporting arrangements are in place, including at senior management and board level.

3. Associated Risks

The potential risks considered in the review were as follows:

- Cost improvement plans are not planned appropriately; and
- Cost improvement plans are not achieved.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Cost Improvement Programme is **Substantial Assurance**.

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

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

The Health Board has robust processes in place for developing, monitoring and delivering the CIP. At the time of our audit the Health Board was on target to meet the agreed year-end deficit of £9.9m.

Each Clinical Board has been given savings targets and asked to develop savings plans to achieve those targets. These are recorded in the 'Savings Tracker' using a traffic light system and are initially recorded on the tracker as red. Savings schemes are then assessed and those that can evidence some key mandatory elements of the savings scheme are upgraded to amber. Savings schemes are not classified as Green until there is sufficient evidence that all mandatory elements of the scheme have been met and savings identified are 'guaranteed'.

The achievement of savings is monitored monthly through the production of financial performance reports which are submitted to each Clinical Board's Cost Reduction Board.

Our audit has confirmed that the CIP is making a significant contribution to the achievement of savings and the financial outturn target. However it was identified through review of a sample of the 'Top 20' savings schemes that the CIP could be further improved by enhancing the quality of supporting documentation underpinning saving schemes through the

completion of Impact Statements and ensuring all fields within the savings tracker are accurately completed.

5. Assurance Summary

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

Assurance Summary					
1	Cost reduction targets are agreed				✓
2	Savings plans are developed to meet agreed targets			✓	
3	CIP savings plans are implemented and delivered				✓
4	Robust monitoring and reporting arrangements are in place				✓

** 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 a weakness in the system control/design for the Cost Improvement Programme.

Operation of System/Controls

The findings from the review has highlighted three issues that are classified as weaknesses in the operation of the designed system/control for the Cost Improvement Programme.

6. Summary of Audit Findings

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

Objective 1: Cost reduction targets are established, agreed and devolved to appropriate management level.

The following areas of good practice were noted:

- Recurrent (3%) and non-recurrent (1%) cost reduction targets have been set for each Clinical Board;
- Achievement of the overall 4% cost reduction target will ensure the Health Board meets the year-end financial deficit agreed by the Welsh Government.

No significant findings were identified for this objective.

Objective 2: Plans are identified and developed to meet cost reduction targets:

The following areas of good practice were noted:

- Responsibility for identifying savings has been devolved to individual Clinical Boards;
- At the time of our audit, green and amber schemes have been identified to meet 95% of the 2018/19 savings targets;
- Any member of staff can put forward ideas for savings plans regardless of value, and these are recorded on the savings tracker;
- A RAG rating system is used to categorise savings plans;
- The assessment criteria for categorising savings schemes as Red, Amber or Green has been documented.

The following significant finding was identified for this objective:

- The existence and quality of supporting documentation underpinning savings schemes was variable and inconsistent.

Objective 3: CIP savings are implemented and delivered:

The following areas of good practice were noted:

- Savings schemes are assessed against a documented criteria;
- Savings schemes are only categorised as Green if the scheme is 'guaranteed' to deliver the planned savings;
- At the time of our audit, savings schemes were delivering against the overall savings targets.

No significant findings were identified for this objective.

Objective 4: Robust monitoring and reporting arrangements are in place, including at senior management and board level.

The following areas of good practice were noted:

- The CIP is overseen by the Cost Reduction Board;
- Monthly monitoring reports are prepared for each Clinical Board;
- A monthly variance analysis report is produced showing the overall budget position and any slippage against the CIP target savings;
- A weekly summary of the CIP savings by Clinical Board is sent out to Clinical Boards each week;
- Progress against the CIP and expected outturn position is reported to the Finance Committee on a monthly basis.

No significant findings were identified for this objective.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**1**	**2**	**3**

Finding 1 - Impact Statements - (O)	Risk
A sample of 15 of the Top 20 Savings Schemes as reported to the Welsh Government in August 2018 was selected for review. Testing was then carried out to ensure that for each scheme an appropriate lead had been identified, savings had been accurately calculated and there was an appropriate level of supporting documentation to support the RAG rating assigned. An appropriate lead had been assigned for each scheme tested, and all schemes had been accurately costed. However the level and quality of supporting documentation held by the scheme lead varied widely, and for 6/15 schemes no supporting documentation was provided although details of the savings calculation were provided by e-mail. A standard Impact Assessment form that records all the salient details of a savings scheme and facilitates sign off by the Head of Finance had been developed by Finance, but this had not been completed for any of the schemes tested.	Cost improvement plans are not planned appropriately.
Recommendation 1	**Priority level**
Management should ensure that sufficient detailed supporting documentation is in place for all Cost Improvement Programme savings schemes. The standard Impact Assessment form should also be completed by the scheme lead and forwarded to Finance for all Green rated schemes.	**Medium**

Management Response	Responsible Officer/ Deadline
CIP Impact statements have been developed and filtered through Clinical Boards for completion when savings schemes are identified and progressed to Amber. Impact statements are required to be completed where schemes have a financial value > £75K or for all schemes that have any patient impact. To be discussed at Directors of Operations meeting with the COO. Completion of impact statements in development of the 2019/20 savings programme will be monitored through Clinical Board Management Teams and Financial Review meetings with the Deputy Director of Finance.	Clinical Board Management Teams & Deputy Director of Finance Implemented through the development of 2019/20 savings programme – April 2019

Finding 2 - Achievement of Savings - (O)	Risk
CIP savings that have been approved and given 'Green' status have been fully costed, with expected savings profiled on the tracker over 12 months. The achieved section of the Tracker is then completed by each Clinical Board finance team on a monthly basis following assessment of the financial position as part of the financial reporting process. However testing of a sample of 15 Green savings schemes showed that two schemes were underachieving and schemes were overachieving against the expected savings as at month 5, but this was not reflected in the monitoring section of the tracker.	Cost improvement plans are not planned appropriately.

Recommendation 2	Priority level
Where it is identified that actual savings are higher or lower than originally anticipated, the monitoring section of the tracker should be amended by the Clinical Board Finance teams to reflect this.	**Low**
Management Response	**Responsible Officer/ Deadline**
Actual savings delivered are reported on a monthly basis as part of the monthly accounts process. Variances against profiled planned savings schemes are clearly reported. The current CIP monitoring process that is in place identifies actual savings against anticipated savings profiles.	Deputy Director of Finance / Complete

Finding 3 - Reporting of Savings Schemes - (O)	Risk
Testing was carried out on a sample of 15 of the top 20 savings schemes as reported to the WG in August 2018 to ensure that each savings scheme had been accurately and fully recorded in both the savings tracker and the August 2018 Welsh Government Monitoring Return. This identified a discrepancy between the savings value reported to the WG and that recorded in the tracker for the Medicine CB's Ward Re-provision savings scheme. The savings in this scheme are split between pay (£421k) and non-pay (61k), but only the pay element of £421k was reported to the WG in the August Top 20 monitoring return.	Cost improvement plans are not planned appropriately.

Recommendation 3	Priority level
The pay and non-pay element of savings schemes should be combined when compiling the top 20 savings schemes monitoring return for the Welsh Government.	**Low**
Management Response	**Responsible Officer/ Deadline**
A process merging pay and non-pay elements of savings schemes will be put in place to ensure this is actioned from month 9 2018/19 onwards. Process now in place.	Deputy Director of Finance / Complete

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.

Shaping Our Future Wellbeing – Capital Projects

Final Internal Audit Report

2017/18

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

Reasonable Assurance


CONTENTS Page

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Committee	Audit Committee

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

Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff & 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

This review of the Shaping Our Future Wellbeing Capital Projects programme at the University Hospital of Wales has been completed in accordance with the agreed internal audit plan.

The University Health Board's updated IMTP (2017/18), indicated that one of the key challenges for the University Health Board was:

"Ensuring our many buildings and critical medical and IT equipment are fit for purpose. Many of our facilities were built many years ago and our maintenance programmes have not been able to keep up with all of the requirements for keeping the buildings fit for purpose. The condition of some of our buildings is impacting on how we deliver services and can have a detrimental effect on a patient's experience of the care we provide"

This audit focused on the UHB's review of the community infrastructure and resulting capital investment to support the 'Shaping Our Future Wellbeing Strategy 2015 – 2025'. It also included a follow up of progress made by management in implementing the outstanding previously agreed recommendations.

This review sought to gain assurance that appropriate arrangements were established to deliver the proposed programme and associated capital projects.

2. Scope and Objectives

The scope and remit of the audit included the following:

- **Previously Agreed Management Action –** to review of the status of agreed management actions arising from the previous audit report.

- **Programme Management & Governance arrangements –** to obtain assurance that adequate management and governance arrangements were applied to the 'Shaping Our Future Wellbeing' programme of capital projects.

- **Business Cases** – to obtain assurance that appropriate business cases were developed for the programme (and as appropriate the constituent projects), in accordance with Welsh Government requirements.

- **Risk Management** – to ensure that there has been an appropriate assessment of all related risks and that sound risk management arrangements have been implemented.

- **Monitoring and reporting** – to obtain assurance that accurate management information is produced to:
  i. Monitor the programme and individual projects;
  ii. Report relevant information to the appropriate group; and
  iii. Ensure the adequacy of overall budgetary controls, including the allocation to individual projects budgets.

- **Other** – to consider any other material issues which may become apparent during the course of the audit.

3. Associated Risks

We sought the mitigation and management of negative impacts to time, cost and quality of the delivered projects.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the 'Shaping Our Future Wellbeing – proposed programme and associated capital projects is **Reasonable Assurance**.

The primary reasons for this level of assurance are:

- the established project structure and report arrangements through to the Board were appropriate for the current stage of the Programme, but there was also a need to further develop the roles and responsibilities of groups within the structure;
- although progress had been made in compiling the required business cases, there had been slippage in the timetable for delivery of the overall Programme Business Case (originally targeted for December 2016, but submitted to Welsh Government in July 2018) and work was still required to deliver the project business cases by the target date of December 2018;

- Arrangements were in place for progress reporting on the Programme and the first tranche of projects.

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	Programme Management & Governance arrangements			✓	
2	Business Cases			✓	
3	Risk Management				✓
4	Monitoring & Reporting				✓

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

Design of Systems/Controls

The findings from the review have highlighted no issues that were classified as weakness in the system control/design for the Shaping Our Future Wellbeing Capital Projects.

Operation of System/Controls

The findings from the review have highlighted two issues that were classified as weaknesses in the operation of the designed system/control for the Shaping Our Future Wellbeing Capital Projects.

Previously Agreed Management Action

We sought to review actions to address outstanding recommendations arising at the previous audit (issued September 2016), review the effectiveness of the current implementation of prior recommendations and re-considered their action status, where applicable.

The status of agreed management action arising from previous audit reports is as follows:

Priority	H	M	L	Total
Number of Recommendations	**1**	**3**	**0**	**4**
Recommendations Implemented/Closed	**1**	**3**	**0**	**4**
Recommendations not Implemented	**0**	**0**	**0**	**0**

Please see **Appendix B** for detail.

Summary of Audit Findings

The key findings are reported within the Management Action Plan (**Appendix A**).

Programme Management & Governance arrangements

We sought to confirm that adequate management and governance arrangements were applied to the 'Shaping Our Future Wellbeing' programme of capital Projects.

Structure:

We confirmed that a Programme and Project Structure had been established and was operating in accordance with the defined terms of reference. The UHB Board held responsibility for the Programme's capital management via the Capital Management Group and the Strategy and Engagement Committee. However, the Programme involved development and delivery of integrated services with partner organisations, including Local Authorities, other Health Boards, Welsh Ambulance Services Trust and the Third Sector, so strategic direction was provided by a Regional Partnership Board – Senior Leadership Group (RPB-SLG) comprising Directors from

partner organisations. This group also monitored the development of the Programme Business Case and steered the implementation of integrated partnership working.

Delivery Group:

At the time of the audit, there was one Programme Team within the Health Board with oversight of the associated projects. The Board met bi–monthly and was chaired by the Executive Director of Strategy and Planning. Membership included Directors from the UHB together with senior representatives of external stakeholder organisations. The Programme Team reported to the UHB Capital Management Group and the RPB - SLG.

In July 2018, the structure was up-dated to include a 'Delivery Group'. This group fulfilled the roles of both a Programme Team and a cross Locality Project Board. Terms of reference had been developed that set out its responsibilities in respect of both of these areas. Membership of the Delivery Group included representation from within the UHB and also a range of external stakeholders.

Project Teams:

The individual projects were managed through Project teams that met monthly and were chaired by the Director of Capital, Estates & Facilities. Membership included Locality Managers, Estates and Planning Managers and clinical representatives as appropriate.

Terms of Reference:

We confirmed that Terms of Reference had been compiled for the Delivery Group and individual Project Teams. These terms of reference documents focussed on the delivery of the required business cases for each project. They set out in detail the responsibilities of the Teams to develop the options, undertake appraisals and set out the financial, and management cases to deliver the projects within the programme.

However, the terms of reference did not cover the stages of the process after the submission and approval of the business cases, i.e. delivery of the capital projects and commissioning of the facilities.

Also, the responsibilities outlined in the original terms of reference did not include reference to management of programme or individual project budgets. **(Recommendation 1).**

Roles and Responsibilities:

We noted that the Investment Decision Maker was confirmed as the UHB Board. The Senior Responsible Owner role for the programme and the constituent projects was allocated to the Executive Director of Strategy and Planning.

Roles and responsibilities of key programme and project individuals had been allocated and documented including Programme and Project Director, Programme Manager, Business Case Manager together with a range of supporting roles including those in Clinical, Capital Planning, Finance, Workforce and IM&T.

Noting the established project structure and report arrangements through to the Board for the current stage of the Programme, we determined **reasonable assurance** in relation to current programme management and governance arrangements.

Business Cases

We sought to confirm that appropriate business cases were being developed for the programme (and as appropriate the constituent projects), in accordance with Welsh Government requirements.

Programme:

A Programme Business Case (PBC) was required by the Welsh Government that determined the approach to developing and reconfiguring the community infrastructure, to support improved access to services, demonstrate collaborative working and deliver a social model of health that would improve outcomes and reduce inequalities. The plan was to submit the PBC to the Welsh Government by the end of July 2018.

It should be noted that at the time of our previous audit (June 2016), the target date for submission of the Programme Business Case has been December 2016. The target date had therefore slipped by nineteen months. Reasons and approvals for the slippage were documented and reported via the Programme Team, RPB-SLG and the UHB in accordance with the programme reporting structure. See Appendix D.

The Capital Programme Report to the Strategy and Delivery Committee in June 2018 confirmed that submission of the PBC to the Welsh Government was still planned for the end of July 2018. Audit confirmed that the Programme Team and Capital Management Group had approved the PBC in June 2018. It was then expected to go to the RPB-SLG meeting on 12 July. We were subsequently advised that the Management Executive had called for the PBC to go to the UHB Board at its earlier meeting on 28 June. This would then enable an earlier submission to Welsh Government.

First Tranche of Projects:

Maelfa & Penarth: Two schemes within the programme had been awarded 'Primary Care Pipeline Funding' by Welsh Government. These were the

Wellbeing Hubs at Maelfa (£8 million funding) and Penarth (£6 million funding). This was advanced notice of award of funding for these schemes. Business cases would still be required to be submitted to Welsh Government for approval purposes.

The Outline Business Cases for each scheme were programmed to be submitted in December 2018, with the full business planned to be submitted by December 2019. The facilities were planned to be opened by the end of 2021. The Business Cases were being prepared in house by the Service Planning Lead Manager and the Programme Manager, with external advisory support from Healthcare Planners and Architects during the feasibility stage.

The Risk Registers included a 'high' risk relating to 'Delays in business case submission, that could risk delivery of the completed facility by December 2021'. Recommended actions were noted as "Careful management of business case progress to gain timely approval". **(Recommendation 2)**

A project plan had been compiled that tracked the completion dates of 'deliverables' within the development of the business cases and service delivery models.

Park View: This project would be a new-build of circa £15- £20 Million. The June 2018 Capital Programme Report stated that an Outline Business Case was in development. Work was required to develop the plans and capital costs. Schedules of accommodation were being confirmed with service leads.

Cardiff Royal Infirmary (CRI): The project structure for the scheme was being developed at the time of the current review with a view to developing an Outline Business Case for submission to the Welsh Government.

Taking due account of the significant progress made in compiling the required business cases, but also noting the slippage in the timetable for delivery of the overall Programme Business Case and the work still required to deliver the project business cases by the target date of December 2018, we have determined **Reasonable assurance** in respect of delivery of Business Cases.

Risk Management

We sought assurance that there had been an appropriate assessment of all related risks and that sound risk management arrangements have been implemented.

Corporate Risk and Assurance Framework:

Tthe risk of not having sufficient services and long term models of care to meet the needs of an increasing and aging population, was included in the UHB's Risk and Assurance Framework. The Clinical Service Strategy 'Shaping Our Future Wellbeing' focusses on the health and care needs of the local population and was developed in response to this risk and collaboration with other stakeholders including the local authority and the Third Sector. Clearly, any unnecessary delays to the implementation of the strategy will impact on the provision of services and thereby extend the risk that the Health Board will be unable to meet the needs of the population and increase associated risks to patients.

Risks to Delivery of the Programme:

A business and service risk appraisal workshop was completed for the first tranche of projects identified within the programme, as part of the process of compiling the Programme Business Case. Risks were identified and scored at a workshop attended by representatives from Estates; Planning; Locality Management; and Finance at the UHB together with Facilitators for Health & Social Care from the Third Sector. The 'High' and 'Medium' rated risks to the delivery of the programme that were identified included:

- Availability of Welsh Government capital funding;
- Sustainability of Primary Care services leading to review of priorities;
- Operational service changes impact on affordability;
- Underestimated revenue costs;
- Inability to deliver new services delivery models;
- Shift of activity from hospital to community not achieved;
- Facilities costs of reconfigured estate not covered by savings from rationalisation of community estate; and
- Delivery of collaborative health and wellbeing services may be impacted by uncertainty of third sector revenue or continued availability
- Increased demand for healthcare resulting from budget reductions in local authority services.

The identified risks to the Programme were formatted into a Programme Risk Register. This included details of impact; likelihood and overall rating; risk owner; mitigation actions; Date of last review and details of actions taken. The risk register was attached to the regular monthly 'Flash Report' for the Programme and presented for review, as a regular agenda item at the Programme Board meetings.

Individual Project Risks:

Individual Risk Registers were produced for each of the first tranche of projects. Details were in the same format as the Programme Risk register. The Project Risk Registers are presented and reviewed as standing agenda items at the respective Project Team meetings.

Noting the existence of programme and project risk registers and the established review process involving the Programme Board and Project Teams, we determined **Substantial** assurance in respect of risk management.

Monitoring & Reporting

We sought assurance that accurate management information was produced to: Monitor the programme and individual projects; report relevant information to the appropriate group; and ensure the adequacy of overall budgetary controls, including the allocation to individual projects budgets.

The Programme Team (Board) and Project Teams regularly received the following reports:

- Project 'Flash' Reports: One-page summary including project timetable; (planned and completion dates for key deliverables; key risks and issues; Key accomplishments and up-coming Major Activities.
- Risk Registers: (See Risk Management section above.)

The format and content of the progress reports was reviewed and considered satisfactory.

The Programme Team also received the minutes of Project Team Meetings for the current first tranche of projects i.e. Park View; CRI; and Maelfa.

None of the projects had reached the construction stage, with the main on the compilation of the required business cases. However, expenditure was being committed to the overall programme and individual projects, e.g. healthcare planner/architect fees etc. This expenditure was funded through the discretionary capital budget and reported to the Capital Management Group.

Noting the arrangements for progress reporting on the Programme and the first tranche of projects, we have determined **substantial assurance** for monitoring & reporting on the Shaping Our Future Wellbeing Programme.

6. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

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

Action Plan

Finding : Programme Team and Project Teams	Risk
Terms of Reference had been compiled for the Delivery Group and individual Project Teams. These terms of reference documents focus on the delivery of the required business cases for each project. They set out in detail the responsibilities of the Teams to develop the options, undertake appraisals and set out the financial, and management cases to deliver the projects within the programme. However, the terms of reference did not cover the stages of the process after the submission and approval of the business cases, i.e. delivery of the capital projects and commissioning of the facilities. Also, the responsibilities outlined in the terms of reference did not include reference to management of the programme or individual project budgets.	Responsibilities of project groups are not fully defined.
Recommendation 1	**Priority level**
1. Terms of Reference should be developed for the Programme Team and Project Teams to cover the all stages of the process after the submission and approval of the business cases, i.e. delivery of the capital projects and commissioning of the facilities. Responsibilities of the Teams should include overseeing programme and project budget management, as appropriate.	**Low**

Action Plan

Management Response 1	Responsible Officer/ Deadline
Terms of reference are reviewed at each stage of the project / Programme, so that they are relevant to the current stage of the process. We will review the current wording to ensure that the responsibility for budget monitoring is clear. Audit has now been provided with a revised structure document and terms of reference for the Delivery Group and the Penarth Project Team.	Director of Capital, Estates and Facilities. 30 November 2018

Finding: First Tranche Project Business Cases	Risk
The identified risks to the Programme were formatted into a Programme Risk Register. This includes details of impact; likelihood and overall rating; risk owner; mitigation actions; Date of last review and details of actions taken. The risk register is attached to the regular monthly 'Flash Report' for the Programme and is presented for review, as a regular agenda item at the Programme Board meetings. Each of the first tranche of projects also has an individual Risk Register which sets out the relevant key risks for the project. Details are in the same format as the Programme Risk register. The Project Risk Registers are presented and reviewed as standing agenda item at the respective Project Team meetings. The Project Risk Registers included a 'high' risk relating to 'Delays in business case submission, that could risk delivery of the completed facility …'. This was stated as likely to cause political embarrassment and a risk to Welsh Government funding. Recommended actions were noted as "Careful management of business case progress to gain timely approval". The Programme Business Case incurred significant slippage to its target date for completion and submission to the Welsh Government.	Risk of delays and additional costs.

Action Plan

Recommendation 2	Priority level
Delivery of the required project business cases should be carefully performance monitored in-house to ensure that resources are adequate and that there are no unnecessary slippages in the target dates.	Medium
Management Response 2	**Responsible Officer/ Deadline**
Supply Chain Partners have now been appointed for the Maelfa and Penarth schemes and their programmes confirm that the schemes can be delivered within the required timescales. The risks of delay have consequently been reduced. The risks of delay on the Park View scheme will continue to be monitored by the Project Team.	Director of Capital, Estates and Facilities. Actioned and on-going

Review of Previous Recommendations

No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
High Priority Recommendations					
3	The UHB's current proposals, timescales and resources for the development and improvement of the primary care estate will be urgently reviewed and strengthened where possible to reduce the perceived level of risk.	Director of Capital, Estates and Facilities 30 November 2016	Closed	N/A	N/A
Medium Priority Recommendations					
4	As the programme progresses and project business cases are developed, risk registers should be established for the programme and each project together with procedures for monitoring and control of risks.	Director of Capital, Estates and Facilities 30 November 2016	Closed	N/A	N/A

Review of Previous Recommendations

No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
5	We recommend the establishment of appropriate budget monitoring arrangements for the programme.	Director of Capital, Estates and Facilities 30 November 2016	Closed	N/A	N/A
7	The planned frequency of Programme Board meetings should be reviewed to ensure that it is sufficient to enable the Board to deliver its responsibilities with respect to monitoring progress and resource requirements.	Director of Capital, Estates and Facilities 30 September 2016	Closed	N/A	N/A

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*

Shaping Our Future Wellbeing: (SOFW)
Reasons for slippage and reporting to Programme Board and other groups.
(compiled by Programme Support Manager**)**

PBC submission date	**Reason for change**	**Reported when**	**Reported to**
Dec 2016	Original date		
Jun 2017	Provisional date for completion of the PBC was revised to reflect the delay in being able to appoint healthcare planners to undertake a high level assessment of capital costs. Also, Executive and Board advice was being sought with regard to strategic direction for some key areas including the outpatient strategy and whole systems service model, to inform high level revenue costs and facility requirements.	• Jan 2017 (Flash)	• Programme Team • Welsh Govt *
Dec 2017	WG agreed reduced level of detail required for subsequent tranches. High level economic assessment of the options was underway to support preferred way forward. As agreed with WG, high level capital and revenue costs being developed for the first tranche of projects only.	• Jun 2017 (Flash) • 06/07/2017 (Papers & Minutes p9) • (verbal) • 15/06/2017 (Minutes p6)	• Programme Team • RPB -SLG • Welsh Govt *
Spring 2018	Timescale for completion of the PBC was revised to Spring 2018 to reflect the complexity of the outstanding pieces of work including Service models not signed off to time, leading to a delay in resource modelling and costing.	• Nov 2017 (Flash) • 26/01/2018 (Papers & Minutes p7) • 16/11/2017 (Minutes p5&6) • (Verbal)	• Programme Team • RPB-SLG • Welsh Govt *
July 2018	Brief discussion with WG to confirm their expectations in relation to the economic appraisal. Written confirmation delayed	• Mar 2018 (Flash) • 01/05/2018 (Papers and Minutes p5) • (verbal) • (Brief)	• Programme Team • RPB - SLG • Welsh Govt *

*WG - progress of all capital schemes is monitored by WG at monthly Capital Review Meetings (CRMs)

Tranche 1 Projects - Background

Maelfa & Penarth:

The Maelfa scheme will be adjacent to the Powerhouse Community Hub in Llanedeyrn. It will include replacement of Llanedeyrn Health Centre and will serve residents in Llanedyrne and Pentwyn. The Penarth scheme will be adjacent to the Cogan Leisure Centre and serve residents in the Eastern Vale Cluster.

Park View:

This scheme involves development of a Wellbeing Hub adjacent to the Ely and Caerau Community Hub. It will include replacement of Park View Health Centre.

Cardiff Royal Infirmary (CRI):

At the time of the audit, work was already underway to safeguard the CRI building. Other work had been prioritised within the SOFW Programme at the CRI. The Sexual Assault Referral Centre (SARC) was to be relocated into houses 54 & 56 at the rear of the CRI site. This project will also involve relocation of the Community Addictions Unit and the Links Community Mental Health Teams (CMHTs) in modular accommodation on the site. This will enable other CMHT staff from Hamaryad and Pendine to be brought together. Architects were to be appointed to develop the plans in more detail and review the space utilisation requirements.

The project structure for taking this forward was being developed with a view to developing an Outline Business Case for submission to the Welsh Government to access capital funding.

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National Standards for Cleaning in NHS Wales Follow-up

Final Internal Audit Report

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NHS Wales Shared Services Partnership

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Committee:	Audit Committee

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

1. Introduction and Background

The follow-up review of the National Standards for Cleaning in NHS Wales (the 'Cleaning Standards') was completed in line with the Internal Audit Plan.

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

The original Cleaning Standards report was finalised in November 2017 and highlighted a total of 6 issues which resulted in an overall assurance rating of limited assurance.

2. Scope and Objectives

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

The purpose of the follow up review is to establish if the previously agreed management actions have been implemented, in order to ensure that the Health Board has appropriate processes in place to enable it to comply with the National Standards for Cleaning in NHS Wales.

In following up the agreed actions the main areas that the review will seek to provide assurance on are:

- The Health Board has clear management, supervisory and staffing arrangements in place for environmental cleanliness including Executive responsibility and a multi-disciplinary group;
- The Health Board has an appropriate and up to date environmental cleanliness strategy, cleaning plans and operational policies / procedures in place;
- Effective processes are in place for obtaining the views of patients and their representatives and utilising them to evaluate the cleanliness strategy and cleaning plans;
- Processes are in place to ensure that all cleaning and domestic staff receive appropriate levels of training;
- Cleaning service provision within the Health Board is effectively prioritised via a risk based assessment, in accordance with the criteria stated within the Cleaning Standards and includes a stand-alone 'rapid response' service;
- Regular audits of cleanliness outcomes are appropriately undertaken across the Health Board and are scored in accordance with the monitoring schedule provided by the All-Wales monitoring tool. Instances of poor performance identified are appropriately reported and addressed; and

- Performance against the standards is regularly reported to appropriate management and groups / committees throughout the Health Board including departments, Directorates, Clinical Boards and Executives.

3. Associated Risks

The potential risks considered in this review are as follows:

- Risk of infection for patients / health and safety risk for the public and staff; and
- Areas of poor performance are not identified or addressed.

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.

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 Health Board has made Reasonable progress against the agreed actions for five of the six recommendations from the original review.

However, one of the high priority recommendations made in the original audit has not been fully achieved. This relates to the continued lack of ward sign-off of technical audits. Further work is also required around the finalisation and introduction of the combined 'Cleaning Strategy and Operational Plan' and the establishment of an appropriate multi-disciplinary Standards of Cleaning Group.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with National Standards for Cleaning in NHS Wales has improved to **Reasonable Assurance**. Management will however need to ensure that the outstanding actions are fully implemented.

5. Summary of Audit Findings

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

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

Priority rating	No of management responses to be implemented	Fully actioned	Partially actioned	Not actioned
High	2	1	1	-
Medium	4	2	1	1
Low	-	-	-	-
Total	**6**	**3**	**2**	**1**

- The process across both sites is more aligned since the original audit in that no audits are overridden at UHL. This was confirmed from sample testing where all 'C4C Audit Score Sheets' agreed to the 'C4C 13 Week Review - Cleaning Audits' report at UHL.
- Our review of the 'C4C 13 Week Review - Cleaning Audits' confirmed that there was a marked improvement on the frequency of the technical audits being undertaken. This was particularly apparent for UHW where the original report highlighted that 'Very High Risk' functional areas were not being audited at the required frequency, being weekly.
- The Health Board has produced schedules for managerial audits at both sites and these meet the minimum frequency as defined in the Standards.
- Our sample testing of technical audits undertaken confirmed that evidence of ward sign-off was not available. However, we acknowledge that the requirement for ward sign-off has been communicated to the Nursing Directorate and disseminated to ward staff.
- The Health Board has communicated with other NHS Wales Health Boards to develop a combined Cleaning Strategy and Operational Plan which was in the process of being drafted at the time of our review. We acknowledge that the change of personnel / structure within the department may have contributed to the original timeframe being missed. We note from review of the draft document that this is more detailed than the exemplars provided in the Standards.
- The Health Board had not identified or established an appropriate multi-disciplinary standards of cleaning group at the time of our review. We were informed that the appropriate group would be identified once the Combined Strategy and Operational Plan is at final draft stage.

Finding 1 - Multi-Disciplinary Standard of Cleaning Group (Control design)	Risk
Standard 1.5 requires that each Health Board **must** ensure a multi-disciplinary standard of cleaning group is in place with responsibility for implementing the Standards and reporting to the Executive Board Member on progress made against the objectives at least twice a year, and that an annual report is submitted to the Executive Board. The Standards detail that anticipated membership of the group be drawn from the following areas: • Patient representative group (e.g. CHC). • Domestic Management. • Hotel Services. • Estates Department. • Infection Control Nursing. • Patient Representative. • Staff Representative and/or Union Representative. • Ward/Departmental Representative. We acknowledge that Appendix 1 of the Cleaning Strategy details the Terms of Reference for the Healthcare Environment Steering Group which includes representation from the groups listed above. However, at the time of our review this Group was no longer in existence. As mentioned in the good practice above, performance against the Standards is reported to a number of Health Board committees and Groups including the QSE and IP&C Committees. The attendance at these committees covers the majority of the anticipated membership for the multi-disciplinary group which therefore partly mitigates the risk of not having a specific group in place.	Risk of infection for patients/ health and safety risk for the public and staff.

Recommendation	Priority level
The Health Board should ensure that there is a Multi-Disciplinary Group in place in line with the requirements of the 'National Standards for Cleaning in NHS Wales' or that the Healthcare Environment Steering Group referred to in the Cleaning Strategy is reconvened.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Formerly add the Cleaning Standards requirement into one of the existing forums described above into the same agenda. This will save additional meetings and labour resources.	Lee A Wyatt, Jan 2018
Current Position	
At the time of our follow-up audit the Health Board were in the process of working on a draft combined Cleaning Strategy and Operational Cleaning Plan – as detailed in Finding 5 of this Action Plan. We were informed that a decision on whether to identify a new multi-disciplinary Cleaning Standards group, or to include the requirements for a Cleaning Standards multi-disciplinary group within the remit of an existing group that already includes the appropriate membership (such as the Infection Prevention & Control Committee) which would demonstrate an efficient use of public resources, would not be decided until a Final Draft of the Cleaning Strategy and Operational Plan has been produced. As such we consider this recommendation to be **not implemented**.	

Finding 2 – Completion of Technical Audits (Operating effectiveness)	Risk
The reported technical audit scoring process is inconsistent across both sites. At UHW the technical audit is undertaken and this is the score that is reported on the C4C Cleaning Audits reports. At UHL the technical audit is undertaken and remedial action is taken to rectify any fails. Management override the initial technical audit carried out and re-take the technical audit; this is the score that is reported for UHL on the C4C Cleaning Audit Reports. Whilst it is acknowledged that the scoring method utilised within UHL is deemed acceptable as part of the C4C process, the current inconsistency across the 2 sites means that the reported levels of performance are not directly comparable. The 'C4C 13 Week Review - Cleaning Audits' report was obtained for both UHW and UHL covering the period 2 January 2017 to week commencing 27 March 2017. We selected a sample of 10 technical audit scores from the reports including 'Very High Risk' and 'High Risk' areas across all weeks (five relating to UHW and five relating to UHL). We obtained the 'C4C Audit Score Sheets' for the sample selected to confirm that the audit undertaken agreed to the report. Two of the Sheets did not agree to the reported technical audit score on the 'C4C 13 Week Review - Cleaning Audits' Report. Both score sheets related to UHL. No explanation was provided for the anomaly, however it could be due to the overriding of the scores as described above.	Areas of poor performance are not identified or addressed.
Recommendation	**Priority level**

The Health Board should ensure that a consistent approach is used for reporting the technical audit scores across the 2 sites and that accurate scores are reported for all completed audits.	**Medium**
Management Response	**Responsible Officer/ Deadline**
On checking with C4C both approaches were in accordance with the system and standards, however Facilities will review their approach and standardise when and if appropriate.	John Smith, Jan 2018
Current Position	
From discussions with relevant staff across both sites the process is now consistent across both sites and the initial audit score is recorded with no management override of the initial score at either site. We obtained a copy of the most recent 'C4C 13 Week Review - Cleaning Audits' report for both UHW and UHL. We selected a sample of 10 technical audit scores (five relating to UHW and five relating to UHL) from the reports including 'Very High Risk' and 'High Risk' areas across all weeks. We obtained the 'C4C Audit Score Sheets' for the sample selected to confirm that the audit undertaken agreed to the report. All but one of the 'C4C Audit Score Sheets' agreed to the reported technical audit score on the 'C4C 13 Week Review - Cleaning Audits' Report. One of the score sheets, relating to UHW, did not agree to the report. We were informed that the reason it did not agree was that the catering supervisor had not changed the system over from technical audit to catering audit. We have accepted this response as 'human error'. As such we consider this recommendation to be **fully implemented**.	

Finding 3 - Ward Staff Sign-off (Control design)	Risk
The Standards require that technical audits are undertaken by the domestic supervisor and are signed off by the ward sister/charge nurse, where appropriate. We sample tested 10 technical audits carried out (five from UHW and five from UHL). No evidence of ward sister/charge nurse sign off was available for any of the 10 technical audits sample tested.	Areas of poor performance are not identified or addressed.
Recommendation	**Priority level**
An appropriate member of the Ward staff should sign off the technical audits undertaken by the domestic supervisor.	**High**
Management Response	**Responsible Officer/ Deadline**
Facilities to coordinate and request clinical support on audit. Ward Sisters and Charge Nurses will be reminded of their responsibility to, when requested check the validity of the audit and sign off.	Sarah Maggs, Nov 2017 Acting Deputy Nurse Director, Nov 2017
Current Position	
We obtained the C4C sign-off sheets for the sample of 10 technical audits selected – 5 from UHW and 5 from UHL. There was no evidence of ward sign-off on the C4C system for the sample selected. However, we acknowledge that the requirement for ward sign-off has been appropriately communicated to the Nursing Directorate but based on the lack of evidence available to demonstrate ward sign-off, it is evident that this is	

not routinely completed.

As such we consider this recommendation to be **partially implemented**.

Finding 4 - Managerial Audits not carried out (Control design)	**Risk**
The standards detail the following in respect of Managerial Audits: ***Managerial.*** *These are planned audits that should verify cleaning outcomes of technical audits and identify any areas for improvement. The audit team should consist of senior domestic management, ward sisters/charge nurses with responsibility for cleaning, infection control and estates. These audits are undertaken at least quarterly to ensure a representative sample is achieved during a twelve month period. The team validates a sample of technical audit information by sampling some elements across all functional areas, some room types or one or more functional areas. The decision concerning the scale of the review is based upon cleanliness levels already achieved; where the team feel emphasis should be placed; or randomly chosen elements, rooms or functional areas generated by the All-Wales Monitoring Tool.* At the time of our review managerial audits were not being undertaken within the Health Board.	Areas of poor performance are not identified or addressed.
Recommendation	**Priority level**
The Health Board should carry out managerial audits on a quarterly basis in line with the requirements of the Standards.	**High**
Management Response	**Responsible Officer/ Deadline**
Facilities Staff to arrange audit schedule and invite ward staff to participate with good prior arrangements in place.	Lee A Wyatt, Jan 2018

Current Position	Updated Deadline
Schedules for managerial audits have been produced for both sites (UHW and UHL). These were reviewed which confirmed that they meet the frequency as defined in the Standard, being *"at least quarterly"*. At UHW these schedules have been appropriately communicated to the Deputy Executive Nurse Director to ensure that ward staff are aware of when managerial audits are going to take place to ensure that they are available. At the time of our review the managerial audits were in their infancy – at UHW they commenced on 2nd July 2018 and at UHL they commenced in April 2018. We were provided with evidence to show that these had taken place. We were informed that Infection Prevention and Control (IP&C) are not represented on the managerial audits as they undertake their own audits. The standards provide guidance on staff groups that should attend not must attend and as such this is considered acceptable. As such we consider this recommendation to be **fully implemented**.	

Finding 5 - Cleaning Strategy & Operational Plan (Control design)	Risk
The Health board has a Cleaning Strategy in place which was approved by the Quality Safety and Experience Committee in September 2015. Review of the strategy showed that it is potentially over detailed in comparison to the exemplar plan within the Standards. The standards require that the Health Board should also have an Operational Cleaning Plan in place which should include the following as a minimum: • The requirements of the standard; • An audit of compliance with the standard covering: A) all existing work schedules; B) all existing service level agreements; and	Risk of infection to patients / health and safety risk for the public and staff.

C) all existing service specifications. • A detailed plan for any changes required in (a) to (c) above; and • A briefing paper for feedback into the strategy document. At the time of our review the Health Board did not have an Operational Cleaning Plan in place. However, we acknowledge that the Cleaning Strategy in place includes a baseline assessment that had been carried out against the standards which could form the basis for an Operational Plan. We also noted that the Health Board's Cleaning Strategy makes reference to the Healthcare Environment Steering Group (HESG). However, this group is no longer in existence.	
Recommendation	**Priority level**
Management should update the Cleaning Strategy and develop an Operational Cleaning Plan in line with the requirements of the Standards.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Facilities Senior Management to develop and disseminate to the Cleaning Group for sign off and approval.	Lee A Wyatt, March 2018
Current Position	
Since our original review the Health Board has decided that instead of producing a separate Cleaning Strategy and Operational Cleaning Plan, as detailed in the Standards, they intend to produce a combined Cleaning Strategy and Operational Plan. We consider this to be more detailed than the exemplar Cleaning Plan and exemplar Cleaning Strategy as detailed on the 'National Standards for Cleaning in NHS Wales' guidance.	

At the time of our review the Health Board was in the process of producing a draft version of this document for consultation but this was not yet at a final draft stage.

We acknowledge that there have been changes in roles and responsibilities within the department which have impacted on the progress towards implementing this recommendation within the initial timeframe provided in the original report.

As such we consider this recommendation to be **partially implemented**.

Finding 6 – Completion of technical audits (Operating Effectiveness)	**Risk**
Review of the '13 Week Review - C4C Cleaning Audits' Reports showed that there were gaps in the reports indicating that the cleaning technical audit had not been carried out on some functional areas that had been assessed as 'Very High Risk' areas. However, review of the report for the same week showed that audits had been carried out on lower risk areas. Additionally, there are inconsistencies in the frequency that the technical audits are carried out across the two sites. Review of the 13 week report of UHL shows that almost all risk areas Very High Risk to Low Risk are audited on a weekly basis which is more than the required frequency as recommended in the Standards	Areas of poor performance are not identified or addressed.
Recommendation	**Priority level**
Management should ensure that technical audits are completed on all high / very high risk areas as per required timescales.	**Medium**

Management Response	Responsible Officer/ Deadline
Facilities to review audit schedule and make clear programme to Senior Management, stating UHB priorities.	Sarah Maggs, Jan 2018

Current Position	

We obtained a copy of the most recent 'C4C 13 Week Review - Cleaning Audits' report for both UHW and UHL. We reviewed the reports to confirm that 'Very High Risk' and 'High Risk' technical audits had been carried out at the required interval as defined in the Cleaning Standards, being weekly for 'Very High Risk' areas and monthly for 'High Risk' areas.

Appropriate explanations were provided for the missed technical audits. However, at UHW we were informed that some 'Very High Risk' technical audits had been not been undertaken for week commencing 16th April 2018 and 23rd April 2018 due to "a really difficult time in the department with a shortage of supervisors due to sickness, maternity leave, annual leave and supervisors leaving the department for other roles". Our review of the 'C4C 13 Week Review - Cleaning Audits' report showed that technical audits had been undertaken on 'Significant Risk' and 'Low Risk' areas during that period. We would advise the Health Board to ensure that resources as re-assigned from 'Significant Risk' and 'Low Risk Areas' to 'Very High Risk' areas for weeks when there are staffing issues. However, we acknowledge that there is a marked improvement in the frequency of the technical audits at the site compared to our original review and these omissions were isolated to this two week period and as such not considered a widespread issue.

As such we consider this recommendation to be **fully implemented**.

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

Follow up - All recommendations implemented and operating as expected.

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

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

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

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

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Follow up - No action taken to implement recommendations.

Prioritisation of Recommendations

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

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

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

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

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

CRC Energy Efficiency Scheme

Final Internal Audit Report

Cardiff & Vale University Health Board

2018/19

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance


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Committee	Audit Committee

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

Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of 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 CRC Energy Efficiency Scheme (CRC) is a UK Government initiative to reduce carbon dioxide (CO2) emissions from large and medium-sized organisations meeting certain qualification criteria.

Participation for these organisations is mandatory. The first phase of the scheme ran from April 2010 to the end March 2014. The second phase (which all NHS Wales Health Boards joined) runs from 1 April 2014 to 31 March 2019.

The UK government announced in 2016 that the CRC energy efficiency scheme will be abolished following the 2018/19 compliance year.

This audit has been cognisant of this fact, and risk appraisal and issues raised have been in this context.

Health Boards were required to submit their annual report for the third year of participation by 31 July 2018.

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

2. Scope and Objectives

The assignment originates from the 2018/19 internal audit plan.

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

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

- Follow up: Assurance that recommendations made in prior audits had been appropriately addressed;
- A review of the 2017/18 annual report (due for submission by 31st July 2018), to assess:
  - Accuracy of reported figures/totals;
  - Correct treatment of data including actuals/estimates, inclusions/exclusions etc.; and
  - Audit trail to supporting evidence;
- Assessment of the management of the purchase of allowances; and
- Sufficiency of the Evidence Pack.

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

3. Associated Risks

The potential risks considered in the review were as follows:

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

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

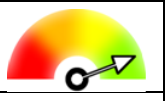
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the CRC Energy Efficiency Scheme is **Reasonable Assurance**.

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	Annual Report Data			✔	
3	Purchase of Allowances				✔
4	Evidence Pack				✔

** 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 a weakness in the system control/design for managing the requirements of the CRC Scheme.

Operation of System/Controls

The findings from the review have highlighted 0 issues that are classified as weaknesses in the operation of the designed system/control for managing the requirements of the CRC Scheme.

6. Summary of Audit Findings

Follow Up

We sought assurance that previously agreed management actions had been implemented. The status of agreed management actions arising from previous reviews is as follows:

Closed	Outstanding	Total
2	0	**2**

Detail behind this summary is included at **Appendix B**.

Annual Report Data

Data System

As in prior years, the UHB had engaged a specialist consultant to advise and assist with regard to the CRC scheme and the European Emissions Trading Scheme (EU ETS), including assistance in the preparation of the final submissions.

Following the introduction of the energy bureau (database) two years ago, the UHB holds its own energy data (obtained from automatic meter readings (AMR) or manual meter reads), in addition to the supplier invoices and supplier annual statements. It is therefore now able to perform a more robust assessment of the quality of the data, when selecting which data to report under the CRC Scheme, than it could in prior years.

We noted however that there remained ongoing issues with the quality of the AMR data being received, with the UHB in discussions with the energy supplier to resolve these.

Data Accuracy

Supplies in relation to University Hospital Wales (UHW) were appropriately excluded from reported totals, noting that the site was included within the EU ETS and was therefore exempt from CRC reporting.

The data preparation process was reviewed, to confirm accuracy of calculations and compliance with CRC guidance. This revealed the following approach to compilation:

- The higher of the bureau & supplier statement consumption figures at each site / meter point were typically selected for reporting, ensuring a prudent approach and minimising the risk of under-reporting; and
- Bureau data was only utilised in a small proportion of cases, with the supplier statements remaining the primary source of data for reporting.

The audit sampled 71% of the reported gas consumption figures and 89% of the reported electricity consumption figures, confirming reconciliation to data taken from supplier statements and/or the UHB's energy bureau database.

The following issues were identified from audit testing:

- The bureau data did not lend itself to the retention of a full audit trail to demonstrate derivation of figures (noting that some manual adjustment of AMR data is required to ensure a full data set);

- Noting the same, it was not possible to trace bureau data to the primary evidence and retained documents (e.g. AMR data), as required by CRC guidance;
- Four errors were identified in the preparation of the data (one resulting from aggregation of bureau data rather than source data). Three of the four errors were insignificant in terms of the effect on the reportable totals, however one would have resulted in an additional cost of £2,755 (based on the 17/18 forecast sale price) had it been reported (**recommendation 1**).

It is recognised that the errors identified would have resulted in over-reporting, as opposed to under-reporting. Therefore, whilst there may have been a cost impact, the Health Board would have remained compliant with the CRC Scheme requirements.

However, the majority of figures calculated for reporting had been correctly determined. See **Appendix C** for full details. All errors were discussed with the UHB during the audit fieldwork, and corrected prior to uploading to the CRC Registry.

Estimated Data

The UHB reported 9.8% of the total gas and 0.9% of the total electricity consumption as estimated at the 2017/18 CRC report. In addition, the solar panel data was also reported as estimated. This incurred a total additional cost of £713 (using the 2017/18 forecast sale allowance price), noting that estimated data incurs a 10% uplift by way of penalty for not holding accurate data.

100% of the estimated consumption was assessed, for accuracy of calculations and compliance with CRC guidance, confirming calculations were compliant and correct.

Corporate Responsibility Questions

The UHB answered positively to the four corporate responsibility questions, and provided sufficient evidence to support the responses, in accordance with the CRC guidance.

Report Submission

The calculated totals were initially uploaded to the CRC Registry on 20th July 2018. However, it was identified by Audit that the figures in respect of on-site electricity generation had not been uploaded correctly (it was acknowledged that the error had an insignificant effect on the reported totals). Following discussion with the consultant, the report was amended correctly in advance of the reporting deadline of 31st July 2018.

This error may have resulted from the lack of clarity at the CRC working paper. Whilst the spreadsheet provided an audit trail of calculated totals

for gas and electricity, at individual worksheets, there was no working paper for the solar panel self-generated electricity. Further, the final presentation of totals on the summary sheet did not reflect those figures uploaded to the Registry (i.e. they were included for reconciliation purposes and included the 10% estimation uplift). (See **recommendation 2)**.

Annual Report Data: Conclusion

Improvements continue to be made in the robustness of data used for CRC reporting, through e.g. the introduction of smart meters and population of the energy bureau. However, this remains an ongoing task to ensure further improvements are achieved in the quality of data held.

While a small number of errors were identified in the data preparation and reporting process (4 data preparation errors, and 1 data reporting error), these did not have a material effect on the reportable totals; however recommendations have been made where controls need to be improved to reduce the risk of future recurrence.

Therefore, we have determined **reasonable assurance** in this section.

Purchase of Allowances

The UHB brought forward a surplus of allowances, and did not therefore require purchase of additional allowances in the forecast sale of 2018/19.

Advance purchase of allowances are cheaper than year-end purchase. However, noting the ending of the scheme (post 2018/19), it has been decided that any additional allowances required will be purchased in the "buy to comply" sale at year end once actual consumption for the year is known. This will reduce the risk of being left with surplus allowances at the end of the Scheme.

These issues were found to have been appropriately considered and reviewed (see also **Appendix B: 2**).

Substantial assurance has therefore been determined in respect of purchase of allowances.

Evidence Pack

A comprehensive electronic evidence pack was retained in accordance with CRC requirements. We therefore determine **substantial assurance** in this area.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding 1: Data comparison process between bureau and statement figures	Risk
Energy Bureau data was compared with supplier statements, with management typically selecting the higher of the two figures for inclusion in CRC totals, to avoid the risk of under-reporting. However, Bureau data was aggregated to a site level prior to this comparison, rather than comparison by meter. Data disaggregated to meter level would enable like-for-like comparison to the statement data, and therefore provide a better basis for understanding and query. This directly led to the error detailed at **Appendix C** (line 4), where the Health Board would have over-reported at a cost of £2,754 (identified and fed back to management as a part of the current audit).	The Health Board may not be able to make an informed decision as to which data source to utilise for CRC reporting. Risk of over / under reporting and associated costs.
Recommendation 1	**Priority level**
Bureau data will be compared at meter level with supplier statements (on a like for like basis) to better inform review and compilation of the annual report.	**Medium**
Management Response	**Responsible Officer/ Deadline**
For sites with multiple meters, the bureau data in the 2018/19 CRC reporting spreadsheet will be presented on a meter by meter basis. If there are instances where this cannot be achieved an alternative approach will be developed and adopted.	Energy Manager At the preparation of the 2018/19 CRC report

Finding 2: CRC working papers	Risk
The CRC consolidated working paper included a 10% estimation uplift, and did not therefore show the figures required for input to the CRC registry. This resulted in a data entry error (in respect of on-site electricity generation) at the initial registry upload. In this case, the error had no financial effect on the reported totals, and was corrected following identification by Audit, prior to the final reporting deadline.	Risk of over / under reporting and associated costs. Risk of financial penalties should the CRC Scheme auditors identify an error in reporting.
Recommendation 2	**Priority level**
The CRC working paper summary page should clearly show those figures that are to be uploaded to the CRC register, including on-site electricity generation and net of the 10% estimation uplifts.	**Low**
Management Response	**Responsible Officer/ Deadline**
For 2018/19 the CRC working summary page will show the figures that are to be uploaded to the CRC Register, including on site electricity generation and net of the 10% estimation uplifts.	Energy Manager At the preparation of the 2018/19 CRC report

Appendix B: Follow up of previously agreed recommendations

Ref	Recommendation made at 2017/18 audit	Priority Rating	Status at 2019/19 audit	Updated Responsibility & Timescale
1	Management will work with the Estates team to determine the ownership of the gas meter at the Lansdowne site to facilitate accuracy of reporting in future years. In the interim, a meter reading will be taken to ensure the database reflects a more accurate consumption reading.	Low	**Closed** The ownership of the meter had still not been determined at the time of follow up. Enquiries were ongoing with the supplier. However, for the 2017/18 year, the Health Board had obtained sufficient meter readings to enable reporting of the actual supply. Noting a prudent approach is being taken, this is sufficient to close this recommendation.	n/a
2	Approval will be sought in advance of all future purchases being made. Should timing available not permit presentation of a full report to the management executive group for approval, email communication will be issued to the relevant officers to facilitate approval in advance of the purchase cut-off date.	Low	**Closed (superseded)** For 2018/19 the Health Board has not purchased any allowances in the forecast sale; instead utilising the remaining surplus of allowances from prior years. Any remaining requirements, once actual usage for the year is known, will be met through purchase in the buy to comply sale at year end.	n/a

Appendix C: Summary of errors in the data prepared for reporting (All errors were corrected prior to reporting)

	Site / Meter	Consumption (kwh): Energy bureau database	Consumption (kwh): Supplier Statement	Calculated consumption figure (kwh)	Corrected consumption figure (kwh)	Financial effect had the figure been reported*	Explanation for amendment
Gas							
1	Cardiff Royal Infirmary (MPAN 74433510)	65,524	Missing from statement	65,524	0	£200 potentially over-reported	Meter should have been excluded as falls under the consumption threshold of 73,200 kwh.
2	Rookwood (MPAN 78271104)	4,380,683	3,478,064	4,380,683	3,478,064	£2,754 potentially over-reported	Bureau total included all meters for the site. When disaggregated, the relevant meter consumption was only 3,337,828. Therefore, the statement figure was selected for prudency in line with the general approach.
3	Rhadyr Health Centre (MPAN 74479209)	72,878	73,980	0	73,980	£226 potentially under-reported	Meter was excluded thinking it was under the consumption threshold of 72,300kwh. It is in fact slightly over.
Electricity							
4	5, Park Road, Whitchurch (MPAN 2199993415156)	13,172	6,330	6,963	6,330	Insignificant, no cost effect	The spreadsheet had added a 10% uplift in error.

*calculated using the 2017/18 forecast sale price of £16.60 per allowance.

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Cardiff and Vale University Health Board

PCIC CB – District Nursing Rotas

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Kay Jeynes, Director of Nursing
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Committee:	Audit Committee

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

1. Introduction and Background

The review of the management of District Nurse Rotas within the Primary Community and Intermediate Care (PCIC) Clinical Board has been completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

District Nurses are employed by the UHB and work closely with General Practitioners ('GPs') and other health and social care professionals within the local community. The aim of the service is to provide skilled nursing care to patients in their own homes, by specially trained community nurses, and to provide support to carers. This service is provided over the 24 hour period, 365 days a year.

The Health Board recognises the value of its nurses and is committed to supporting them to provide high quality patient care. The scheduling of nurse time is critical to the delivery of patient care, resource utilisation and employee satisfaction. The need to run the service effectively brings the rostering process under scrutiny, making the balancing of the needs of the community and its staff a challenge. Staffing remains the most important factor in the delivery for safe and effective care.

The Welsh Government response to the Francis Report, 'Delivering Safe Care Compassionate Care', issued in July 2013 identified that there is a link between patient safety, quality of care and nurse staffing levels. This highlights the importance of ensuring that efficient utilisation of nursing staff can be achieved and demonstrated.

The National Assembly of Wales passed the Nurse Staffing Level (Wales) Act 2016 which currently applies to medical and surgical wards with the expectation that it will be extended in the future to cover all areas where nurses are employed, ie. District Nursing. The purpose of the bill is to:

- Ensure that nurses are always deployed in sufficient numbers to enable the provision of safe nursing care to patients at all times;
- Improve working conditions for nurses and other staff; and
- Strengthen accountability for the efficacy, safety and quality of workforce planning and management.

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

2. Scope and Objectives

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

The purpose of the review was to establish if district nursing rotas are effectively planned and managed.

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

- There are appropriate local procedures and processes in place for drawing up district nursing rotas and the PCIC District Nursing team are compliant with the Health Board's 'Rostering Procedure for Nurses and Midwives';
- District nursing rotas are fit for purpose with deployment of sufficient number and an appropriate skill mix to ensure safe, high quality standards of care;
- There are processes in place to ensure that district nurses work their contracted hours including breaks and annual leave; and
- There are appropriate management systems in place for reviewing and reporting the effectiveness of the rostering process, thereby driving efficiencies in the district nursing workforce.

3. Associated Risks

The potential risks considered in this review are as follows:

i. Processes and procedures do not allow quality workforce planning and management;

ii. Patient care and staff safety is not optimised with the available resource due to district nurse staffing levels and/ or skill mix; and

iii. District nurses do not work their contracted hours

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 PCIC CB – District Nursing Rotas 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.

Currently, the Health Board's District nursing teams are using the Health Board's Rostering Procedure for Nurses and Midwives to guide their process for rostering. Whilst this provides a good foundation, there are elements of the current system which need enhancing to ensure full compliance with the recently published Welsh Government (WG) interim District Nurse Guiding Staffing Principles.

Rotas are managed locally by each of the District Nursing Team Sisters; the approach taken is inconsistent across the teams, even within the same locality. The main variation is the level of use of the Rosterpro system. However, despite this, rotas were found to be well prepared with appropriate consideration of skill mix and staff experience.

Each team reports their escalation levels weekly and a monthly performance report for each locality is provided to PCIC management. This ensures there is good oversight and review of compliance with KPIs, challenges faced and any capacity issues.

5. Assurance Summary

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

Assurance Summary					
1	Procedures and Processes for Rotas			✓	
2	Rotas are Fit for Purpose				✓
3	Contracted Hours and Annual Leave			✓	
4	Review and Reporting of the Effectiveness of Rostering				✓

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for PCIC CB – District Nursing Rotas.

Operation of System/Controls

The findings from the review have highlighted five issues that are classified as weakness in the operation of the designed system/control for PCIC CB – District Nursing Rotas.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: There are appropriate local procedures and processes in place for drawing up district nursing rotas and the PCIC District Nursing team are compliant with the Health Board's 'Rostering Procedure for Nurses and Midwives'.

The following areas of good practice have been noted:

- The staffing complements within five of the seven district nursing teams visited are within the maximum levels recommended in the WG Interim District Nursing Staffing Principles;
- All the teams tested as part of the review had access to at least 15 hours of administration support per week, which is in line with the WG interim principles;
- The Health Board's Rostering Procedure for Nurses and Midwifes requires each week of the roster to be produced, signed off and published a minimum of 6 weeks in advance; five of the seven District Nursing teams tested were within these timescales; and
- Five out of the seven District Nursing teams tested were verifying their rotas within 72 hours of the last shift worked.

No significant findings were identified under this objective.

Objective 2: District nursing rotas are fit for purpose with deployment of sufficient numbers and an appropriate skill mix to ensure safe, high quality standards of care.

The following areas of good practice have been noted:

- No incidents have been recorded with a patient or staff safety impact due to insufficient rotas, staffing or workforce planning; and
- Each rota has been prepared with staffing experience and skills being appropriately considered.

No significant findings were identified under this objective.

Objective 3: There are processes in place to ensure that district nurses work their contracted hours including breaks and annual leave.

The following areas of good practice were noted:

- Rotas were found to be correctly prepared to allow District Nursing staff to work their contracted hours, including an allocated break in accordance with the Rostering Procedure for Nurses and Midwives; and
- All Annual Leave was found to be correctly recorded within ESR from the Rosterpro automatic feed.

The following significant finding was identified:

- As per the last internal review of Rosterpro use carried out by the District Nursing team, the current audit tested the same threshold of no more than 14% of staff should be taking Annual Leave at any one time. All of the seven teams tested were above this threshold on numerous occasions throughout the July and August period.

Obj 4: There are appropriate management systems in place for reviewing and reporting the effectiveness of the rostering process, thereby driving efficiencies in the district nursing workforce.

The following areas of good practice were noted:

- The North and West Locality Manager performed a review of five district nursing teams in January 18 to audit their compliance with Rostering guidelines;
- Each month the Service Delivery Board meets to discuss and monitor PCIC performance, delivery and planning. This includes a performance report for each locality with a section on District Nursing. The report looks at compliance with KPIs, challenges faced and a review of capacity.

  These reports note capacity and workload pressures across the localities leading to a lack of compliance with client risk assessments, there is work ongoing with the PARIS team to establish improvements; and
- Weekly, each district nursing team establishes and reports an escalation level on a scale of 1-5; this is a judgement on the level of quality and safety concerns. Whilst the audit notes that for a few teams these levels have been high, there is work ongoing across the localities to set new parameters of each level to reduce the element of judgement needed.

No significant findings were identified under this objective.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**1**	**4**	**5**

Finding 1 - Annual Leave (Operating effectiveness)	Risk
As per the last internal review of Rosterpro use carried out by the District Nursing team, the current audit tested the same threshold of no more than 14% of staff should be taking A/L at any one time. All of the 7 teams tested were above this threshold on the following volume of occasions during July and August: • North Cardiff - 16 days; • Ely - 8 days; • OoH - 2 days; • Butetown – 5 days; • Pentwyn - 1 day; • Western Vale - 11 days; and • Penarth - 7 days Further sample testing of individual annual leave episodes was performed, whilst the audit is content that annual leave has been recorded correctly within Rosterpro and subsequently ESR; there are some notable errors with use of the paper Annual Leave Request system: • North - 1 episode of A/L not on individuals request sheet; • Ely - 1 episode of A/L not on individuals request sheet, 1 episode is not authorised on the request sheet and the incorrect dates are written down;	Patient care and staff safety is not optimised with the available resource due to district nurse staffing levels and/ or skill mix.

• OoH - no request sheets kept in office; • Butetown - no requests authorised; • Pentwyn - no requests authorised; • Western Vale - episode of A/L not on individuals request sheet, 1 episode is not authorised on the request sheet; and • Penarth - no requests authorised, 1 A/L not on request sheet.	
Recommendation	**Priority level**
The District Nurses should ensure they are enforcing rules over how many staff can take annual leave on the same day. This should be reviewed periodically to ensure compliance. They should also ensure that Annual Leave requests are fully complete, updated when changes are made and authorised.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A local annual leave procedure has been developed since the audit to ensure that staff understand how the annual leave can be requested approved and rostered.	Senior nurses have implemented November 2018

Finding 2 - Rosterpro Use (Operating effectiveness)	Risk
There are varying levels of Rosterpro usage within the District Nursing localities and notable inconsistencies across the teams. Whilst all rotas eventually are recorded within Rosterpro, the process before this differs. Of the 7 teams tested: • 5 teams complete their rotas manually offline from Rosterpro and enter these into the system before or after the shifts have been worked; • 1 team completes their Rota manually within the Rosterpro system; and • Only 1 team uses the automatic generation function within Rosterpro. The audit also notes, that whilst there is no effect on the contracted hours worked, the shifts for the North Cardiff team are entered into Rosterpro as 8:30-17:00hrs with an hour break, as opposed to the actual shift of 8:30-16:30hrs with a 30 minute break.	Processes and procedures do not allow quality workforce planning and management.
Recommendation	**Priority level**
District Nurses should work in conjunction with the Rosterpro team to ensure details in Rosterpro are correct to enable use of the automated generation of rotas. Rotas should be entered into Rosterpro prior to shifts being worked.	**Low**
Management Response	**Responsible Officer/ Deadline**
District Nursing sisters will be expected to use Rosterpro to roster all staff, this will be reviewed through regular 1-1's with them and the Locality senior nurse.	Senior Nurses - Ongoing regular commitment going forward.

Finding 3 - Timeliness & Authorisation (Operating effectiveness)	Risk
As per the Rostering policy, rotas should be prepared, authorised and published 6 weeks in advance. Testing of the 7 teams completed showed that 2 teams within the North & West Locality were not in compliance with this; North Cardiff and Ely. When rotas are prepared manually and subsequently entered into Rosterpro (5/7 of the teams), these are not formally signed and preparation dates are not recorded.	Processes and procedures do not allow quality workforce planning and management.
Recommendation	**Priority level**
District Nurse Sisters should ensure rotas are prepared on a timely basis. Where rotas are prepared manually, these should be formally signed and the date of preparation recorded.	**Low**
Management Response	**Responsible Officer/ Deadline**
District Nursing sisters will be expected to use Rosterpro to roster all staff, rosters will be audited quarterly to ensure that rosters are provided 4-6 weeks in advance, and signed off, this will be reviewed through regular 1-1's with them and the Locality senior nurse	Senior Nurses - Ongoing regular commitment going forward.

Finding 4 - Rota Verification (Operating effectiveness)	Risk
There is a policy requirement for the Sister to ensure that entries on the e-roster are confirmed as accurate and a true record of hours/ shifts worked. During the District Nurse internal review, this was tested to be within a 72 hour window after the last shift worked and therefore audit has followed the same principles. Out of the 7 teams tested, 2 teams were not in compliance with this verification timing, North Cardiff and Penarth. However, it is noted that this verification was still done within the Rosterpro Payroll deadlines.	Processes and procedures do not allow quality workforce planning and management.
Recommendation	**Priority level**
District Nurse Sisters should verify rotas weekly, within 72 hours of the last shift worked. This should be reviewed periodically to ensure compliance.	**Low**
Management Response	**Responsible Officer/ Deadline**
District Nursing sisters will be required to verify rosters weekly and this will be monitored through regular 1-1's with the Locality Senior nurse	Senior Nurse - Ongoing regular commitment going forward.

Finding 5 - Rota Shortfalls (Operating effectiveness)	Risk
No teams are recording their shortfall of staffing on their rota. Each team books their bank staff separately, not through temporary staffing department and therefore only filled shifts are recorded. This does not aid in identifying rotas gaps for future workforce planning.	Processes and procedures do not allow quality workforce planning and management.
Recommendation	**Priority level**
District Nurse Sisters should be reminded of the importance of recording shortfalls on the rota. Compliance should be reviewed periodically.	**Low**
Management Response	**Responsible Officer/ Deadline**
A revised process for recording gaps in staffing is to be developed	Lead Nurses - January 2019.

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

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

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

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

Cardiff and Vale University Health Board

Mental Health Clinical Board – Section 17 Leave

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Ian Wile, Director of Operations
	Jayne Tottle, Director of Nursing
	Sunni Webb, Mental Health Act Manager
	Simon McDonald, Mental Health Act Administration Manager
Committee:	Audit Committee

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

1. Introduction and Background

The review of the management of Section 17 Leave within the Mental Health Clinical Board was completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board.

A patient, who is detained in hospital under the Mental Health Act 1983, can only leave hospital lawfully if they are granted a leave of absence by the responsible clinician under Section 17 of the Act. This includes those detained under section 2, 3, 37 and 47 of the Act. Section 17 leave of absence applies to any short and long term leave from the hospital or its grounds and includes leave to reside in other hospitals.

Only the patient's responsible clinician can grant leave of absence to a patient detained under the Act. Responsible clinicians cannot delegate the decision to grant leave of absence to anyone else.

For patients who are subject to restriction orders (i.e. subject to section 41 or 49). The responsible clinician must seek approval from the Secretary of State for Justice. A responsible clinician may not grant leave of absence to patients detained under sections 35, 36 and 38 of the Act.

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

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Mental Health Clinical Board for the management of Section 17 leave, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the review was to establish if appropriate processes were in place to ensure effective compliance with providing leave to detained patients in accordance with Section 17 of the Mental Health Act 1983 and The Code of Practice for Wales 2016.

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

- Appropriate documented policies, procedures and / or guidelines are in place for Section 17 and these are made available to all relevant staff;
- A Section 17 leave of absence is appropriately granted by the responsible clinician before any patients, who are detained under the relevant sections of the Mental Health Act, leave hospital;
- Approval from the Secretary of State for Justice is obtained for any Section 17 leave granted to patients who are subject to restriction orders;

- Section 17 leave is appropriately utilised as part of the patient's rehabilitation and is only granted after effective consideration of risk and consultation with the patient and other parties;
- All granted section 17 leave is appropriately documented within the patient's case notes and effectively communicated to all required parties;
- All episodes of Section 17 leave taken are supported by an up to date risk assessment and specific care plan along with any required documented notes, including review of the patient on return;
- Any requirement to revoke Section 17 leave is taken by the responsible clinician and / or Secretary of State for Justice and is appropriately recorded within the patient's case notes; and
- The utilisation of Section 17 leave across the Clinical Board is appropriately recorded, monitored and reported and any issues are effectively identified and escalated when required to enable resolution.

3. Associated Risks

The potential risks considered in the review were as follows:

- Sectioned patients may unlawfully leave the hospital;
- Section 17 leave may be inappropriately granted; and
- There may be a lack of evidence to support the granting of section 17 leave.

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 Mental Health Clinical Board Section 17 Leave 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 findings from the review have identified that Section 17 leave is being adequately managed within the Clinical Board with a few issues being identified.

Section 17 Leave of Absence forms were available in the patient's notes within PARIS for all reviewed instances of leave granted and all had been authorised by a responsible clinician and detailed any conditions relating to the leave. In addition, there were letters available from the Ministry of Justice approving Section 17 leave for restricted patients.

The Section 17 leave is reviewed as part of the weekly or fortnightly ward rounds which involves the multi-disciplinary team and they will agree the type of leave that should be granted.

In cases where patients' section 17 leave had been revoked there were forms in place detailing the reason these had been signed by the responsible clinician.

The Health Board has produced a Guideline for Section 17 Leave of Absence which is generally in line with the Mental Health Act 1983 Code of Practice for Wales Revised 2016. However, it has yet to be formally approved.

In addition, the guideline refers to patients having up to date risk assessments and intervention plans in place relating specifically to the section 17 leave. The review confirmed that whilst up to date assessments and plans are in place they do not relate specifically to the section 17 leave. However, this requirement is not in line with the Mental Health Act and the Ward staff also confirmed that it would be too onerous to undertake these on each occasion of leave. The Health Board therefore needs to clarify the requirements to be followed and ensure they are correctly stated in the guidelines.

There were no high findings to report.

5. Assurance Summary

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

Assurance Summary					
1	Appropriate documented policies, procedures and / or guidelines			✓	
2	Section 17 leave of absence is appropriately granted				✓
3	Approval from the Secretary of State for Justice				✓
4	Section 17 leave is appropriately utilised as part of the patient's rehabilitation			✓	
5	All granted section 17 leave is appropriately documented within the patient's case notes			✓	
6	All episodes of Section 17 leave taken are supported by an up to date risk assessment			✓	
7	Any requirement to revoke Section 17 leave is taken by the responsible clinician				✓
8	Utilisation of section 17 leave across the Clinical Board is appropriately recorded				✓

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

Design of Systems/Controls

The findings from the review have highlighted two issues that are classified as weakness in the system control/design for MH CB – Section 17 Leave.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for MH CB – Section 17 Leave.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: Appropriate documented policies, procedures and / or guidelines are in place for Section 17 Leave and these are made available to all relevant staff

The following areas of good practice were noted:

- There is a Health Board Guideline in place for Section 17 Leave of Absence Mental Health Act 1983 which has been produced in accordance with the Mental Health Act 1983 Code of Practice for Wales Review revised 2016; and
- The Guideline provides information on the processes for granting leave and recording of the leave.

The following significant finding was noted:

- The Health Board Guideline for Section 17 Leave of Absence Mental Health Act 1983 has yet to be formally approved.

Objective 2: A Section 17 leave of absence is appropriately granted by the responsible clinician before any patients, who are detained under the relevant sections of the Mental Health Act, leave hospital

The following areas of good practice were noted:

- Responsible Clinicians are required to complete the Section 17, MHA 1983 - Leave of Absence form confirming the type of leave the patient is entitled to and any conditions of that leave. Audit selected a sample of 20 patients that had been granted section 17 leave. All the Section 17 forms had been completed and signed by responsible clinicians. The forms had been completed on the day the leave commenced or prior to the leave; and
- Audit visited a sample of wards and it was evident that section 17 leave was only granted to patients following the ward rounds that consisted of the multi-disciplinary team.

There were no significant findings noted.

Objective 3: Approval from the Secretary of State for Justice is obtained for any Section 17 leave granted to patients who are subject to restriction orders

The following areas of good practice were noted:

- Patients that are subject to restriction orders require the Secretary of State's permission to have leave of absence as well as approval from the responsible clinician. Audit selected a sample of patients that were subject to restricted orders and there were letters from the Secretary of State for Justice confirming approval of the patients leave.

There were no significant findings noted.

Objective 4: Section 17 leave is appropriately utilised as part of the patient's rehabilitation and is only granted after effective consideration of risk and consultation with the patient and other parties

The following areas of good practice were noted:

- Audit visited a sample of wards to ascertain the process for granting section 17 leave to patients. From discussions with ward staff Audit was advised that multi-disciplinary ward rounds are undertaken on a weekly or fortnightly basis which includes the Consultant, Nursing staff and the patient. Section 17 leave is considered within the ward rounds;
- Where appropriate, Family, friends and carers are consulted with when agreeing for the patient to have Section 17 leave; and
- A copy of the Section 17 Leave of Absence form is provided to the patient and/ or family if requested.

The following significant finding was noted:

- There is currently a lack of any recording of the reasons for the granting of section 17 leave.

Objective 5: All granted section 17 leave is appropriately documented within the patient's case notes and effectively communicated to all required parties

The following areas of good practice were noted:

- Audit selected a sample of 20 patients and a copy of the Section 17 Leave of Absence form was available in the patient's case notes in PARIS.
- There are signing in and out books in each of the wards confirming the date and time the patient has left the ward, what the patient was wearing and the time the patient returned to the ward.

There were no significant findings noted.

Objective 6: All episodes of Section 17 leave taken are supported by an up to date risk assessment and specific intervention plan along with any required documented notes, including review of the patient on return

The following areas of good practice were noted:

- The majority of the sampled patients had risk assessments and intervention plans in place prior to the section 17 leave being taken.

The following significant findings were noted:

- The Guideline for Section 17 Leave of Absence Mental Health Act 1983 states that the risk assessments and intervention plans should be specific to the section 17 leave. It was evident from our review that although there were risk assessments and intervention plans in place for all the patients they did not specifically relate to Section 17 leave. There is however no reference in the Mental Health Act 1983 Code of Practice for Wales Review Revised 2016 that patients on section 17 should be supported by specific risk assessments.

Objective 7: Any requirement to revoke Section 17 leave is taken by the responsible clinician and / or Secretary of State for Justice and is appropriately recorded within the patient's case notes

The following areas of good practice were noted:

- Audit reviewed a sample of patients that had leave revoked and there was a Revoking Leave of Absence form available for each. The forms had been signed by the responsible clinician as authorisation to the leave being revoked and were available within the patient's notes section in PARIS.

There were no significant findings noted.

Objective 8: The utilisation of section 17 leave across the Clinical Board is appropriately recorded, monitored and reported and any issues are effectively identified and escalated when required to enable resolution

The following areas of good practice were noted:

- The Mental Health Act Administration Manager has designed a Mental Health Inpatients Leave Report which is a report for the wards detailing the patients and their current section 17 leave entitlement which the wards are able to run as and when required. In addition, there is also a Mental Health Inpatients Leave Report which is an individual report specifically for the patients confirming where they are allowed to go and a map will be attached so they know where they can go.

- There is no specific performance report produced on Section 17 but any issues are currently reported on by exception to the Mental Health Capacity and Legislation Committee. The Mental Health Legislation and Governance Group has recently been reconvened which will report into the Mental Health Capacity and Legislation Committee and in the future any issues about Section 17 will be reported via this Group.

There were no significant findings noted.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**3**	**1**	**4**

Finding 1 - Guideline for Section 17 Leave of Absence (Control design)	Risk
The Clinical Board has produced a 'Guideline for Section 17 Leave of Absence Mental Health Act' which details the procedures for granting and recording leave and has been produced in accordance with the Mental Health Act 1983 Code of Practice for Wales Review revised 2016. It is however noted that the Guidelines have yet to be formally approved and still remain in draft.	Sectioned patients may unlawfully leave the hospital.
Recommendation	**Priority level**
The Guideline for Section 17 Leave of Absence Mental Health Act 1983 should be approved as soon as possible.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Guideline for Section 17 Leave of Absence Mental Health Act 1983 will be presented for approval at the Clinical Board Quality and Safety Committee in December 2018.	Dr Annie Proctor 13 December 2018

Finding 2 - Risk Assessments and Intervention plans (Operating effectiveness)	Risk
The Health Board Guideline for Section 17 Leave of Absence Mental Health Act 1983 confirms that "prior to any leave being undertaken, the patient must have an up to date risk assessment and a specific care plan relating to the leave." Audit reviewed 20 patients that have had section 17 leave and it was evident that although there were risk assessments and intervention plans in place for all the patients they did not specifically relate to the section 17 leave. This point was discussed with a number of Ward Managers who advised that it would be unfeasible to complete a risk assessment each time a patient went on leave. Furthermore, there is no reference in the Mental Health Act 1983 Code of Practice for Wales Review Revised 2016 that patients on section 17 should be supported by specific section 17 risk assessments. It is also noted that general risk assessments and intervention plans should be updated and reviewed on a regular basis. However, as at the time of testing (11th October 2018) a risk assessment and intervention plan for 1 of the sampled patients had last been updated on the 12th March 2018.	There may be a lack of evidence to support the granting of section 17 leave.
Recommendation	**Priority level**
The Health Board should clarify if there is a requirement for specific risk assessments and intervention plans to be produced before patients go on leave. The Guideline should then be updated to reflect the clarified requirements and management should ensure that these are followed in all instances. Risk assessments and intervention plans should be updated and reviewed on a regular basis.	**Medium**

Management Response	Responsible Officer/ Deadline
Consideration of the risk assessment and care and treatment plan will have taken place during a review with the Responsible Clinician prior to any Section 17 leave being granted. This is documented on the CPA 3 Review record and in the relevant case note entry.	Responsible Clinician – completed
The Guideline for Section 17 Leave will be updated to remove the requirement for a specific Section 17 risk assessment and care plan.	Jayne Tottle – December 18
Wards have been reminded to ensure current contact details are correct prior to a patient commencing Section 17 leave.	Jayne Tottle - completed

Finding 3 - Granting of leave (Control design)	Risk
The findings from the review have illustrated that the granting of Section 17 leave is being approved by the responsible clinician and discussions are held with the multi-disciplinary team and patient / carers as required. There is however a lack of any documented recording of the clinical reasons for granting the leave. The Section 17 Leave of Absence form confirms the duration of the leave including whether the leave is escorted, unescorted, ground or community and any other conditions of the leave. However, the form does not detail the reason why the patient has been granted leave. It was also evidenced that within some of the patients notes it recorded that leave had been granted but not the reason for the leave.	There may be a lack of evidence to support the granting of section 17 leave.

Audit were therefore unable to establish if the section 17 leave had been appropriately utilised as part of the patient's rehabilitation.	
Recommendation	**Priority level**
Management should consider updating the Section 17 Leave of Absence form to record the reason why leave has been granted to the patient.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The recording of the reason why leave has been granted is not a requirement of the MHA or Code of Practice. The conditions attached to the leave that are documented on the form, is the record if the leave is granted for a specific reason. The form does not therefore require updating.	Completed

Finding 4 - Patients signing in and out book (Operating effectiveness)	**Risk**
Signing in and out books are held by the exit of the wards to confirm when the patient leaves and returns to the wards. However, it was identified from review of these books that they were not always being completed properly and in some cases the patients had not been signed back into the ward.	There may be a lack of evidence to support the granting of section 17 leave.
Recommendation	**Priority level**
Staff should ensure that they complete all sections of the signing in and out book when patients leave and return to the wards.	**Low**

Management Response	Responsible Officer/ Deadline
The Director of Nursing has emailed all Ward managers to remind their staff to complete the signing in and out book each time a patient leaves/returns to the ward.	Jayne Tottle Completed

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.