Bundle Audit Committee 23 April 2019

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John Union

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9.1 INTERNAL AUDIT REPORT

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9.1.2 Ward Nurse Staffing Levels

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9.1.8 - e IT Learning Final report.pdf

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

11 REVIEW OF THE MEETING

12 DATE AND TIME OF AUDIT COMMITTEE WORKSHOP

Tuesday, 21 May 2019 at 9..0am - Corporate Meeting Room, Headquarters, UHW

AGENDA

AUDIT COMMITTEE

Tuesday, 23 April 2019
Corporate Meeting Room, Woodlands House Maes y Coed Road, Heath, Cardiff
CF14 4TT

1.	Welcome & Introductions	John Union
2.	Apologies for Absence	John Union
3.	Declarations of Interest	John Union
4.	Minutes of the Committee Meeting held on 26 February 2019	John Union
5.	Action Log – 26 February 2019	John Union
6.	Chairs Action taken since last meeting	John Union
7.	**Items for Review and Assurance**	
7.1	Internal Audit Progress and Tracking Report	Ian Virgill
	Limited Assurance Reports: 1. Surgery Clinical Board – Medical Finance Governance Report 2. Medicine Clinical Board – Internal Medicine Follow-up	Steve Curry Steve Curry
7.2	Wales Audit Office Progress Report	Anne Beegan
7.3	Post Payment Verification Report	Scott Lavendar
7.4	Draft Annual Report including Governance Statement	Nicola Foreman
7.5	Declarations of Interest	Nicola Foreman
7.6	Tracking Report - Update on Progress	Nicola Foreman
8.	**Items for Approval/Ratification**	
8.1	Annual Internal Audit Plan and Charter	Ian Virgill
9	**Items for Noting and Information**	
9.1	**Internal Audit Reports** **Assignment** — **Assurance Rating** 1. Delayed Transfers of Care — Substantial 2. Ward Nurse Staffing Levels — Substantial 3. Capital Project - Rookwood Relocation — Reasonable 4. PCIC Clinical Board – Interface Incidents — Reasonable 5. Medicines Clinical Board – Sickness Absence Management Report — Reasonable 6. Capital – CRI Safeguarding Works Report — Reasonable 7. Commissioning Report — Reasonable 8. E-IT Learning Report — Reasonable	Ian Virgill

10	**Items to bring to the attention of the Board/Committee**	
11	**Review of the Meeting**	
12	**Date and time of Audit Workshop:** Tuesday, 21 May 2019, at 9.00am – Corporate Meeting Room, Woodlands House Maes y Coed Road, Heath, Cardiff CF14 4TT	

CONFIRMED MINUTES OF THE AUDIT COMMITTEE
HELD ON TUESDAY 26 FEBRUARY, 2019
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

John Union	JU	Chair – Audit
Charles Janczewski	CJ	UHB Vice Chair
Dawn Ward	DW	Independent Member – Trade Union

In attendance:

Anne Beegan	AB	Wales Audit Office
Emily Thompson	ET	Local Counter Fraud Specialist
Ian Virgil	IV	Interim Head of Internal Audit
Mike Usher	MU	Wales Audit Office
Nicola Foreman	NF	Director of Corporate Governance
Nigel Price	NP	Local Counter Fraud Specialist
Robert Chadwick	RC	Director of Finance
Sharon Hopkins	SH	Director of Transformation and Informatics
Simon Cookson	SC	Director of Internal Audit Shared Services
Tom Haslam	TH	Wales Audit Office

Observer:

Mandy Collins	Interim Head of Corporate Governance

Secretariat: Glynis Mulford

Apologies:

Steve Curry	SC	Chief Operating Officer

AC: 19/02/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
AC: 19/02/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
AC: 19/02/003	**DECLARATIONS OF INTEREST** The Chair invited Members to declare any interests in the proceedings. Charles Janczewski stated that he presided over the WHSSC Quality and Patient Safety Committee.	
AC: 19/02/004	**MINUTES OF THE AUDIT COMMITTEE HELD ON 4 DECEMBER 2018** **Resolved that:** Subject to a minor amendment, the Committee received and approved the minutes of the meeting held on 4 December 2018.	

AC: 19/02/005	**ACTION LOG FOLLOWING THE LAST MEETING** **AC 18/079 – Losses and Special Payments**: This item would come forward to the April meeting. It was asked for job titles to be added to the appendices of future reports. **AC 18/072 - Primary Care Planning Update:** This would be addressed in the tracking report and in future would have one allocated lead. **18/071 – Medical equipment:** Wales Audit Office was asked in the last meeting to review how other Health Boards dealt with inventories of up to £5k. The Committee informed no comparisons could be made as this was not done in all Health Board in Wales. The Chair stated he attended a meeting with the Director of Therapies and Health Sciences who undertook actions around this issue and would liaise with her on this matter. **18/070 - Consultant Job Planning:** John Union and John Antoniazzi, the former chair, had met with the Medical Director and this item would be taken forward to the May meeting. **Resolved that:** The Committee received the Action Log from the December meeting.	JU
AC: 19/02/006	**CHAIRS ACTION TAKEN SINCE LAST MEETING** No actions have been taken.	
AC: 19/02/007	**INTERNAL AUDIT PROGRESS REPORT** Mr Ian Virgil, Acting Head of Internal Audit presented an overview of the progress report. The following comments were made: • Regarding PCIC Interface Incidents – Since submitting papers to Audit Committee a meeting had taken place with the Director of Operations and a way forward had been agreed. This report had now received a rating of reasonable assurance. • Concerns were raised about delays in management responses. It was explained that some complications had derived and there were personal circumstances with valid reasons but recognised that it had taken time to engage with management. It was suggested if there were issues in the future for the Committee to be made aware in order to take it forward. • Concern was raised around the number of reports delayed and what support could be given. The delays with other reports was explained but confirmed those internal audits would be completed by the next meeting. • Wider discussion ensued on the audit plan and timetable. It was explained there was a safety margin and contingency within the plan and the Committee was assured the reports in the plan	

would be delivered, assuring a more positive review was envisaged for this year.

- It was raised that as a Committee there needed to be an understanding of how to deal with limited assurance reports in terms of a reasonable turnaround. It was stated that there would be a tracking system put in place of both internal and external reports which would be taken in the first instance through Management Executives and then to the Committee. These would be more robust in the future.
- The Committee was informed that 10 reports had been finalised two with substantial assurance, four reasonable and four limited.
- A total of six limited reports had been presented to date but from the point of view of an opinion forecast it was rated as reasonable assurance for the organisation across the year.
- The Committee had previously agreed to three audits being deferred to next year's plan which can be found in appendix 1 with a description of the reasons why they had been rescheduled.
- The Committee agreed to defer a further five reports and an explanation was presented to the meeting, taking the total deferred to eight.
- A further 46 would be completed for 2018/19. The reports were spread across each domain and thought sufficient to present a balanced review for the year. A draft plan for 2019/20 was underway and would be presented to Management Executives (ME).

Limited Assurance Reports:

1. **Legislative / Regulatory Compliance Report –** This was the second limited assurance report for the Corporate Governance Department. An interim Head of Governance had made progress with this piece of work and the tracker would be presented later on in the meeting. The timescales were tight but considered these achievable. The trackers would need to go through ME. This was a step forward in tracking and ensuring the process was more robust.

   In response to there being any consequences of not having adequate processes in place, it was stated some of the follow up reviews were lost in the process and a tracking report would highlight areas that need to be focussed. Licences and accreditation visits was a large piece of work but needed to ensure arrangements were in place. Meetings had been set up with leads to gather information. The Committee was informed this would be a live document for Members to review going forward.

   It was stated that it was disappointing to see where the organisation was currently but encouraged to see the work being undertaken around this area.

2. **Information Governance: GDPR Report –** The Director of Transformation gave an overview of where the Health Board was

presently with the new regulation. Concentration had centred on preparation and not on compliance but she was now confident the staff were in place to take defined actions forward and to ensure these would be within the timescales. The Committee was assured that actions for end of February would be completed. In regard to the recommendation to set up a formal group on GDPR, this would be put in for a year. A decision was taken not to set up another group but this work would be undertaken at operational level, stating this had not acquired the traction envisaged. It was acknowledged this needed to be embedded in Clinical Boards and other departments and the action plan supported delivery of this. The work to be undertaken on the website was in progress. Other projects had been identified with the communications team.

It was recognised there was insufficient understanding and awareness of GDPR although the Director of Transformation and Informatics was confident this could be achieved. The model would be pushed down through the Clinical Boards. It was explained that PCIC understood the issues with information flowing into contractor services and had developed a much greater understanding. It was acknowledged there was work to be done around cultural and patient issues within the organisation. Managers were working with PCIC to understand how they had achieved implementing GDPR.

With regards to resources, this was about people needing to organise their thinking and work differently. The ICO expected to see a process and progress that was working towards compliance. The Committee was assured they would be able to deliver on what was being asked for in the recommendations.

3. **Surgery Clinical Board – Medical Finance Governance Report –** The recommendations had been reviewed and considered management responses and timescales were reasonable. The Chief Operating Officer would provide an update at next meeting. It was noted that actions would be completed by end of March. It was recognised that the report also related to consultant job planning and some of the issues interlink between two reports. **SC**

4. **Medicine Clinical Board – Internal Medicine Follow-up –** It was considered that the decision for follow-up happened too quickly and emphasised the importance for lead executives to liaise with internal audit for timely reports. The Committee was informed of a number of changes within the Clinical Board and through this there had been a loss of knowledge and tracking of initial agreed actions. A new general manager had been put in place and had provided more realistic timescales and actions. This was a big piece of work undertaken and meeting with COO mid-March before meeting at end of April. Although assurance was given that senior nurses were robustly actioning recommendations, it was suggested that the responses should

show a more compassionate element.

It was asked for Peter Durning, Assistant Medical Director to present an update on Job Planning in April. **PD**

Resolved that:

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

AC: 19/02/008 **WALES AUDIT OFFICE – AUDIT PLAN 2019**

Mike Usher, Wales Audit Office gave an overview of the Audit Plan and went through several key points of the final draft document which would be formalised after the meeting.

Regarding the fee it was stated that any savings would be passed on and this would materialise throughout the year.

Resolved that:

The Committee noted the Wales Audit Plan 2019

AC: 19/02/009 **GOVERNANCE IMPROVEMENT PROGRAMME**

The Director of Corporate Governance gave a comprehensive presentation on the Governance Improvement Programme. The following comments were made:

- It was stated Corporate Governance did not reflect too well in the Wales Audit Office Structured Assessment and were starting from a low base but work was happening to ensure Corporate Governance was at the heart of the Health Board.
- It was explained that doing things right and safely as an organisation and being compliant led to good quality. Work was being undertaken on putting good foundations in place and as a team to be more engaging and listening.
- It was explained and outlined what the department had achieved to date, what would was currently being undertaken and what would be achieved with future projects. Timeframes would be put against actions and be measured through the Committee to ensure it was delivering against key priorities.

Resolved that:

(a) The Committee noted the presentation

AC: 19/02/010 **ANNUAL REPORT TIMETABLE 2018/2019**

This item had been reviewed by Management Executives and the

Director of Corporate Governance had reviewed the manual of accounts.

Resolved that:

(a) The Committee reviewed the proposed timetable and approach for the Annual Report 2018-19

AC: 19/02/011 **WALES AUDIT OFFICE STRUCTURED ASSESSMENT 2018**

Tom Haslam, Wales Audit Office (WAO) presented the report and thanked The Director of Corporate Governance and team for their engagement in its production. The following comments were made:

- Some governance arrangements had improved but had concerns around risk management. Improvements on performance monitoring was needed and acknowledged day to day activities and use of resources encountered a wide range of challenges.
- The Committee thanked the WAO for report which was deemed a fairly balanced and accurate report. It was well considered and reflected where we were as a Health Board with improvements that needed to be undertaken. Members were confident that the Director of Corporate Governance would be able to achieve this in undertaking the role. There was a strong desire within the Committee to put things right and ensure recommendations were being addressed.
- Recommendations on exhibit 7 and had been covered in the governance presentation and the report was considered a helpful document.

Resolved that:

(a) The Committee noted the Wales Audit Office Structured Assessment 2018

AC: 19/02/012 **AUDITOR GENERAL ANNUAL REPORT**

Mike Usher Wales Audit Office, presented the report, which pulled together the financial and performance audit. The following was highlighted:

- There was insufficient use of the National Fraud Initiative around data matching which may be indicative of fraud. A previous exercise provided 850 activities and only 53% had been reviewed. It was considered there was more that could be done through follow-up.
- In response it was stated that this would be covered by Counter Fraud who were under Shared Services which was out of the Health Board's control. It was highlighted that resource had been placed into tracking high risk matches.

Resolved that:

(a) The Committee noted the report and
(b) Recommended the Auditor General Annual Report to the Board

AC: 19/02/013 **CLOSURE REPORT: AUDIT OF CARDIFF AND VALE CONTRACTUAL RELATIONSHIPS WITH RKC ASSOCIATES AND ITS OWNER**

The Committee was informed that all actions had been completed. It was suggested that this be reviewed by the Committee annually to ensure we stayed compliant. This had been built into the plan.

Resolved that:

a) Reviewed the attached action plan in relation to UHB's Contractual Relationships with RKC Associates Ltd and its Owner
b) Recommended closure of the action plan to the Board on 31st March 2019
c) Received an assurance report from the Director of Corporate Governance on an annual basis to ensure ongoing compliance and sustainability of actions in the future.

AC: 19/02/014 **AUDIT COMMITTEE ANNUAL REPORT 2018/2019**

Resolved that:

a) The Committee reviewed the draft Annual Report 2018/19 of the Audit Committee.
b) Recommended the Annual Report to the Board for approval.

AC: 19/02/015 **AUDIT COMMITTEE WORKPLAN 2019/2020**

Feedback on the workplan had been received from Wales Audit Office and the Deputy Finance Director. The workplan had been adapted accordingly and would go forward to the Board for sign off.

Resolved that:

a) The Committee reviewed the Work Plan 2019/20
b) Approved the Work Plan 2019/20
c) Recommended approval to the Board of Directors

AC: 19/02/016 **AUDIT COMMITTEE TERMS OF REFERENCE 2019/2020**

The Terms of Reference was followed up from the previous meeting. There was a change of name of meeting to incorporate a broader title which may help in understanding the role of committee. A vice chair would be placed in position by the next meeting. The Committee was informed that a review of all IMs and Committees would be undertaken at end of financial year.

Resolved that:

a) Approved the changes to the Terms of Reference for the Audit Committee and
b) Recommended the changes to the Board for approval.

AC: 19/02/017 **COMMITTEE SELF-ASSESSMENT**

Resolved that:

a) The Committee approved the effectiveness review is undertaken and results and action plan reported back to the next meeting of the Committee.

AC: 19/02/018 **AUDIT ENQUIRIES TO THOSE CHARGED WITH GOVERNANCE AND MANAGEMENT**

The Director of Finance stated this was an annual event with Wales Audit Office and gave a brief overview of the report.

Resolved – that:

a) The Audit Committee reviewed the draft response to the Wales Audit Office enquiries and
b) Approved its submission to the Wales Audit office, subject to any agreed changes made by the Audit Committee and any further comments received from the Chief Executive and Chair

AC: 19/02/019 **REVIEW OF STANDING ORDERS**

The Director of Corporate Governance informed the Committee the Standing Orders were based on the Welsh Government model and was required to review the proposed amendments. Members were asked to note inclusion of schedule 3 and 4. There was a need for the Standing Orders to be updated to ensure compliance. Welsh Government would be updating the manual shortly and would incorporate any modifications made.

These would be placed on the governance webpage.

Resolved that:

a) The Committee reviewed the proposed amendments to Standing Orders.
b) Recommended to the Board that it adopts the proposed amendments.
c) Noted that once they have been reviewed and agreed by the relevant Committee or Advisory Group, the Terms of Reference of each of the Board's Committees and Advisory Groups would be included in Schedule 3 and 4 of the

Standing Orders.

d) Noted work on the Scheme of Reservation and Delegation is ongoing. This would be circulate to Committee members for comment prior to submission to the Board.

e) Noted that prior to submission to the Board, the Contents page would be updated and the Standing Orders document fully proof read.

Capital Ordering Authorisation Protocol

The Director of Finance informed the Committee that the report was a refresh of longstanding arrangements around the Capital Programme. If there were any queries, would be happy for these to be discussed outside the meeting.

Resolved that:

- The Committee approved the protocol which would govern how the UHB places capital orders and request that the IHB's scheme of delegation is updated to include the Deputy Chief Executive for IM&T expenditure approvals.

AC: 19/02/020 **ITEMS FOR NOTING AND INFORMATION**

Resolved that:

Items for information were noted

AC: 19/02/021 **ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE**

There were no items to bring to the attention of the Board / Committee.

AC: 19/02/022 **REVIEW OF THE MEETING**

- There was agreement that the meeting had been well conducted in terms of pace and focus covering the agenda and the presentations were succinct.
- Regarding Limited Assurance Reports, for people to be appraised on what to do prior to meeting.
- It would have been beneficial to have executive feedback on internal audit reports.
- Challenge was delivered with good responses in trying to address issues presented.

AC: 19/02/023 **DATE OF THE NEXT MEETING OF THE COMMITTEE**

Tuesday, 23 April 2019, 9.00am – 12.00pm Corporate Meeting Room, Headquarters

ACTION LOG
FOLLOWING AUDIT COMMITTEE MEETING
26 FEBRUARY 2019

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	|STATUS/COMMENTS
Actions Completed					
AC 18/079	Losses and Special Payments	Review of ex-gratia payments made to ensure that no precedents have been set.	C Lewis	26/0219	**COMPLETED.** Verbal Update provided at February meeting
AC 18/077	Tracking Report	The Director of Corporate Governance would bring back a tracking report to the Committee.	N Foreman	26/02/19	**COMPLETED.**
AC 18/072	Primary Care Planning Update	Agreement was made to review the allocated leads for management responsibilities	N Foreman	26/0219	**COMPLETED.** Verbal Update provided at February meeting
AC 18/071	Wales Audit Report on Medical Equipment	Investigate how other Health Boards deal with equipment <£5k inventory	T Haslam	26/02/19	**COMPLETED.** Verbal update provided at February meeting
Actions in Progress					
AC 19/02/19	Limited Assurance Reports: Medical Finance Governance	For the Chief Operating Officer to provide an update at the next meeting.	S Curry	23/04/19	An update to be provided at the April meeting
AC 19/02/19	Limited Assurance Reports: Medicine Clinical Board – Internal Medicine Follow up	For the Assistant Medical Director to provide an update on Job Planning.	P Durning	23/04/19	An update to be provided at the May meeting
AC 18/071	Wales Audit Report on Medical Equipment	To arrange meeting between the Chair and Director of Therapies and Health Sciences to see how the Health Boards deal with equipment under £5k inventory	Secretariat	26/02/19	Liaised with Executive Assistant to arrange discussion.
AC 18/058	Post Payment Verification	In future reports provide more detail, explanation and comparison.	PPV Manager	23/04/19	On agenda for April 2019
AC 18/079	Losses and Special	Job titles to be added to the	C Lewis	23/04/19	Will be actioned when the next losses

	Payments	appendices of future reports.			and special payments report is due to be considered by the Committee.
Actions referred to other Committees/Board					

REPORT TITLE:	**Internal Audit Progress Report**								
MEETING:	**Audit Committee**							**MEETING DATE:**	**23rd April 2019**
STATUS:	**For Discussion**		**For Assurance**	**X**	**For Approval**	**x**	**For Information**		
LEAD EXECUTIVE:	**Director of Governance**								
REPORT AUTHOR (TITLE):	**Acting Head of Internal Audit**								

PURPOSE OF REPORT:

SITUATION:

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

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

REPORT:

BACKGROUND:

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

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

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

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

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

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

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

RECOMMENDATION:

The Audit Committee is asked to:

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

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

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

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

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

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

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee April 2019

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

1. INTRODUCTION

1.1. This progress report provides the Audit Committee with the current position regarding the work being undertaken by the Audit & Assurance Service as part of the delivery of the approved 2018/19 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 April Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Estates Statutory Compliance - Water	Draft	Limited	On-going discussions with Management to agree the report and provide management responses.
Strategic Planning / IMTP	Draft	Reasonable	Completion of fieldwork took longer than planned.
Core Financial Systems	Work in Progress		Commencement of audit delayed to Q4 at request of management.
Cyber Security	Work in Progress		Commencement of audit delayed at request of management.
e-advice	Work in Progress		Completion of fieldwork taking longer than planned
Specialist Clinical Board	Work in Progress		Delay in agreeing brief & commencing fieldwork
MHRA Compliance	Work in Progress		Delay in commencing fieldwork

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	
Delayed Transfers of Care Reporting	Substantial	
Ward Nurse Staffing Levels		
Capital Project – Rookwood Relocation	Reasonable	
PCIC CB - PCIC Interface Incidents		
Medicine CB – Sickness Absence Management		
Capital – CRI Safeguarding Works		
Commissioning		
E IT Learning		

4. DELIVERY OF INTERNAL AUDIT PLAN

4.1. From the table in section three above it can be seen that eight audits have been finalised since the Committee met last. In addition to that, there is one further audit that have reached draft report stage.

To date six reports have been given Limited assurance as well a further audit that is at draft report stage. Whilst the current forecast year-end opinion is still reasonable assurance, any further Limited assurance reports from the remaining audits could have an impact on this.

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

4.2. <u>Delivery of the 18/19 plan.</u>

The Audit Committee has previously agreed the deferral of 8 audits from the current Internal Audit plan into the 2019/20 plan. The detail

of these, along with the reasons for their requested deferral, are recorded within Appendix A.

The number of audits remaining within the current plan, and their spread across the assurance domains, is still sufficient to allow for the provision of the overall year-end assurance opinion for the Health Board.

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

4.3. Development of the 19/20 plan.

A draft Internal Audit plan for 2019/20 has been developed following Meetings and correspondence with the Health Board's Executive Directors and also with the Clinical Board Directors of Operations.

The draft plan was submitted to the Management Executive Team meeting on 8th April 2019 and has been updated following comments received.

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

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

5. FINAL REPORT SUMMARIES

5.1 Delayed Transfers of Care Reporting

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 a rigorous, detailed process for identifying DToC activity, which is monitored closely on a weekly basis. This process is in line with the Health Boards policy and procedures regarding discharge.

There is active engagement throughout the Health Board in order to validate the DToC data on a monthly basis. The activity data is shared internally with the Clinical Boards, Strategic Leadership Group and Regional Partnership Board; and further to this the Health Board are in compliance with their submissions to Welsh Government.

5.2 Ward Nurse Staffing Levels

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 findings from the review have identified that Ward Nurse Staffing Levels are being well managed within the Health Board, in accordance with the requirements of the Nursing Staffing Levels (Wales) Act 2016. The Substantial assurance rating reflects the fact that only a small number of issues have been identified.

Information and guidance relating to the Act is readily available via the Health Board's intranet and a local Operating Framework has also been developed.

Robust processes are in place for effectively calculating the ward nurse staffing levels on a 6 monthly basis. The resulting levels are formally

reported to the Board by the Executive Director of Nursing, who is the Designated Person for the Health Board.

An adequate process is currently in place for reviewing the actual daily nurse staffing levels against the calculated levels. A monitoring spreadsheet has also been introduced recently to improve the recording and reporting of the review process.

Further work is however required to ensure that each ward's calculated nurse staffing levels are formally approved by all required managers and Executives and the correct levels are then displayed outside all wards.

5.3 Capital Project – Rookwood Relocation

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.

General compliance was noted with the establishment control frameworks in each of the objective areas sampled, particularly in relation to project governance.

The overall assurance determined is cognisant of the recommendations made to enhance the control environment and the current stage of the project (i.e. early in the construction programme).

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

5.4 PCIC CB – PCIC Interface Incidents

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

The audit notes that the management of the interface incidents reporting process prior to the time of our review, had been adversely effected by the loss of the dedicated Admin support for over a year. However, the filling of the PCIC Quality and Safety Officer role, in conjunction with support from the Patient Safety team, means that the backlogs of logging incidents in Datix have been cleared.

Despite this improvement, there is recognition that there remains little engagement and communication with General Practitioners and this can be seen as a recurring theme throughout the findings in Appendix A.

It is acknowledged that the interface incident reporting system was put in place as an additional, voluntary process introduced to monitor incident trends and highlight potential improvements. GP practices are required to manage their own incidents through the GMS contract and report any significant events through the Health Board's Assistant Medial Director (AMD). However, interface incidents are currently only being regularly reported by a minority of GP practices which creates the risk that the Health Board is not aware of all interface incidents occurring. Whilst the level of reporting needs to increase, achievement of this would have a significant impact given the current resource available to manage the process.

The current interface incident reporting process was introduced as a temporary system and there was an intention to commence scoping the roll out of Datix to GPs in the autumn of 2018, in order to make the reporting and management of incidents within Primary Care more efficient. Whilst preliminary scoping has been undertaken, the Health Board is still utilising the current system for managing interface incidents.

Whilst the audit has highlighted a number of weaknesses in the current interface incidents process, the overall assurance rating of reasonable assurance reflects the lower level of risk associated with the stated purpose of the system.

5.5 Medicine CB – Sickness Absence Management

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

The audit has identified that the sampled wards had a good level of awareness of the All Wales Sickness policy and appropriate processes are in place to enable effective control and management. However, there is variation in the consistency with which those controls are being applied in practice. There is also a need to ensure all managers are fully aware of the new All Wales Managing Attendance at Work Policy.

It was identified that the required documentation is not always being completed for all episodes of sickness absence. Also, episodes of frequent, short term sickness absence are not always being effectively monitored to ensure that the required sickness interviews are identified and undertaken.

A number of the sampled wards have sickness absence levels above the current target levels. This is mainly due to the numbers of staff on long term sickness absence. However our review identified that the appropriate meetings, support and other interventions are being undertaken to manage instances of long term sickness.

Sickness absence management training is provided to key managers and the Workforce department provide additional training and support to identified hot spot areas. The findings of the audit have however highlighted the need to ensure that additional training is provided when there are changes in ward management and further interventions are targeted at those wards where a lack of compliance has been identified.

5.6 Capital – CRI Safeguarding Works

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 following positive aspects were noted at the project:

- The project was delivered within budget and to the agreed revised programme;
- Appropriate business case and funding approvals were in place; and
- The final account was reviewed and confirmed to be appropriately calculated and supported.

However, it was noted that works were instructed on a letter of intent, the value of which was exceeded by March 2018. The project continued without corresponding contractual documentation. This was addressed two months after completion in December 2018.

Further enhancements have been recommended in respect of:

- The risk assessment of progressing work prior to full Listed Building Consent being received;
- The absence of a Project Execution Plan; and
- The approach to post project evaluation and benefits realisation assessment.

However, noting the largely positive delivery arrangements at the project, the effectiveness of the system of internal control in place to manage the risks associated with the delivery of the CRI Safeguarding project has been assessed as providing **Reasonable Assurance**.

5.7 Commissioning

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

The UHB has a Commissioning Framework in place that reflects Welsh Government requirements and best practice, although the iteration provided at the time of the review was not dated and did not state its duration of applicability. The Framework was compiled as a wholly collaborative exercise involving internal and external stakeholders and is published on the Commissioning pages of the UHB intranet site. There has however been no publicity undertaken to promote its existence nor are there any public facing commissioning pages via the UHB internet site.

The UHB Commissioning Intentions document is current and its content aligns with that of the Commissioning Framework and the UHB IMTP. There is a formal UHB Strategic Commissioning Group that meets regularly, is well attended and reports to Executive Board. These meetings are also supported by informal monthly commissioning meetings that review and provide progress updates. However, the Group's Terms of Reference document is not dated, does not state quoracy attendance levels and its listed membership was out of date and does not include any Clinical Board representation.

Sample testing undertaken to establish the level of compliance with the policies and procedures in place relating to the management of Individual Patient Funding Requests (IPFR) and European Economic Area (EEA) funding requests established that all the required checks, documentation, evaluation and approval processes were effectively undertaken and outcomes were provided to clinicians and patients accordingly.

Furthermore, the three sampled Clinical Boards (Mental Health, PCIC and Children & Women's) have a good awareness of the Commissioning Framework and Commissioning Intentions documents and are effectively utilising to identify and support their own commissioning requirements and arrangements in line with the content of their respective IMTPs.

5.8 e IT Learning

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

Overall the UHB has a good system in place for developing and delivering training on the key IT systems used. Learning packages are appropriately developed in consultation with managers and are available for online and classroom learning. Feedback is sought after training provision, and the results of this are positive. Post learning support in the form of handouts and guides are available and there are service leads in place for assistance.

The audit identified a small number of areas for improvement specifically relating to reduced service delivery due to lack of staff availability and the use of a training system that had not been updated to match the live version.

CARDIFF AND VALE UHB INTERNAL AUDIT ASSIGNMENT STATUS SCHEDULE

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Annual Quality Statement	18	5.1	Nursing	Q1	Final – Issued July 18	Substantial	Sept
Ombudsman Reports	20	5.6	Nursing	Q1/2	Final – Issued August 18	Substantial	Sept
Dental CB – Theatre Cancellations	38		COO/Clinical Board	Q1/2	Final – Issued August 18	Reasonable	Sept
Dental CB – Dental Nurse Provision	39		COO/Clinical Board	Q1/2	Final – Issued August 18	Reasonable	Sept
Sustainability Reporting	43	6.4	Planning	Q1	Final – Issued August 18	Reasonable	Sept
Electronic Staff Record	42		Workforce	Q1	Final – Issued September 18	Reasonable	Sept
Management of the Disciplinary process.	41		Workforce	Q1	Final – Issued September 18	Reasonable	Sept
Charitable Funds	15		Finance	Q1/2	Final – Issued September 18	Substantial	Sept
Carbon Reduction Commitment	4		Planning	Q1/2	Final – Issued October 18	Reasonable	Dec
IT system follow up – Neuroscience It System	23	6.8	COO	Q1/2	Final – Issued October 18	Substantial	Dec
MH CB – Sickness Management	35	6.2.1	COO/Clinical Board	Q1/2	Final – Issued October 18	Limited	Dec

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Shaping Our Future Wellbeing – Capital Projects	**3**		**Planning**	**Q1/2**	**Final – Issued October 18**	**Reasonable**	**Dec**
Standards of Behaviour (DoI & G&H)	**5**	**8.2**	**Corporate Governance**	**Q3**	**Final – Issued November 18**	**Limited**	**Dec**
Cost Improvement Programme	**16**	**6.7**	**Finance**	**Q2**	**Final – Issued November 18**	**Substantial**	**Dec**
PCIC CB – District Nursing Rotas	**30**		**COO/Clinical Board**	**Q1/2**	**Final – Issued November 18**	**Reasonable**	**Dec**
MH CB – Section 17 Leave	**34**	**6.2.1**	**COO/Clinical Board**	**Q1/2**	**Final – Issued November 18**	**Reasonable**	**Dec**
Cleaning Standards – Follow up	**44**	**6.4.8**	**Planning**	**Q1/2**	**Final – Issued November 18**	**Reasonable**	**Dec**
Renal It System	**24**	**6.8**	**COO**	**Q1/2**	**Final – Issued December 18**	**Reasonable**	**Feb**
Claims Reimbursement	**2**		**Nursing**	**Q3**	**Final – Issued January 19**	**Substantial**	**Feb**
Legislative / Regulatory Compliance	**4**	**8**	**Corporate Governance**	**Q2/3**	**Final – Issued January 19**	**Limited**	**Feb**
Performance Reporting data quality - Non RTT	**10**	**5.3**	**Public Health**	**Q2**	**Final – Issued February 19**	**Substantial**	**Feb**
Information Governance - GDPR	**25**	**8.1.5**	**Public Health**	**Q3**	**Final – Issued February 19**	**Limited**	**Feb**
Surgery CB – Medical Finance Governance	**31**		**COO/Clinical Board**	**Q1/2**	**Final – Issued February 19**	**Limited**	**Feb**
Contract Compliance (added in to plan)	**48**		**Finance**	**Q2**	**Final – Issued February 19**	**Reasonable**	**Feb**

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Medicine CB – Internal Medicine Follow up	**49**		**COO/Clinical Board**	**Q3**	**Final – Issued February 19**	**Limited**	**Feb**
CD&T CB – Bank, Agency & Overtime Spend	**36**		**COO/Clinical Board**	**Q1/2**	**Final – Issued February 19**	**Reasonable**	**Feb**
Estates Time recording / KRONOS system	**46**	**6.4**	**Planning**	**Q1**	**Final – Issued February 19**	**Reasonable**	**Feb**
Delayed Transfers of Care	13		COO	Q3	Final – Issued April 19	Substantial	April
Capital project – Rookwood Relocation		6.4	Planning	Q2/3	Final – Issued April 19	Reasonable	April
PCIC CB – PCIC Interface Incidents	29		COO/Clinical Board	Q1/2	Final – Issued April 19	Reasonable	April
Medicine CB – Sickness Absence Management	32		COO/Clinical Board	Q1/2	Final – Issued April 19	Reasonable	April
Capital– CRI Safeguarding works		6.4	Planning	Q2/3	Final – Issued April 19	Reasonable	April
Ward Nurse Staffing Levels	21	6.2	Nursing	Q3/4	Final – Issued April 19	Substantial	April
Commissioning	11	2.1	Public Health	Q2/3	Final – Issued April 19	Reasonable	April
e IT learning	28	6.8	Therapies	Q3	Final – Issued April 19	Reasonable	April
Risk Management / CRAF development /Risk registers	3	8.2	Corporate Governance	Q3/4	Work in Progress (The outcome of this review will feed into the Annual Opinion and no separate report will be issued)	N/A - feeds into Annual Opinion	May
Estates statutory compliance - Water		6.4.1	Planning	Q2	Draft – Issued February 2019	Limited	Sept

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Strategic Planning/IMTP	7	5	Planning	Q3/4	Pre-draft report	Reasonable	Sept
UHB Core Financial Systems	14	6.7	Finance	Q3/4	Pre-draft report	Reasonable	Sept
Cyber Security	27	6.8	Therapies	Q3/4	Work in progress		Sept
e-advice	26	6.8	Therapies	Q2/3	Work in progress		Sept
Specialist Clinical Board	37		COO/Clinical Board	Q4	Work in Progress		Sept
MHRA Compliance	22	8	COO	Q3/4	Work in Progress		Sept
UHB Transformation Process	12	10	Public Health	Q3/4	Work in progress		Sept
Health & Care Standards	1		Corporate Governance	Q4	Scheduled to start April 19		Sept
Performance Reporting Data Quality RTT	9	5.3	Public Health	Q3	Scheduled to start May 19		Sept
Deferred reviews							
Continuing Healthcare Follow up	*6*	*5.1.13*	*COO*	*Q3/4*	*Deferred to 19/20 at request of Clinical Boards. – Agreed at Dec AC*		
Public Health Targets	*8*	*1.2*	*Public Health*	*Q1*	*Deferred to 19/20 At request of Director of Public Health. – Agreed at Dec AC*		
Consultant Job Planning Follow-up	*40*	*6.2*	*Medical*	*Q3*	*Deferred to 19/20 At request of Medical Director. – Agreed at Dec AC*		

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
DOLS Follow-up	*19*	*8.1.3*	*Medical*	*Q4*	*Deferral to 19/20 requested by Medical Director due to implementation of new process for standard authorisations in Feb / March 19. – Agreed at Feb AC*		
Private and Overseas patients	*17*		*Medical*	*Q2/3*	*Deferral to 19/20 requested by Medical Director due to potential effect of Brexit outcome. – Agreed at Feb AC*		
C&W CB – Paeds & Adults Transition Plans	*33*		*COO/Clinical Board*	*Q1*	*Work to be deferred. Despite many requests to management, scope not signed off. – Agreed at Feb AC*		
Commercial Outlets (Deferred1718)	*45*	*6.4*	*Director Planning*	*Q3*	*Dir of Planning proposed deferral to 19/20 due to work being undertaken by Finance staff – Agreed at Feb AC*		
Estates Service Improvement Team	*47*	*6.4*	*Director Planning*	*Q1 - Q4*	*Dir of Planning proposed deferral to 19/20 due to changes in Estates structure – Agreed at Feb AC*		

C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2018/19 (Draft reports highlighted in red italics)									
Assurance domain	**Audits**		**Final & Draft Audit Assurance Rating**					**Audits to be completed**	**Deferred Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**		
Corporate Governance, Risk and Regulatory Compliance	6				● Standards of Behaviour ● Legislative / regulatory Compliance	● Contract Compliance	● Claims Re-imbursement	● H&CS ● Risk Management	
Financial Governance and Management	4						● Charitable Funds ● CIPs	● Core Financials	● Private & Overseas patients
Clinical Governance, Quality and Safety	5						● Annual Quality Statement ● Ombudsman Reports ● Ward Nurse Staffing Levels	● MHRA Compliance	● DoLS Follow-up
Strategic Planning, Performance Management and Reporting	8					● Commissioning	● Performance Reporting Non RTT ● DToC Reporting	● Strat Plan IMTP ● Performance Reporting RTT ● UHB Transformation	● CHC Follow-up ● Public Health Targets
Information Governance and Security	6				● Information Governance - GDPR	● Neuroscience It System follow up ● Renal It system ● e IT Learning		● e-advice ● Cyber Security	

C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2018/19 (Draft reports highlighted in red italics)									
Assurance domain	**Audits**		**Final & Draft Audit Assurance Rating**					**Audits to be completed**	**Deferred Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**		
Operational Service and Functional Management	12				● Mental Health CB - Sickness Mgt. ● Surgery CB - Medical Staff Governance ● Medicine CB – Internal Medicine Follow-up	● Dental – Nurse Provision ● Dental – Theatre Sessions ● Mental Health CB – Section 17 ●PCIC District Nursing rotas ● CD&T CB – Bank, Agency & OT Spend ● Medicine CB – Absence Management ● PCIC Interface Incidents		● Specialist CB - Medical Staff Governance	● C&W CB – Transition Plans
Workforce Management	3					●Electronic Staff Record ●Management of the Disciplinary Process			● Consultant Job Planning Follow-up
Capital and Estates Management	10					● Capital Schemes – Future Wellbeing *(17/18)* (SSU) ● Environmental Sustainability Reporting ● Cleanliness Standards Follow up ● Carbon Reduction Commitment (SSU) ● Estates Time Recording System – Kronos ● Capital Project – Rookwood ● Capital – Safeguarding Work CRI	● *Estates Statutory Compliance – Water (Draft)*		● Commercial Outlets ● Service Improvement Team

INTERNAL AUDIT REPORT RESPONSE TIMES								
Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G	
Annual Quality Statement	Substantial	Final	13/6/18	04/07/18	02/07/18	02/07/18	G	
Ombudsman Reports	Substantial	Final	23/8/18	13/09/18	23/08/18	24/08/18	G	
Dental CB – Theatre Cancellations	Reasonable	Final	07/08/18	28/08/18	22/08/18	30/08/18	G	
Dental CB – Dental Nurse Provision	Reasonable	Final	26/07/18	16/08/18	22/08/18	30/08/18	A	
Sustainability Reporting	Reasonable	Final	18/07/18	08/08/18	22/08/18	23/08/18	A	
Electronic Staff Record	Reasonable	Final	13/07/18	03/08/18	04/09/18	10/09/18	A	
Management of the Disciplinary Process	Reasonable	Final	13/07/18	03/08/18	04/09/18	10/09/18	A	
Charitable Funds	Substantial	Final	31/08/18	21/09/18	10/09/18	10/09/18	G	
Carbon Reduction Commitment	Reasonable	Final	29/08/19	19/09/18	24/10/18	25/10/18	R	
Neuro IT System Follow-up	Substantial	Final	21/10/18	03/10/18	04/10/18	04/10/18	G	
Mental Health Sickness Absence	Limited	Final	26/09/18	25/10/18	25/10/18	30/10/18	G	
Shaping our Future Wellbeing - Capital	Reasonable	Final	23/07/18	13/08/18	01/10/18	01/10/18	R	
Standards of behaviour	Limited	Final	06/11/18	21/11/18	13/11/18	15/11/18	G	
Cost Improvement Programmes	Substantial	Final	16/11/18	07/12/18	20/11/18	21/11/18	G	
PCIC district nursing rotas	Reasonable	Final	18/10/18	10/11/18	16/11/18	19/11/18	A	
Mental Health CB - S17 Leave	Reasonable	Final	26/10/18	16/11/18	12/11/18	16/11/18	G	
Cleaning Standards Follow-up	Reasonable	Final	24/8/18	14/9/18	21/11/18	21/11/18	R	
Renal IT System	Reasonable	Final	07/11/18	28/11/18	02/01/18	10/01/19	R	
Claims Re-imbursement	Substantial	Final	06/12/19	31/12/18	09/01/19	11/01/19	A	
Legislative / Regulatory Compliance	Limited	Final	18/12/19	11/01/19	18/01/19	18/01/19	A	
Performance Reporting – Non RTT	Substantial	Final	01/02/19	21/02/19	08/02/19	12/02/19	G	
Information Governance - GDPR	Limited	Final	07/12/18	01/01/19	12/02/19	12/02/19	R	
Surgery CB – Medical Finance Gov	Limited	Final	12/11/18	03/12/18	09/02/19	12/02/19	R	
Contract Compliance	Reasonable	Final	04/02/19	26/02/19	13/02/19	14/02/19	G	

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G	
Medicine CB – Internal Med Follow-up	Limited	Final	03/01/19	24/01/19	12/02/19	14/02/19	A	
CD&T CB – Bank Agency & OT Spend	Reasonable	Final	31/01/19	21/02/19	15/02/19	15/02/19	G	
Estates Time Recording / KRONOS	Limited	Final	15/08/18	05/09/18	15/02/19	15/02/19	R	
Delayed Transfers of Care	Substantial	Final	26/03/19	16/04/19	02/04/19	04/04/19	G	
Capital Project - Rookwood Relocation	Reasonable	Final	08/03/19	01/04/19	27/03/19	04/04/19	G	
PCIC CB - PCIC Interfaces Incidents	Reasonable	Final	26/09/18	25/10/18	04/04/19	09/04/19	R	
Medicine CB – Sickness Absence Man	Reasonable	Final	08/02/19	01/03/19	04/04/19	09/04/19	R	
Capital – CRI Safeguarding Works	Reasonable	Final	20/03/19	10/04/19	09/04/19	09/04/19	G	
Ward Nurse Staffing Levels	Substantial	Final	22/03/19	12/04/19	10/04/19	11/04/19	G	
Commissioning	Reasonable	Final	04/04/19	25/04/19	10/04/19	11/04/19	G	
E IT Learning	Reasonable	Final	28/03/19	18/04/19	11/04/19	12/04/19	G	

AUDIT & ASSURANCEKEY PERFORMANCE INDICATORS						
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**	84% 36 from 43	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	**A**	89% 32 from 36	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	**R**	51% 18 from 35	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	**G**	100% 35 from 35	80%	v>20%	10%<v< 20%	v<10%

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

Cardiff and Vale University Health Board

Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Fieldwork commencement:	11th October 2018
Fieldwork completion:	5th December 2018
Draft report issued:	3rd January 2019
Management response received:	12th February 2019
Final report issued:	14th February 2019
Auditor/s:	Ian Virgill, Kimberley Rowe
Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Geraldine Johnston, Director of Operations David Allison, General 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 follow-up review of Internal Medicine – Mandatory Training and PADRs was completed in line with the Internal Audit Plan.

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

The original Internal Medicine 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 mandatory training and PADRs, 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 all staff members comply with statutory and mandatory requirements and annual PADRs are effectively planned and completed.

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

- The Directorate have developed a Project Outline Document to support ward areas to complete PADR, along with a trajectory of expected completions and mandatory training fields;
- Bi-weekly operational meetings are taking place with a standing agenda item for PADR compliance;
- There is an assigned member of the Directorate team responsible for improving the mandatory training position;
- Key reports from ESR to be circulate and remain on the Performance Review agenda;
- The staff database within the Directorate office is to be regularly maintained and agree with ESR data;
- All staff are appropriately using ESR and hierarchies are correct for their area; and
- PADRs to be uploaded in ESR.

3. Associated Risks

The potential risks considered in this review are as follows:

- Staff members are not appropriately trained;
- Staff performance isn't effectively assessed and addressed; and

- Non-compliance with PADR or training requirements isn't 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.

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 sampled wards tested during the original review and follow-up have shown some improvement in compliance levels for both PADRs and Statutory and Mandatory Training. However, there is a lack of evidence to confirm that the improvements are a result of appropriate implementation of the agreed management actions. This has contributed to the conclusion that no actions are fully complete; with 3 actions being part complete (2 High, 1 Low), 2 actions not complete (1 High, 1 Medium) and the remaining medium priority action no longer applicable. There is therefore a lack of assurance that the controls in place are sufficient to ensure that the improvement in compliance levels will continue and be sustained in the future.

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 Internal Medicine – Mandatory Training and PADRs has remained as **Limited 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.

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

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

- No evidence has been provided of the Project Outline Document – the Directorate Manager (who has changed since the previous audit) is not aware of such a document. There was also no evidence provided to support a trajectory of PADR completions or monitoring at Bi-weekly operational meetings. Despite this, sample testing proved an improvement in the completion of PADRs, although for 40% of the staff sampled there was still no evidence that a PADR had been completed in the last 12 months;
- Sample testing supported an improved position on completion of statutory and mandatory training modules. However it is noted that evidence to confirm 100% compliance with the required training was only available for 41% of the sampled staff;
- The Directorate Performance reviews have not consistently been taking place. The only minutes available for audit were from the meeting on 26 July 18. There is no evidence within the minutes that PADR and training compliances are presented and discussed;
- Copies of previous PADRs continue not to be retained on employee files and are not uploaded to the ESR system; and
- All line managers evidenced that they had access to ESR, however, hierarchies are delayed being updated when staff are moved from different departments or there is a new Senior Nurse in the hierarchy. This was found to be a particular issue on Ward B7.

Finding 1 - Completion of PADRs (Operating effectiveness)	Risk
Audit selected ten staff from each of three sampled Internal Medicine wards (C7 at UHW, East 4 at UHL and B7 at UHW) to establish if a PADR has been carried out within the last twelve months. Audit then checked if the PADRs had been fully and correctly completed with the PADR signed off as approved by both reviewee and reviewer with personal objectives set alongside a personal development plan. The findings for each ward were as follows: **Ward C7 Medical UHW** • 9 of the 10 employees sampled had not had a PADR completed within the last 12 months. • The one PADR completed within twelve months was completed using the old format. • Staff are completing PADRs on a training day, individual objectives and personal development plans were completed in groups and were not specific to each individual. **Ward East 4 UHL** • 1 out of 10 employees sampled had not had a PADR completed within the last 12 months. • 5 of 9 PADRs were completed using the old format. • 4 of 4 PADRs completed using the current format were not completed correctly, only organisational objectives were given no personal objectives or a personal development plan.	Staff performance isn't effectively assessed and addressed.

Ward B7 Respiratory UHW • 5 out of 10 employees sampled had not had a PADR conducted in the last 12 months. • 1 of the 5 PADRs completed was not dated with a review date. • 1 of the 5 PADRs completed did not set any personal objectives or create a personal development plan. • 5 of the 5 PADRs completed within the last 12 months were not signed by the employee. • 3 of the 5 PADRs completed within the last 12 months were not signed by the reviewer/manager.	
Recommendation	**Priority level**
Management should ensure that all staff within Internal Medicine undertake a PADR, which is completed in full with both organisational and personal objectives agreed by the reviewing manager and employee. Management should create a personal development plan for each employee to help achieve each objective set. Management must ensure that when completing the annual review with staff they are completing the latest and most up to date version of the PADR format.	**High**

Management Response	Responsible Officer/ Deadline
The Directorate has developed a Project Outline Document to support ward areas to complete PADR. This POD included timelines.	December 2017 Jane Murphy / Dave Pitchforth
The directorate has provided a trajectory of expected completion of PADRs.	March 2018 Jane Murphy / Dave Pitchforth
The directorate will share best practice to ensure learning.	November 2017 Jane Murphy / Dave Pitchforth
Bi-weekly operational meetings will now include PARD compliance as a standing agenda item.	December 2017
Implementation of Tier 1 target meetings chaired by Lead Nurse, this will include a robust discussion of actions required. Senior Nurses will support this robustly.	December 2017 and ongoing
*__Note –__the Directorate Team feels that the actual current position with regard to PADR compliance, since completion of the audit, is now more positive than the results of the sample testing within the report indicate.	

Current Position
<u>Part Complete</u> No evidence has been provided of the Project Outline Document – the Directorate Manager (who has changed since the previous audit) is not aware of such a document. There was also no evidence provided to support a trajectory of PADR completions or monitoring at Bi-weekly operational meetings. Despite this, sample testing proved an improvement in the completion of PADRs: • 60% of sampled staff had an evidenced PADR in the past 12 months. (C7=3/5, E4 = 5/5, B7 1/5);

• 89% of the available PADRs were fully and correctly carried out (1/9 incorrect). With all PADRs containing a personal development plan; • All PADRs were signed by the reviewer, but only 78% were signed by the reviewee (7/9); • All PADRs evidenced were completed using the relevant form format; and • PADRs were completed individually and not as a group.

Updated Management Response	Updated Responsible Officer / Deadline
All PADRs are signed by the employee prior to them leaving the room at the end of their PADR or employee to sign and return within 7 days of PADR completion.	Ward Sisters/Charge Nurses June 2019

Finding 2 - Mandatory Training Level of Compliance (Operating effectiveness)	Risk
There are currently 13 core training modules expected to be completed by C&V staff members. Audit tested 5 Directorate support staff and 10 staff from each of the three sampled wards to establish their level of compliance with the required mandatory training. The findings for each area were as follows: **Directorate Support** • No member of staff sampled was 100% compliant on their statutory / mandatory training; • Out of a total of 65 core modules that should have been completed, two modules completed had surpassed the expiry date and 23 had not been completed; • Individual Compliance rates ranged from 30.77% to 84.62%; and	Staff members are not appropriately trained.

• Overall compliance for the area based on the employees sampled was 61.54%. **Ward East 4 UHL** • No member of staff sampled was 100% compliant on their Statutory / Mandatory Training; • Out of a total of 130 core modules that should have been completed, ten modules completed had surpassed the expiry date and 60 modules had not been completed; • Individual Compliance rates ranged from 7.69% to 92.31%; and • Overall compliance for the ward based on employees sampled was 46.15%. **Ward B7 Respiratory Unit UHW** • 9 out of 10 members of staff were not 100% compliant on their Statutory/Mandatory Training; • Out of a total of 130 core modules that should have been completed, 11 modules completed had surpassed the expiry date and 43 modules had not been completed; • Individual compliance rates ranged from 15.38% to 100%; and • Overall compliance for the ward based on employees sampled was 66.15%. **C7 Medical UHW** Audit were unable to check the compliance matrix for the staff located in the ward as they were not included in the hierarchy on ESR. Personal files were checked for certificates but only one employee had any certificates to prove completion of training modules.	

The audit notes that LED and Workforce's compliance rates only reflect 10 modules with a plan to report on all 13 from April 2018.	
Recommendation	**Priority level**
Management should ensure that all members of staff within the directorate are fully compliant and up to date with their mandatory training. If staff members believe that ESR is not tracking when a module is completed, staff should print out the certificate available to provide proof and store it within their personal file.	**High**
Management Response	**Responsible Officer/ Deadline**
The Directorate has assigned a member of the team to improve the mandatory training position. All colleagues have been reminded of their requirements. Signposting to where to access the training was provided. If required 'timeout' for colleagues will be provided. POD referenced above includes mandatory training fields – see above	March 2018 (Sarah Edwards Deputy DM, Jane Murphy / Dave Pitchforth) December 2017 (development of POD)
Current Position	
Part Complete As above, no evidence has been provided for the referenced POD. Sample testing supported an improved position on completion of statutory and mandatory training modules:	

- 17/20 sampled employees compliance matrices were available using the line managers ESR. The remaining 3 employees (Ward B7) were not listed within the line manager hierarchy;
- Overall, 41% of staff with an available compliance matrix were 100% compliant – this is an improved position to the prior review; and
- Of the available compliance matrices, a total of 78% modules have been completed (this figure has been adjusted to reflect the unavailability of the Mental Capacity Act training due to ESR issues (6/204 modules had expired and 33/204 had not been completed)

Updated Management Response	Updated Responsible Officer / Deadline
Improved compliance for 85% of staff with completion of 100% mandatory and statutory training modules (44% improvement over 6 months). Staff to be allocated onto study leave planner and compliance monitored monthly via ESR and discussed with ward managers at 121s.	Ward Sisters/Charge nurses September 2019

Finding 3 - Monitoring and Reporting (Operating effectiveness)	Risk
Audit were supplied with the previous three Performance Review meeting minutes for the Internal Medicine Directorate. From review of the minutes it was clear that PADR compliance is not always reported, the minutes also showed that Statutory & Mandatory training compliance rates have not been reported in the previous three meetings. From the Performance Review meeting dated 21/09/2017, it is minuted that PADRs were discussed within the meeting with the current compliance percentage supplied, the minutes show that the percentage figure was obtained	Non-compliance with PADR or training requirements isn't identified or addressed.

from the database held within the directorate office, this database is currently out-dated as outlined in the issue 'Directorate Database' below. Statutory & Mandatory training was not discussed during the meeting due to the directorate 'waiting on data in relation to training'. For the Directorate Performance Review dated 01/05/2017 PADR compliance rate was discussed within the meeting, however there was no reference to Statutory & Mandatory training or the compliance rate at the time. For the Directorate Performance Review dated 29/11/2016 both PADR and Statutory & Mandatory training were not discussed during the review based on the minutes. Based on the latest report from the Directorate Performance review for Internal Medicine the current PADR compliance rate is at 41.47%.	
Recommendation	**Priority level**
Management should ensure that workforce runs monthly reports that highlight the current PADR compliance rate and also separate reports highlighting the current compliance rate for Statutory & Mandatory Training. These reports should be fed back and reported on during the Directorate Performance Review as and when they are held.	**High**
Management Response	**Responsible Officer/ Deadline**
Key links with ESR team will be established and core reports determined, including circulation and frequency, this will ensure that any data discrepancies are highlighted to ensure accurate reporting. Accurate reporting of figures can be provided by Directorate team in due course.	Cari Randall, January 2018

Issues to remain on Performance review agenda Operational meeting and Tier 1 meeting referenced above will review nursing position at ward level readily. Ongoing training by Lead and Senior Nurse to support ward sisters to be able to undertake the process and ensure all reporting hierarchies are correct for reporting.	MCB November 2017 Jane Murphy December 2017 and ongoing Jane Murphy December 2017 and ongoing

Current Position
Not Complete The Directorate Performance reviews have not consistently been taking place. The only minutes available for audit were from the meeting on 26 July 18. There is no evidence within the minutes that PADR and training compliances are presented and discussed.

Updated Management Response	**Updated Responsible Officer / Deadline**
Monthly Performance Meetings with the MCB to be undertaken monthly (avoid cancellation) and PADR compliance reported and discussed, and progress monitored against 6 month improvement trajectory.	General Manager, Integrated Medicine Directorate March 2019

Finding 4 - Retention & review of PADRs (Operating effectiveness)	Risk
The personal files for the sampled staff were reviewed to establish if copies of PADRs from the previous year were retained in order to evidence effective monitoring of progress against previously agreed actions. The findings for each area were as follows: **Ward C7 Medical UHW** • Only two of the ten employees sampled had previous years PADRs stored within their personal files which were both signed and completed. • No individuals sampled have completed a PADR in the current period. • PADR dates are not currently being uploaded onto ESR. **Ward East 4 UHL** • Signed and completed paper copies of previous years PADR forms are stored within the individual's personal files within the ward office and viewed by audit, with the exception of one employee where no PADR completed during the period and another who was new to the organisation. • Audit found that five of the PADRs for the current year did not have personal objectives or personal development plans in place so were unable to determine if any tracking and monitoring had taken place on a year on year basis. • PADR dates are not currently being uploaded onto ESR. **Ward B7 Respiratory UHW** • Four of the ten employees sampled were new to the Health Board and were not expected to have a PADR held in the personal file. Five out of the six	Staff performance isn't effectively assessed and addressed.

remaining employees did not have the previous year's PADR held within the personal file.	
Recommendation	**Priority level**
Management should ensure that any completed PADRs are retained in employees personal files and recorded onto ESR as evidence the PADR has been completed. PADRs should be retained to support the reviewer when establishing progress against agreed objectives during the year and on a year on year basis.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Directorate has developed a POD to support ward areas to complete PADR. See above	December 2017 Jane Murphy / Dave Pitchforth
The directorate has provided a trajectory of expected completion of PADRs.	March 2018 Jane Murphy / Dave Pitchforth
The directorate will share best practice to ensure learning.	November 2017 Jane Murphy / Dave Pitchforth
Current Position	
Not Complete Sample testing showed: • 2/15 staff sampled were not in employment in the previous year so have not been included in this test. • 2/13 employees had copies of their previous years' PADR. However, 1 of these employees had not had a current year appraisal therefore tracking could not be monitored. • 11/13 employees sample did not have previous PADRs stored within their personal files; and	

- Whilst ESR contains a record of PADR completion, evidence of these PADRs is not uploaded.

Updated Management Response	Updated Responsible Officer / Deadline
Copies of all completed PADRs must be placed in personal files. Record of a completed PADR must be recorded on ESR.	Ward Sisters/Charge Nurses April 2019

Finding 5 - Directorate Database (Operating effectiveness)	Risk
The directorate office has an Excel document in place containing all staff within the directorate which records the dates of the most recent PADRs and the dates each statutory training module was completed. Audit found that the database was not kept up to date and did not contain new staff members, with old staff members for the directorate still held on the database. Also dates recorded for the mandatory training and PADRs were not reflecting the most recent completion dates.	Non-compliance with PADR or training requirements isn't identified or addressed.
Recommendation	**Priority level**
Management must ensure that the staff database is regularly maintained, with the deletion of staff that have left the directorate and the inclusion of new employees. Management must look to tie in the mandatory training dates with the ESR matrices to ensure they tie back to LED.	**Medium**

Management Response	Responsible Officer/ Deadline
Role to be included in job description of Directorate Team	Cari Randall March 2018

Current Position
No Longer Applicable No database is maintained by the directorate office. They are now reliant on reports from ESR therefore consistent figures are being used and reported.

Finding 6 - ESR (Operating effectiveness)	Risk
As part of the review the following issues were identified in relation to the use of ESR: • During the review Audit became aware that Internal Medicine were only placed on ESR as of the 1st July 2017. Since the introduction of the directorate onto ESR the ward managers and directorate office staff visited had stated that no training had been supplied by LED or Workforce on how to use ESR. They stated there was a power point training package available but were unsure how to access it; • Audit found that staff were having issues logging onto ESR with unknown user names and passwords. Once on ESR staff were having difficulty navigating the system and were unsure how to access the different functions;	Staff members are not appropriately trained.

• Audit discovered during testing that a ward selected as part of the sample had not been assigned a hierarchy with both ward manager and deputy ward manager not having access to the staff's records. This was also the case for the senior nurse; and • Audit found that no areas within Internal Medicine were utilising the ESR function and were not uploading the PADR review dates.	
Recommendation	**Priority level**
Management should ensure that all staff using ESR attends the training courses provided by LED/Workforce on how to use and utilise the ESR function. All ward managers and the senior nurse should check to see that there is a hierarchy in place within their area and that the hierarchy is correct and includes all members of staff under their management. The directorate should start uploading the review dates for individuals PADRs into ESR once they have been complete. This will assist Workforce when running compliance reports and also aid ward managers as it provides reminders when the next PADR review is approaching.	**Low**
Management Response	**Responsible Officer/ Deadline**
To be included in the reports for ESR to ensure all have access and training.	Cari Randall January 2018
Current Position	
Part Complete	

Whilst all line managers evidenced that they had access to ESR, hierarchies are delayed being updated when staff are moved from different departments or there is a new Senior Nurse in the hierarchy. This was found to be a particular issue on Ward B7, where 3 out of 5 staff sampled were not in the correct structure.

Updated Management Response	Updated Responsible Officer / Deadline
Timely changes made by ESR when staff or hierarchies change.	General Manager/Directorate management team, Integrated Medicine Directorate March 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

Follow up - All recommendations implemented and operating as expected.

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

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

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

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

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

Follow up - No action taken to implement recommendations.

Prioritisation of Recommendations

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

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

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

Cardiff and Vale University Health Board

Surgery Clinical Board – Medical Finance Governance

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Committee:	Audit Committee

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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 Medical Finance Governance within the Surgery Clinical Board was completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board.

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 Surgery Clinical Board for the management of Medical Finance Governance, 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 there are effective governance arrangements in place within the Clinical Board to ensure that Medical staff time and costs are appropriately monitored and controlled.

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

- There are appropriate local procedures and processes in place for the management of medical staff time that are in line with the relevant Health Board policies and procedures and Welsh Government (WG) guidance;
- Consultant staff are appropriately working the required core contracted hours as stated within their current job plans and flexible sessions are appropriately managed;
- The activity undertaken by consultant staff as part of the core hours stated within their job plans is in line with the requirements of the service and needs of the organisation;
- Additional sessions worked by consultants and other medical staff are justified, subject to appropriate authorisation and are worked in addition to their core contracted hours;
- Payments for additional sessions are based on appropriately verified and authorised claims and are made at the correct rate in accordance with Agenda for Change (A4C) and WG guidance; and
- Requests for locum medical staff are made following an effective assessment of need and are appropriately authorised and correctly paid.

The scope of the review did not include the consultant job planning process as this was subject to a recent, separate review by Internal Audit.

Testing for the review was undertaken within the Ophthalmology and General Surgery Directorates.

3. Associated Risks

The potential risks considered in this review were as follows:

- Delays in patient treatment / non-achievement of objectives or targets;
- Inappropriate / ineffective medical staff activity; and
- Unnecessary / inappropriate expenditure.

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 Surgery CB – Medical Finance Governance 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 current review has identified that the processes in place for managing Medical Finance Governance are not being consistently applied across the two sampled Directorates.

The majority of significant issues were identified within the General Surgery Directorate and this is the main reason for the current limited assurance rating. A number of Consultant's job plans were out of date and one consultant had no job plan in place at all. Clinics and theatres had been cancelled for one Consultant without appropriate reasons being recorded. Furthermore, sessions are being cancelled within the colorectal service due to a lack of cover between the colorectal consultants. There

was also a lack of paperwork available within the Directorate to evidence appropriate authorisation when requesting Locum Consultants.

Fewer issues were noted within Ophthalmology where it was identified that consultants are appropriately working their core contracted clinic and theatre sessions. Additional Waiting List Initiative (WLI) sessions are appropriately authorised and paid although displaced SPA sessions are not always being adequately recorded or agreed. Appropriate documentation is completed when requesting Locum Consultants although the extension of one Locum Consultant cover request was completed retrospectively.

It was also noted that neither Directorate has any documented procedure notes in place outlining the processes to be undertaken.

The review did identify that, within both Directorates, core consultant time and additional sessions are being effectively planned around the requirements of the services.

5. Assurance Summary

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

Assurance Summary					
1	Appropriate local procedures and processes			✓	
2	Consultant staff are working required core contracted hours		✓		
3	Activity undertaken by consultant staff is in line with requirements of the service				✓
4	Additional sessions worked by consultants and other medical staff		✓		
5	Payments for additional sessions are based on appropriately verified and authorised claims			✓	
6	Requests for locum medical staff		✓		

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

Design of Systems/Controls

The findings from the review has highlighted one issue that is classified as weakness in the system control/design for Surgery CB – Medical Finance Governance.

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 Surgery CB – Medical Finance Governance.

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 the management of medical staff time that are in line with relevant Health Board policies and procedures and Welsh Government (WG) guidance.

The following areas of good practice were noted:

- It was evident that there are processes in place for the management of medical staff time within both the General Surgery and Ophthalmology Directorates.
- Within the Ophthalmology Directorate there are timetables for each of the Consultants detailing where they are working on each day.

The following significant findings were noted:

- There are no documented procedure notes in place within the General Surgery or Ophthalmology Directorates for the management of medical staff time.

Objective 2: Consultant staff are appropriately working the required core contracted hours as stated within their current job plans and flexible sessions are appropriately managed

The following areas of good practice were noted:

- There are timetables in place for each of the Ophthalmology Consultants that detail the times and days that they are working clinic, theatre and SPA sessions. The Audit review confirmed that Consultants are working their contracted hours and all clinic and theatre sessions are undertaken apart from when the Consultants are on annual leave, study leave, bank holiday or Audit.
- Nine of the 10 General Surgery Directorate consultants reviewed had appropriately completed their required clinic sessions apart

from occasions when they were on annual leave, study leave or on-call; and

- There is a spreadsheet maintained for the Colorectal General Surgery Consultants confirming the sessions that the Consultants are working. There are 8 Colorectal Consultants who undertake lists over the 5 days.

The following significant findings were noted:

- Job plans were not up to date for all the General Surgery Consultants selected and 1 Consultant did not have any job plan in place;
- One General Surgery consultant had not carried out all required clinic and theatre sessions during the period under review; and
- Colorectal Consultants were not always covering the other Colorectal Consultants theatre sessions if they were on annual leave or study leave.

Objective 3: The activity undertaken by consultant staff as part of the core hours stated within their job plans is in line with the requirements of the service and needs of the organisation

The following areas of good practice were noted:

- The requirement for consultant sessions are derived from the Ophthalmology IMTP that details the needs of the services which have been agreed from the plans within the service. Within the IMTP it confirmed that there would be 48 Waiting List additional sessions undertaken for this financial year.
- The requirements of the service are agreed and stated within the General Surgery IMTP. The past years activity is reviewed including the number of referrals, number of people treated and the number of patients left on the list at the end of the year and how much activity would be required. The waiting list initiative is considered as well to assess how many extra WLI sessions will be required.

There were no significant findings noted.

Objective 4: Additional sessions worked by consultants and other medical staff are justified, subject to appropriate authorisation and are worked in addition to their core contracted hours

The following areas of good practice were noted:

- The additional sessions within Ophthalmology and General Surgery have occurred due to the demands of the service. The Directorate IMTPs confirm the number of WLI sessions required and within which specialities. There are weekly RTT meetings held and the performance for the Clinical Board is reported within this forum. An

additional sessions report is sent to Finance confirming the sessions worked, who completed them, how many patients were seen and the reason for the sessions.

Additional areas of note:

- Audit was advised by the Ophthalmology Service Manager that there are also additional sessions undertaken by CESP consultants and the patients are vetted by the lead Consultant for CESP. Audit were advised that the patients reviewed are based on longest waiting times. CESP activity is not recorded through WLI payments as it is a separate company to whom the payments are paid. The CESP Consultants were outside the scope of the current Audit.

The following significant findings were noted:

- Within Ophthalmology a number of waiting list initiative sessions were carried out when the consultants were due to undertake SPA sessions. The claim forms did not detail when the SPAs had been rescheduled.
- Additional sessions were undertaken in May within General Surgery but the claim forms were not annotated to confirm when the displaced sessions that were due to be undertaken were rescheduled.

Objective 5: Payments for additional sessions are based on appropriately verified and authorised claims and are made at the correct rate in accordance with Agenda for Change (A4C) and WG guidance

The following areas of good practice were noted:

- There are specific rates in place for Consultants additional sessions and these are agreed throughout the whole of Wales.
- Audit reviewed Ophthalmology Waiting List Initiative claim forms and they were authorised by the Directorate Manager of Ophthalmology and ENT. All had received the standard payment of £579.
- Audit reviewed the two additional sessions worked during May for General Surgery and both had received the standard payment of £579 and both claims had been authorised by the Director of Operations.

There were no significant findings noted.

Objective 6: Requests for locum medical staff are made following an effective assessment of need and appropriately authorised and correctly paid

The following areas of good practice were noted:

- The timesheets for Locums working within Ophthalmology were available and they had been approved by the Service Manager.
- The rotas are reviewed to identify where there are gaps and junior medical staff will undertake on call sessions where there are gaps within General Surgery. In cases where the junior medical staff are unable to cover the shift, Medacs will be contacted to request Locum Consultants.

The following significant findings were noted:

- The Ad-hoc Locum cover request form for an Ophthalmology Locum Consultant was completed retrospectively.
- General Surgery did not follow the correct process to obtain a Locum Consultant.

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 - General Surgery Consultants working required hours (Operating effectiveness)	Risk

Audit reviewed a sample of 10 General Surgery Consultants to establish if they were working the required Direct Clinical Care Sessions. The following findings were noted from the testing of sessions worked during May 2018:
• One Consultant only undertook 1 of the 4 clinics that he was due to carry out during May, with 2 being cancelled due to meetings. The same Consultant was due to undertake 8 theatre sessions but 4 were cancelled. However, there was no evidence or reason provided for the cancellations. This point was discussed with the Clinical Director for General Surgery and he confirmed that this Consultant is a mentor. Audit were advised that the Consultant was mentoring on these dates and the theatre sessions were undertaken by the mentee. However, it was not recorded on Theatreman that the Consultant was mentoring for those theatre sessions;
• Three of the Consultants reviewed were Colorectal Consultants. There are 8 Colorectal Consultants who undertake theatre lists over the 5 days and therefore if a Consultant is unable to carry out a session they should ensure that there is cover for that session. However the following was noted:
  • It was identified that 1 of the Consultants was on leave for 1 session, study leave for 1 session and on call for 1 session during May and none of the other Colorectal Consultants undertook the theatre lists. In addition, the Consultant was due to do a theatre list on the 23 May 2018 but it was cancelled and there was no reason provided.
  • Another of the Consultants had 2 theatre sessions cancelled due to the Consultant having study leave for 1 session and annual leave for 1 session, again none of the other Colorectal Consultants undertook the
	Inappropriate / ineffective medical staff activity.

theatre lists. • A 3rd Consultant had 2 theatre sessions cancelled due to the Consultant being on military leave and none of the other Colorectal Consultants undertook the theatre list.	
Recommendation	**Priority level**
The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres. Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session.	**High**
Management Response	**Responsible Officer/ Deadline**
• A new system to accurately record consultant activity in theatre is being developed with a clear desktop procedure. • Through job planning each consultants expected activity will be agreed in weeks and monitored accordingly by the Directorate • Expectation around backfill sessions will be agreed and signed by consultants and a system to monitor this will be managed by the Directorate team • Systems will be put in place by end of March 2019	Directorate/Speciality Manager for General Surgery in conjunction with Clinical Director End March 2019

Finding 2 – Additional Sessions (Operating effectiveness)	Risk
The Waiting List Initiative Policy confirms that "WLI work may be accommodated through the temporary displacement of SPA job plan commitments…The nature of the displaced SPA activity and when this will be rescheduled must be agreed and recorded on the WLI claim form." The Waiting List Initiative Forms for Ophthalmology in May were reviewed and all had been authorised by the Directorate Manager. It was however identified that six of the eight Waiting List Initiative additional sessions were undertaken when the Consultant was timetabled to do an SPA session. It was evident from reviewing the WLI claim forms that there was no record confirming if the SPAs had been displaced and rescheduled and therefore no record of agreement. There were only 2 instances of additional sessions worked by General Surgery Consultants in May. The job plan of the Consultant that undertook the extra sessions confirmed that they were planned to do a pre-op ward round and multi-disciplinary team at the time of the additional sessions. There was no recorded detail or agreement to confirm that these sessions were rescheduled.	Unnecessary / inappropriate expenditure.
Recommendation	**Priority level**
The Directorates should ensure that any displaced SPA sessions are appropriately recorded and agreed on the WLI form, in accordance with the policy.	**High**

Management Response	Responsible Officer/ Deadline
• Systems will be put in place to ensure that the governance for displaced SPA will be aligned to health board policy and audited within Directorates. • Job plans will have clear timetables to ensure it is simple to follow WLI against working week • Key responsible officers will be allocated to this task	Directorate/Specialty managers in conjunction with Clinical Directors

Finding 3 – Requests for General Surgery Locum Consultants (Operating effectiveness)	Risk
During the period of review there had only been 2 occasions where Locum Consultants were required within General Surgery. It was identified that the request for the locum cover was made via an Email to Medacs from the Directorate Administrator. Audit was advised that the CV of the Locum would have been reviewed by the Clinical Director and the Professional Clinical Lead. However, there was no paperwork in place within the Directorate to authorise the request for the Locum Consultant or any documentation approving the Locum Consultant provided by Medacs. The Medical Personnel department have confirmed that whilst it is adequate for Locum Consultants to be requested via Email, the actual approval process should have been performed within the Directorate and evidence of the approval should be maintained there.	Unnecessary / inappropriate expenditure.

Recommendation	Priority level
General Surgery should ensure that they follow the correct procedure for recruiting and authorising Locum Consultants.	**High**
Management Response	**Responsible Officer/ Deadline**
• Ensure CD signs off paperwork for locum highlighting rationale for locum • Create SOP/DTP so all staff can follow clear process • Review paperwork to ensure it is up to date These actions will be put in place by end of March 2019	Directorate/Speciality manager in conjunction with CD End March 2019

Finding 4 - Desk top procedures (Control design)	Risk
There are processes in place for managing Consultant medical staff time and costs within both of the Directorates reviewed. However, the processes are not recorded on any local documented procedure notes within either of the Directorates. The lack of documented procedure notes creates the risk that the processes may not be consistently carried out or may not be completed at all during periods of staff absence or turnover.	Delays in patient treatment / non-achievement of objectives or targets.

Recommendation	Priority level
Management should produce desk top procedures to ensure that Consultants medical staff time and costs are being managed appropriately and consistently.	**Medium**
Management Response	**Responsible Officer/ Deadline**
• Standardised procedure notes to be created and shared with key personnel (March 2019)	Directorate/Speciality Manager End March 2019

Finding 5 - Job Plans for General Surgery Consultants (Operating effectiveness)	Risk
Audit tested a sample of 10 General Surgery Consultants to establish if they were appropriately working their contracted sessions in clinics and theatres as recorded on their individual job plans. It was identified that the job plans for five of the Consultants were out of date as their recorded working patterns for theatres were not in line with the actual theatre sessions that they were required to deliver. In addition, there was another of the Consultants who had no job plan in place at all. The issue of out of date and / or missing job plans has been previously raised as part of a specific Internal Audit review of Consultant job planning that was completed in May 2018. Actions to address the findings from the previous review are currently being progressed via the Medical Director's office and	Inappropriate / ineffective medical staff activity.

Clinical Boards. The issue has been raised here due to the impact it had on Audit's ability to test if the sampled consultants were working the correct sessions. The difficulty created by the lack of up to date job plans was partly mitigated by the information on current consultant clinical and theatre sessions held by the Directorate team. This is reflected in the current priority rating for this finding.	
Recommendation	**Priority level**
In conjunction with the actions already being taken following the Consultant Job Planning Audit, the Directorate should ensure that all consultants have an up to date, agreed job plan in place that accurately reflects the current required sessions.	**Medium**
Management Response	**Responsible Officer/ Deadline**
• All job plans will be completed and recorded appropriately (March 2019)	Clinical Director End March 2019

Finding 6 - Ophthalmology Locum cover (Operating effectiveness)	Risk
There were 2 Ophthalmology Locum covers during the period Audit reviewed. An extension of one of the Locum Consultants was required. The extension was for the period 2 April - 13 July 2018, however, the Locum request document was dated the 2 July 2018. The request form should be completed prior to an extension for the locum cover. This point was discussed with the Directorate and Audit were advised that there had been a verbal approval of the extension but there was a delay in the paperwork being processed to Medacs.	Unnecessary / inappropriate expenditure.
Recommendation	**Priority level**
Management should ensure that request for Locum cover documentation is fully completed prior to the cover required.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Clinical Board Response • SOP/DTP will be developed and standardised for all Directorates to record adherence to agree protocols (March 2019)	Directorate Manager/Deputy Director of Operations End March 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.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

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

Date issued: April 2019

Document reference: CVACU2019

Contents

Summary report

About this document

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

Financial audit update

Exhibit 1: Financial audit update

Annual Accounts and other financial-audit work
We are due to receive the Health Board's 2018-19 Financial Statements on 26 April 2019; and its 2018-19 Accountability Report on 3 May 2019. We are scheduled to report to the Audit Committee and Board on 30 May 2019, setting out the key findings of our audit of the two documents and the Auditor General's proposed audit opinion. The Auditor General is scheduled to certify the documents on 11 June 2019. With regard to the above work, we have undertaken our audit planning and interim audit testing in accordance with the key milestones and dates that we agreed with senior officers. To date, we have not identified any significant audit matters that we need to report, formally or informally, to senior officers and the Audit Committee.

Performance audit update

Work completed since the last Audit Committee update

Exhibit 2: Work completed since last Audit Committee update

Topic	Conclusions	Status	Executive lead	Considered by Audit Committee	Management response status
Structured Assessment 2018	The Auditor General has a statutory requirement to satisfy himself that NHS bodies have proper arrangements in place to secure economy, efficiency and effectiveness in the use of their resources as set out in Section 61 of the Public Audit Wales Act 2004. As in previous years, the key focus of our structured assessment work remains on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically.	Final report	Nicola Foreman	February 2019 Noted by Board in March 2019	Complete

Work underway

Exhibit 3: Work currently underway

Topic	Focus of the work	Status	Executive Lead	For Audit Committee
Integrated Care Fund (thematic review)	We are looking at how health boards and local authorities are using the Integrated Care Fund (ICF) to develop integrated services.	Regional findings presented to the Regional Partnership Boards. National report due for publication in June 2019 alongside a short report setting out the local findings.	Abi Harris	September 2019
Clinical coding (thematic review)	In 2014, we carried out work on clinical coding at all relevant health bodies in Wales. We found that not all health bodies understood the importance of clinical coding to their business and they were missing opportunities to use this more extensively. During 2018-19 we will follow up the Health Board's progress against our 2014 recommendations.	Draft report issued in April 2019 for clearance	Sharon Hopkins	September 2019
Examination under the Well-being of Future Generations Act 2015 (thematic review)	This examination is being undertaken to help discharge the Auditor General's statutory functions under section 15 of the Well-being of Future Generations (Wales) Act 2015. The Auditor General for Wales is statutorily required to examine public bodies to assess the extent to which they have acted on accordance with the sustainable development principle when: a. setting their wellbeing objectives; and b. taking steps to meet them.	Set-up	Fiona Kinghorn	September 2019
Follow-up of operating theatres (local)	Between 2011 and 2013, the Wales Audit Office reviewed operating theatres across Wales. In 2015 we carried out work to assess the health board's progress. We concluded that the Health Board had improved theatre utilisation by	Set-up	Steve Curry	September 2019

Topic	Focus of the work	Status	Executive Lead	For Audit Committee
	focussing on processes and performance management. But there wasn't the same focus on improving service quality and addressing problems with staff engagement. At that time, we made some additional recommendations. In 2018-19 we will follow up progress against these recommendations.			
Orthopaedic Services follow-up (thematic review)	This work will examine the progress made in orthopaedic services since our 2015 all Wales review. The will assess whether recommendations and areas we identified for improvement have been effectively responded to and to determine whether health boards are developing arrangements to help manage the demand on, and supply of, orthopaedic services.	Briefing issued	Steve Curry	December 2019

Work planned

Exhibit 4: Work currently planned

Topic	Focus of the work	Status	Executive Lead	For Audit Committee
Follow-up of previous IM&T recommendations (local)	In 2014, we carried out work to assess progress in addressing previous IM&T related issues and recommendations. We concluded that the Health Board had made some progress, but further work was needed. At that time, we made some additional recommendations. In 2018-19 we will follow up progress against these recommendations.	Scoping	To be confirmed	To be confirmed
Structured Assessment 2019	Structured Assessment will continue to form the basis of the work we do at each NHS body to examine the existence of proper arrangements for the efficient, effective and economical use of resources. Building on previous years' work, we will seek to describe the progress that is being made in embedding sound arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management.	Scoping	To be confirmed	To be confirmed
Quality Governance arrangements (thematic review)	As an extension of our structured assessment work, we plan to undertake a specific thematic review of quality governance arrangements and how these underpin the work of quality and safety committees. In recent years our structured assessment work across Wales has pointed to various challenges with such governance arrangements. We therefore intend to undertake a review that will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting.	Scoping	To be confirmed	To be confirmed

Responses to queries

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

Raised	Query
	No queries raised.

Other Auditor General studies

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

Exhibit 6: Auditor General Reports published since last audit committee

Output	Summary
What's the hold up? Discharging patients in Wales NHS Board member checklist	During 2017, the Auditor General for Wales reviewed discharge planning arrangements at local health boards and Velindre NHS Trust with bodies receiving detailed reports of their local findings along with recommendations for improvement. Since then, we are aware of the development of Welsh specific guidance on the SAFER patient flow bundle and ongoing work by the Delivery Unit to support improvements and to publicise practical ideas in its report, 'Why Not Home, Every Day Counts'. It is important that NHS bodies have assurance that hospital discharge arrangements are safe and timely and facilitate patient flow. To help support this, we have produced a checklist for NHS board members.

Good Practice Exchange

The Good Practice Exchange (GPX) helps public services improve by sharing knowledge and practices that work. We run events where people can exchange knowledge face to face and share resources online.

Details of past and forthcoming events, shared learning seminars and webinars can be found on the GPX page on the Wales Audit Office's website. The table in Exhibit 5 lists recent and forthcoming events.

Exhibit 7: Good Practice Exchange

Recent and forthcoming events
Recent events
Webinar: Let's talk cyber security 26 March 2019 The aim of this interactive webinar was to equip board and non-executive members with the necessary tools and knowledge to seek assurance that their organisation has the necessary cyber security arrangements in place.
Young people influencing decisions about what matters to them 12 March 2019 and 28 March 2019 In partnership with Inspection Wales and the Children's Commissioner for Wales, the Good Practice Exchange hosted an event which highlighted the key challenges facing young people of Wales today.
Webinar: Preparations in Wales for a 'no deal' Brexit 5 March 2019 This webinar followed on from our recent report. It provided non-executives and councillors with considerations to help them scrutinise Brexit plans at their organisations.
Supporting people in their communities: Reducing unnecessary hospital admissions 5 February 2019 and 14 February 2019 Following on from 'I'm a patient get me out of here' in March 2018, this seminar sought to highlight innovative approaches where public services are delivering services that help prevent unnecessary hospital admissions.
Upcoming
Working in partnership to combat fraud 7 May 2019 and 16 May 2019 An opportunity for Welsh public services to learn about recent developments in relation to combatting fraud. We will share investigation techniques, intelligence and the use of data analytics in fraud prevention and detection.

Diary markers and details of new events are circulated in advance to the Health Board, together with information on booking delegate places. Further information on any of our past or planned GPX events can be obtained by contacting the local audit team or emailing good.practice@audit.wales.

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Post Payment Verification Progress Report

For the period: 1st April 2018 to 31st March 2019

Cardiff & Vale University Health Board

Issued:
Prepared by: Mrs Sara Jeremiah (PPV Location Manager)

This document has been prepared for the internal use of Cardiff & Vale University Health Board.
For any queries or further information relating to this report, please contact Mr Scott Lavender. E-mail: scott.lavender@wales.nhs.uk

1. Introduction

This report has been prepared for the audit committee of Cardiff & Vale University Health Board. The aim of this report is to summarise the work undertaken by the Post Payment Verification (PPV) department in accordance to the Welsh Assembly Government (WG) directions in respect of General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS).

The purpose of a PPV visit to GMS contractors is to ensure that claims submitted by contractors in respect of GMS Enhanced Services are correct and in accordance with the Statement of Financial Entitlement (SFE) and service specifications set by WG and LHBs.

The purpose of a PPV visit to GOS contractors is to ensure that claims submitted by contractors in respect of GOS are correct and in accordance with the relevant NHS General Ophthalmic Services regulations and any specific LHB procedure.

The purpose of a PPV visit to GPS contractors is to ensure that claims submitted by contractors in respect of GPS are correct and in accordance with the relevant NHS General Pharmaceutical Services regulations and any specific LHB, CPW or WG procedures.

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

2. Post Payment Verification process

The PPV department carry out routine visits to all General Practitioner contractors on a three year cycle. During a GMS visit, the PPV department will analyse a sample of 20 claims or 10% of the total number of claims submitted during the year prior to the visit (whichever is the greater) for each enhanced service commissioned to the Practice.

The PPV department carry out routine visits to ophthalmic contractors based on the average number of GOS3 forms submitted during the year. The following table is used in determining the GOS visit schedule in a three year cycle:

Average monthly GOS3 submissions	Number of visits within a three year cycle
Up to 200	1
201 – 400	2
401 – 600	3

During a GOS visit, the PPV department will analyse a sample of 100 claims consisting of GOS1 (Sight tests), GOS3 (Vouchers), GOS4 (Repairs and replacement) and EHEW claims.

The purpose of a GPS PPV audit is to ensure that claims submitted by Pharmacy contractors in respect of GPS are correct and in accordance with the relevant NHS General Pharmaceutical Services regulations and any specific specification set by WG, HB's and CPW.

Following a visit, an initial report is sent to the General Practitioner/ Ophthalmic contractor summarising the observations and findings of the visit and request further information from the contractor to queries that arise from the visit. The contractor is given 28 days to reply to the queries. If no response is received by the contractor, it will be assumed that they are satisfied with the report findings. If the contractor provides feedback, the PPV department will consider this information and assess if it clarifies the queries.

Taking the above into account, the report is finalised with recommended recoveries (If appropriate) and sent to the UHB Finance and Primary Care lead for approval.

If the report is approved, the PPV team will instruct the Payments department within NWSSP Primary Care Services to make the recovery against the contractor.

Where the PPV team identify a high number of claim errors for a particular service (10% for GMS, GOS & GPS), a recommendation will be made to the UHB that a more substantive review of the service needs to be carried out. If this is the case, the PPV team will carry out a revisit to the contractor within one year of the routine visit. During this visit all claims submitted by the contractor for the identified services only will be analysed for the period between the last visit and the routine visit date, usually three years.

In addition to carrying out visits, the PPV team continually monitor claims submitted by GMS, GOS and GPS contractors to assist in the identification of trends and outliers. This information is used to assist in the preparation of visit samples and also to alert the UHB and Local Counter Fraud Specialist if suspicious claiming patterns emerge.

The PPV team are also available to provide advice, support and guidance to contractors and UHBs when required.

3. Summary of findings and observations

General Medical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
35	22	13	35	0

During the period 1st April 2018 to 31st March 2019, the PPV team has visited 35 GMS contractors as per the visit plan agreed with the UHB. The PPV team have recovered £20,330.95 from completed visits to GMS contractors in the UHB area due to errors identified in contractor's enhanced service claims. Recoveries are also to be made from on-going visits. These recoveries have not been included in the above total as they have not been authorised by the UHB. A summary of the GMS visits can be found in appendix one of this report.

The overall claim error rate for the locality was 4.57% from all claims sampled. A graphical representation of the claim error rates following GMS visits can be found in appendix two of this report.

General Ophthalmic Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
18	15	3	18	0

During the period 1st April 2018 to 31st March 2019, the PPV team have visited 18 GOS contractors as per the visit plan agreed with the UHB. The PPV team have recovered £4,052.15 from completed visits to GOS contractors in the UHB area due to errors identified in contractors' GOS claims. A summary of the GOS visits can be found in appendix three of this report.

The overall claim error rate for the locality was 4.76% from all claims sampled. A graphical representation of the claim error rates following GOS visits can be found in appendix four of this report.

General Pharmaceutical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
36	30	6	36	0

During the period 1st April 2018 to 31st March 2019, the PPV team has visited 36 GPS contractors as per the visit plan agreed with the UHB. The PPV team have recovered £1,242.87 from completed visits to GPS contractors in the UHB area due to errors identified in contractor's Medical Review Use claims. A summary of the GPS visits can be found in **Appendix 5** of this report.

The overall claim error rate for the Health Board was 2.18% from all claims sampled.

A summary of the PPV teams findings from visits by service can be found in **Appendix 5** of this report with a graphical representation of the error rates by service can be found in **Appendix 6**

4. Conclusion

The PPV cycle has been running to the agreed plan and we have not had any difficulties in ensuring this happens. The team have been working hard to collaborate with practices and their staff to ensure they have the support needed and that the process can be smooth.

The PPV team are collaborating with the Primary Care Team well and any issues that get identified by the PPV team will be given straight to primary Care as normal. New specifications are discussed with the Primary Care team in the UHB to ensure we deliver an effective service. We are still looking to work together with Contractors to build healthy relationships whilst also offering our advice and help where necessary or requested.

The PPV team collaborate with Counter Fraud in regards to trends data and ensure that the link is kept to give assurance on any issues.

The PPV team offer one to one training to practices to help them with their claiming processes. We currently have a project in place that is being organised for the PPV team to undertake a presentation to GOS practice staff to them with understanding the process.

5. Visit schedule 2019-2020

	Routine	Revisit	Extended	Visit due to HB Request	Total Visits
GMS (Medical)	20	5	2	0	**29**
GOS (Opticians)	37	4	0	0	**41**
GPS (Pharmacy)	41	1	0	0	**42**
					112

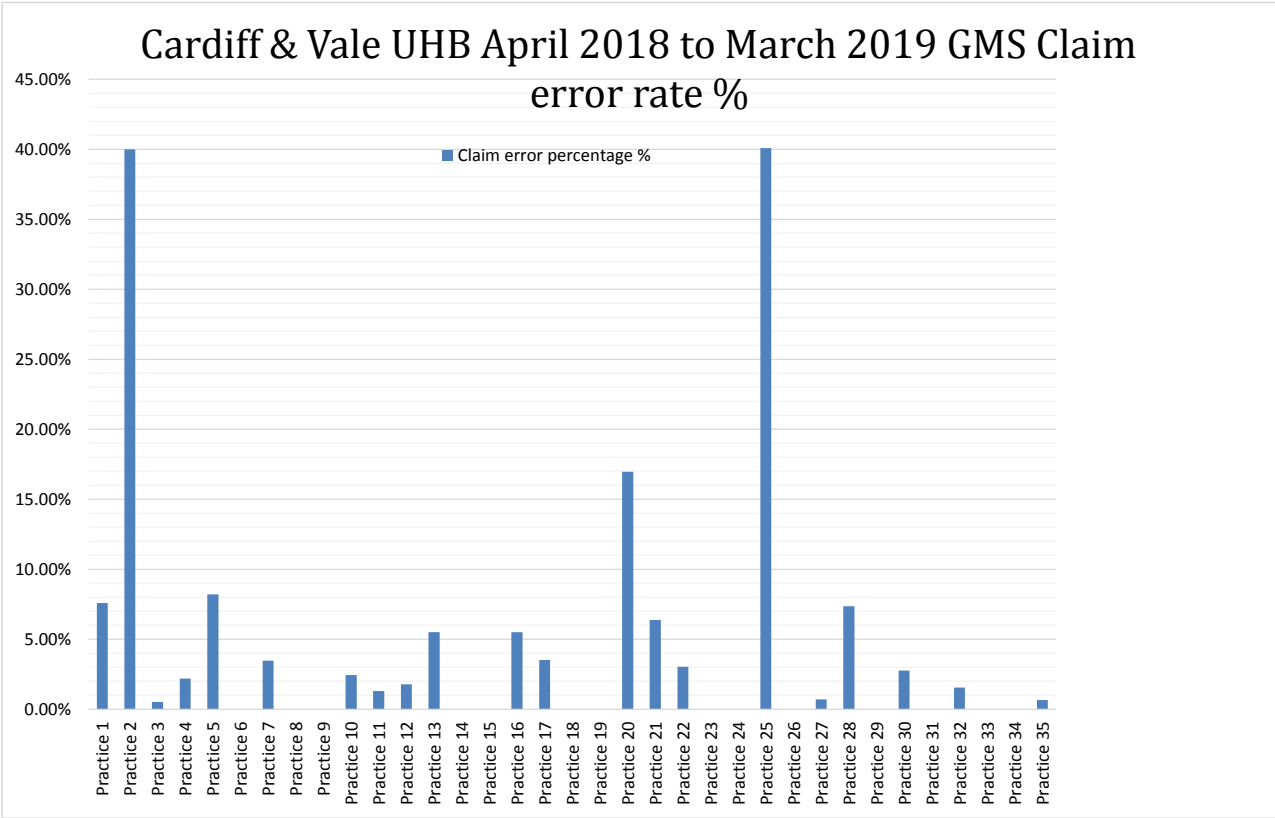
Cardiff & Vale University Health Board
GMS PPV Progress Report: 2018/19

Completed GMS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Revisit	1093	83	94.14%	7.59%	£748.95	83 x FLU
Practice 2	Revisit	90	36	21.11%	40.00%	£2,933.18	35 x Minor Surgery and 1 x Administration of Gonadorelins
Practice 3	Routine	390	2	4.10%	0.51%	£118.45	1 x Minor Surgery and 1 x Non UK Residents
Practice 4	Revisit	734	16	0.00%	2.18%	£608.23	16 x Anti-Coagulation Monitoring
Practice 5	Revisit	122	10	9.84%	8.20%	£258.40	10 x Administration of Gonadorelins
Practice 6	Routine	199					File in progress, awaiting response from UHB
Practice 7	Routine	374	13	2.94%	3.48%	£759.83	3 x Anti-Coagulation Monitorning, 3 x Minor Surgery, 1x Post Natal MMR, 1x NOAC and 5 x Care Homes
Practice 8	Routine	181					File in progress, awaiting response from UHB
Practice 9	Revisit	197					File in progress, initial report sent to practice
Practice 10	Routine	245	6	2.04%	2.45%	£199.79	1 x Near Patient Testing, 1 x Anti-Coagulation Monitoring, 1 x Contraceptives, 1 x Minor Surgery, 1 x Administration of Gonadorelins and 1 x Pertussis
Practice 11	Routine	308	4	12.66%	1.30%	£244.82	1 x Near Patient Testing, 1 x Minor Surgery, 1 x Administration of Gonadorelins and 1 x Learning Disability

Practice 12	Routine	396	23	5.81%	1.77%	£1,812.81	11 x Anti-Coagulation Slow Loading, 1 x NOAR, 1 x Contraceptives, 4 x Minor Surgery, 1 x Administration of Gonadorelins and 5 x Learning Disabilities
Practice 13	Revisit	454	25	0.00%	5.51%	£688.25	25 x Near Patient Testing
Practice 14	Routine	282					File in progress, initial report sent to practice
Practice 15	Revisit	985					File in progress, initial report sent to practice
Practice 16	Routine	109	6	18.35%	5.50%	£123.18	10 x Near Patient Testing, 2 x Anti-Coagulation Monitoring, 1 x Contraceptives and 2 x Pertussis
Practice 17	Routine	284	10	0.35%	3.52%	£670.08	1 x Learning Disabilities, 8 x Minor Surgery and 1 x Near Patient Testing
Practice 18	Revisit	734					File in progress, initial report sent to practice
Practice 19	Routine	230					File in progress, initial report sent to practice
Practice 20	Revisit	290	72	3.33%	16.97%	£2,067.83	59 x Near Patient Testing and 13 x Administration of Gonadorelins
Practice 21	Routine	235	15	8.51%	6.38%	£474.85	11 x NOAR, 1 x Near Patient Testing, 1 x Pertussis and 2 x Care Homes
Practice 22	Revisit	99	3	3.03%	3.03%	£90.87	3 x Near Patient Testing
Practice 23	Routine	225					File in progress, initial report sent to practice
Practice 24	Routine	155					File in progress, initial report sent to practice
Practice 25	Revisit	257	103	0.00%	40.08%	£5,495.68	103 x Nursing Home
Practice 26	Routine	245					File in progress, initial report sent to practice
Practice 27	Routine	142	1	0.70%	0.70%	£9.80	1 x Pertussis
Practice 28	Revisit	516	38	0.00%	7.36%	£2,672.23	24 x Minor Surgery, 11 x Near Patient Testing, 1 x NOAC and 2 x NOAC
Practice 29	Routine	263					File in progress, initial report sent to practice
Practice 30	Routine	218	6	0.00%	2.75%	£240.57	3 x Near Patient Testing, 2 x Minor Surgery and 1 x Administration of Gonadorelins
Practice 31	Routine						Visit scheduled for 28/03/2019
Practice 32	Revisit	65	1	0.00%	1.54%	£103.35	1 x Learning Disabilities
Practice 33	Revisit	273					File in progress, initial report sent to practice
Practice 34	Routine	292	0	0.00%	0.00%	£0.00	All claims were verified
Practice 35	Routine	154	1	1.30%	0.65%	£9.80	1 x FLU
UHB average		**10,836**	**474**		**4.37%**	**£20,330.95**	

Practice	Claim error percentage %
Practice 1	7.59%
Practice 2	40.00%
Practice 3	0.51%
Practice 4	2.18%
Practice 5	8.20%
Practice 6	
Practice 7	3.48%
Practice 8	
Practice 9	
Practice 10	2.45%
Practice 11	1.30%
Practice 12	1.77%
Practice 13	5.51%
Practice 14	
Practice 15	
Practice 16	5.50%
Practice 17	3.52%
Practice 18	
Practice 19	
Practice 20	16.97%
Practice 21	6.38%
Practice 22	3.03%
Practice 23	
Practice 24	
Practice 25	40.08%
Practice 26	
Practice 27	0.70%
Practice 28	7.36%
Practice 29	
Practice 30	2.75%
Practice 31	
Practice 32	1.54%
Practice 33	
Practice 34	0.00%
Practice 35	0.65%



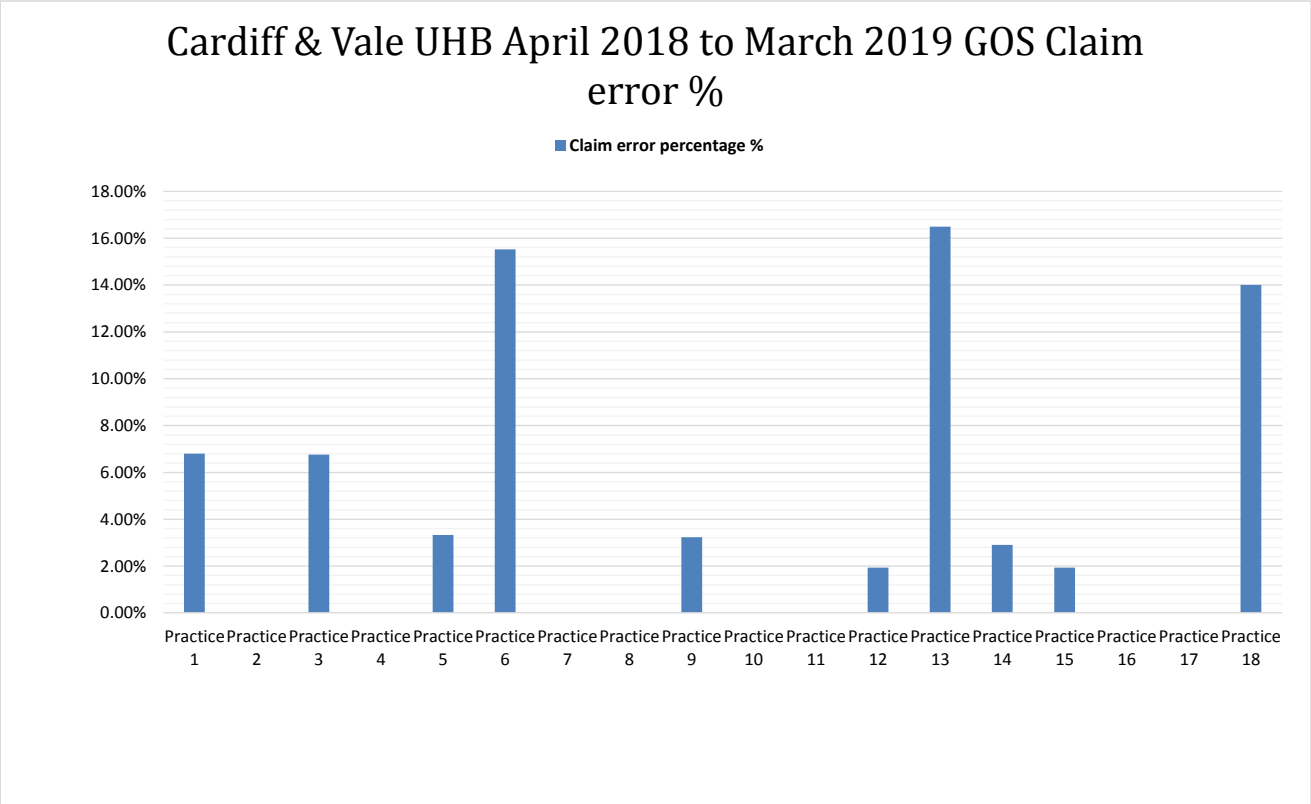
Cardiff & Vale University Health Board
GOS PPV Progress Report: 2018/19

Completed GOS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	103	7	41.75%	6.80%	£251.60	5 x EHEWs and 2 x GOS 4
Practice 2	Routine	103	0	0.97%	0.00%	£0.00	All claims were verified
Practice 3	Revisit	74	5	8.11%	6.76%	£107.20	5 x GOS 4
Practice 4	Routine	103	0	15.53%	0.00%	£0.00	All claims were verified
Practice 5	Revisit	300	10	2.67%	3.33%	£341.00	11x EHEWs
Practice 6	Routine	103	16	67.96%	15.53%	£401.15	7 x GOS 4, 3 x GOS 3 and 6 x EHEWs
Practice 7	Routine	103	0	12.62%	0.00%	£0.00	All claims were verified
Practice 8	Revisit						Visit in progress
Practice 9	Routine	93	3	97.85%	3.23%	£137.50	2 x GOS 3 and 1 x GOS 4
Practice 10	Routine	50					File in progress, initial report sent to practice
Practice 11	Revisit	300					File in progress, awaiting UHB response
Practice 12	Routine	103	2	1.94%	1.94%	£50.20	1 x GOS 3 and 1 x EHEW

Practice 13	Routine	103	17	51.46%	16.50%	£662.80	8 x EHEW, 8 GOS 4 and 1 x GOS 3
Practice 14	Routine	103	3	7.77%	2.91%	£136.00	2 x EHEW and 1 x GOS 4
Practice 15	Routine	103	2	27.18%	1.94%	£23.60	1 x GOS 4 and 1 x GOS 3
Practice 16	Routine	100	0	6.00%	0.00%	£0.00	All claims were verified
Practice 17	Routine	103	0	14.56%	0.00%	£0.00	All claims were verified
Practice 18	Revisit	300	42	8.00%	14.00%	£1,941.10	34 x EHEW and 6 x GOS 4
UHB average		**2,247**	**107**		**4.76%**	**£4,052.15**	

Practice	Claim error percentage %
Practice 1	6.80%
Practice 2	0.00%
Practice 3	6.76%
Practice 4	0.00%
Practice 5	3.33%
Practice 6	15.53%
Practice 7	0.00%
Practice 8	
Practice 9	3.23%
Practice 10	
Practice 11	
Practice 12	1.94%
Practice 13	16.50%
Practice 14	2.91%
Practice 15	1.94%
Practice 16	0.00%
Practice 17	0.00%
Practice 18	14.00%



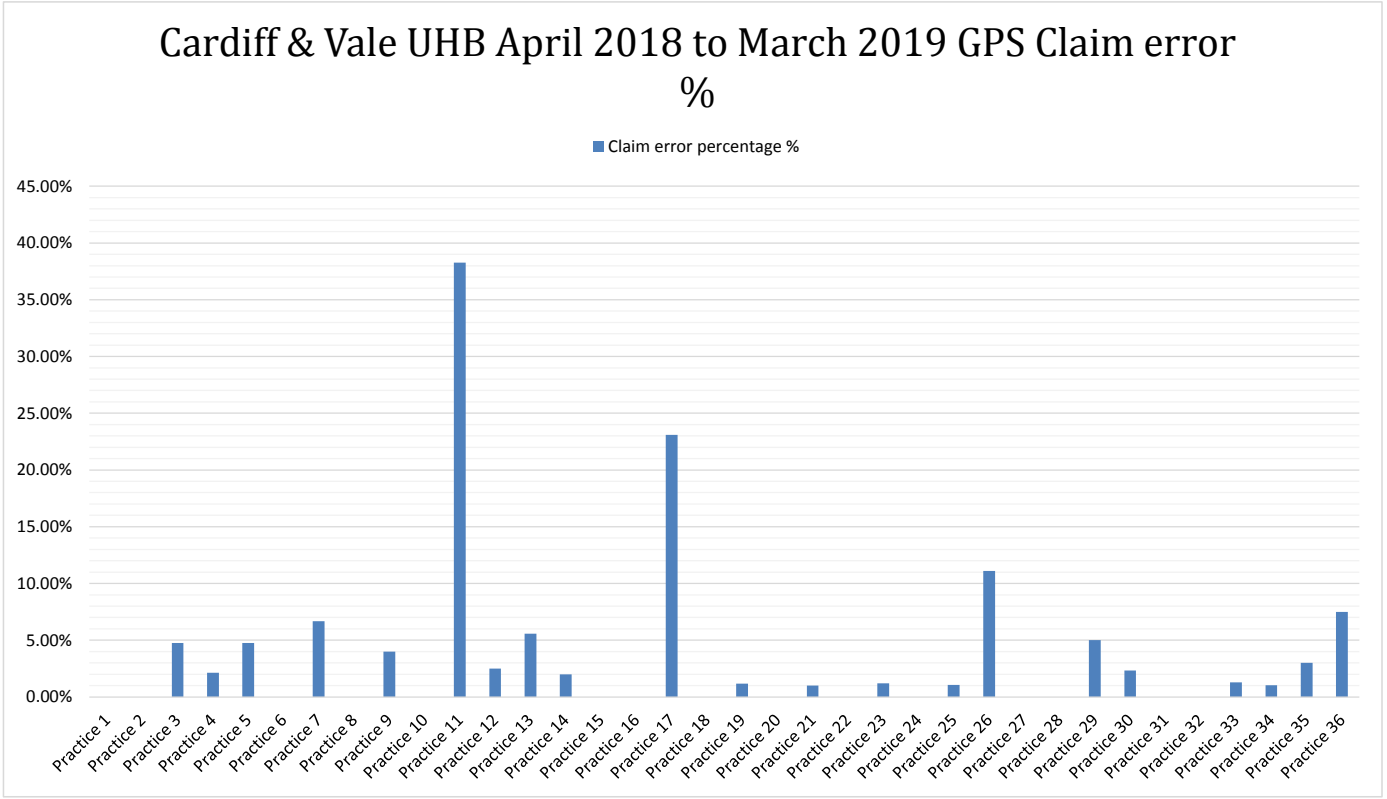
Cardiff & Vale University Health Board
GPS PPV Progress Report: 2018/19

Completed GPS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	55	0	12.73%	0.00%	£0.00	All claims were verified
Practice 2	Routine	57	0	3.51%	0.00%	£0.00	All claims were verified
Practice 3	Routine	63	3	65.08%	4.76%	£45.41	3 x FLUs
Practice 4	Routine	94	2	31.91%	2.13%	£56.00	2 x MURs
Practice 5	Routine	42	2	16.67%	4.76%	£32.10	2 x FLUs
Practice 6	Routine	100	0	18.00%	0.00%	£0.00	All claims were verified
Practice 7	Routine	45	3	6.67%	6.67%	£44.04	3 x FLUs
Practice 8	Revisit	32	0	65.63%	0.00%	£0.00	All claims were verified
Practice 9	Routine	100	4	20.00%	4.00%	£112.00	4 x MURs
Practice 10	Routine	44					File in progress, initial report sent to practice
Practice 11	Routine	81	3	3.70%	38.27%	£84.00	3 x MURs
Practice 12	Routine	100	2	86.25%	2.50%	£56.00	2 x MURs
Practice 13	Revisit	36	2	13.89%	5.56%	£32.10	2 x FLUs
Practice 14	Routine	100	2	4.00%	2.00%	£56.00	2 x MURs
Practice 15	Routine	100	0	4.00%	0.00%	£0.00	All claims were verified
Practice 16	Routine	74					File in progress, awaiting UHB response
Practice 17	Revisit	65	15	6.15%	23.08%	£238.12	15 x FLUs

Practice 18	Routine	100					File in progress, awaiting UHB response
Practice 19	Routine	86	1	1.16%	1.16%	£28.00	1 x MUR
Practice 20	Routine	100	0	1.00%	0.00%	£0.00	All claims were verified
Practice 21	Routine	100	1	7.00%	1.00%	£28.00	1 x MUR
Practice 22	Routine	38	0	2.63%	0.00%	£0.00	All claims were verified
Practice 23	Routine	84	1	48.81%	1.19%	£28.00	1 x MUR
Practice 24	Routine	97	0	8.25%	0.00%	£0.00	All claims were verified
Practice 25	Routine	94	1	12.77%	1.06%	£28.00	1 x MUR
Practice 26	Revisit	3	8	4.17%	11.11%	£127.68	8 x Flu
Practice 27	Routine	100					File in progress, initial report sent to practice
Practice 28	Routine	100	0	6.25%	0.00%	£0.00	All claims were verified
Practice 29	Routine	20	1	30.00%	5.00%	£28.00	1 x MUR
Practice 30	Routine	51	1	65.41%	2.33%	£28.00	1 x MUR
Practice 31	Routine	0	0	0.00%	0.00%	£0.00	Waste Audit only
Practice 32	Routine	100	0	0.00%	0.00%	£0.00	All claims were verified
Practice 33	Routine	98	1	24.23%	1.28%	£28.00	1 x MUR
Practice 34	Routine	98	1	8.16%	1.02%	£28.00	1 x MUR
Practice 35	Routine	100	3	16.00%	3.00%	£96.30	6 x Flu
Practice 36	Routine	100	3	11.25%	7.50%	£71.22	2 x MURs and 1 x Flu
UHB average		**2,657**	**60**		**2.26%**	**£1,274.97**	

Practice	Claim error percentage %
Practice 1	0.00%
Practice 2	0.00%
Practice 3	4.76%
Practice 4	2.13%
Practice 5	4.76%
Practice 6	0.00%
Practice 7	6.67%
Practice 8	0.00%
Practice 9	4.00%
Practice 10	
Practice 11	38.27%
Practice 12	2.50%
Practice 13	5.56%
Practice 14	2.00%
Practice 15	0.00%
Practice 16	
Practice 17	23.08%
Practice 18	
Practice 19	1.16%
Practice 20	0.00%
Practice 21	1.00%
Practice 22	0.00%
Practice 23	1.19%
Practice 24	0.00%
Practice 25	1.06%
Practice 26	11.11%
Practice 27	
Practice 28	0.00%
Practice 29	5.00%
Practice 30	2.33%
Practice 31	0.00%
Practice 32	0.00%
Practice 33	1.28%
Practice 34	1.02%
Practice 35	3.00%
Practice 36	7.50%



Report Title:	**2018-19 Annual Report: Progress Update**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	23.04.19	
Status:	**For Discussion**	x	**For Assurance**	x	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Interim Head of Corprorate Governance								

SITUATION

This paper provides the Audit and Assurance Committee with an update on the progress being made with the drafting of the 2018-19 Annual Report.

REPORT

BACKGROUND

As Committee members will be aware (*see Paper considered by the Committee on 26 February 2019*) the Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. This guidance is based on HM Treasury's Government Financial Reporting Manual (FReM)1 and is intended to simplify and streamline the presentation of the annual reports and accounts so that they better meet the needs of those who read and use them.

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

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

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

Part 3 The Financial Statements

The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be must be completed and submitted to Welsh Government by 1 July 2019.

ASSESSMENT

The proposed timetable and approach for the production of the 2018-19 Annual Report was considered by the Committee when it met in February 2019. A summary of progress against key deadlines is provided at Appendix 1. Committee Members will note that the

draft Annual report was not considered by Management Executive as planned on 15 April 2019, however the draft report provided at Appendix 2 has been circulated to Executive Directors for consideration. The draft provided does not include the Financial Statements as these ill not be available until May 2019, neither does it included the performance data that will be provided by Welsh Government in June 2019.

RECOMMENDATION

The Audit Committee is asked to:

NOTE the progress made in relation to the drafting of the 2018-19 Annual Report.
REVIEW and PROVIDE COMMENTS the content of the draft report attached as Appendix 2.

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										

Appendix 1

ANNUAL REPORT AND ACCOUNTS TIMETABLE 2018/19: PROGRESS UPDATE

Date	Meeting	Required	Completed
25th February	Management Executives	Annual Report Contents and Format List and timetable	
26th February	Audit Committee	Annual Report Contents and Format List and timetable	
1st April	Head of Communications, Interim Head of Corporate Governance, Director of Corporate Governance	Review progress of Review Draft Annual Report (including performance Report and Accountability Report)	
15th April	Management Executives	Review Draft Annual Report (including performance Report and Accountability Report) and Financial Statements	Draft Report not presented to ME on 15 April. Draft to be circulated to Executive Directors on 18 April. Financial Statements not available until May
23rd April	Audit Committee	Review Draft Annual Report (including performance Report and Accountability Report) and Financial Statements	Draft report circulated to Committee Members.
26th April	WAO	Submission of Draft Annual	

		Report Review Draft Annual Report (including performance Report and Accountability Report)	
3rd May	WAO	Submission of Draft Financial Statements	
24th May	WAO Meeting and Cardiff and Vale Officer	Discuss Draft Audit Report	
28th May	WAO	Final Audit Report Issued	
30th May (AM)	Audit Committee	Review Annual Report and Financial Statements and recommend approval to the Board Receive WAO on Financial Statements	
30th May (PM)	Board Meeting	Approve Annual Report and Financial Statement and recommend and consider WAO on Financial Statements	
31st May	Welsh Government	Submission of Whole of Government Accounts Return to Welsh Government	
25th July	AGM	Presentation of Annual Report and Financial Statement and Quality Account.	

Key:

	Deadline met
	Slight delay but no significant impact on overall timeline

	On track to meet deadline

Report Title:	**REGISTER OF INTERESTS**									
Meeting:	Audit and Assurance Committee							**Meeting Date:**	23.04.19	
Status:	**For Discussion**	x	**For Assurance**	x	**For Approval**		**For Information**			
Lead Executive:	Director of Corporate Governance									
Report Author (Title):	Interim Head of Corprorate Governance									

SITUATION

The purpose of this paper is to provide the Audit and Assurance Committee with a summary of the declarations of interest made by members of the Board prior to the start of the 2019-20 Financial Year.

REPORT

BACKGROUND

Cardiff and Vale University Health Board's (the UHB's) Standing Orders (*Standing Order 7*) makes it clear that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business.

Board members must also declare any interests held by family members or persons or bodies with which they are connected. The onus regarding declaration resides with the individual Board member. Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- roles and responsibilities held within member practices;
- directorships, including non-executive directorships, held in private companies or PLCs;
- ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the UHB;
- shareholdings of companies in the field of health and social care;
- a position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;
- any connection with a voluntary or other organisation contracting for NHS services;
- research funding/grants that may be received by the individual or any organisation in which they have an interest or role; and
- any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the UHB.

ASSESSMENT

The Chief Executive, through the Director of Corporate Governance/Board Secretary, ensures

that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register includes details of all Directorships and other relevant and material interests which have been declared by Board members.

The register is held by the Director of Corporate Governance/Board Secretary and is updated during the year, as appropriate, to record any new interests or changes to the interests declared by Board members. The Director of Corporate Governance/Board Secretary also arranges an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

Openness

In line with the Board's commitment to openness and transparency, the Director of Corporate Governance/Board Secretary must take reasonable steps to ensure that those served by the UHB are made aware of, and have access to view, its Register of Interests. Further, a Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the UHB shall be published in the Board's Annual Report.

It should also be noted that the work in relation to Standards of Business Conduct Internal Audit Report (which provided a limited assurance rating) is ongoing and a new policy and system is currently being developed to improve assurance in this area of Corporate Governance

RECOMMENDATION

It is recommended that the Audit and Assurance Committee:

APPROVES the declarations of interest report at Appendix 1.
AGREES to the declarations of interests made by Board members being published on the UHB's website**.**

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									

Appendix 1

Register of Declarations of Interest: Board Members [as at April 2019]

Surname	First Name	Position	Declaration of Interest (s)	Date Declaration Made
Independent Members				
Battle	Maria	Chair	▪ Child Protection, Safeguarding Officer for St Teil's Parich, Tenby	9 January 2019
Antoniazzi	John	Independent Member (Estates)	▪ Premier Forst Limited - Non-executive Chairman ▪ Spouse - Chief Executive of National Assembly	7 February 2019
Baxter	Gary	Independent Member (university)	▪ Employed by Cardiff University – Department of Bio-medical and life sciences	7 March 2019
Brandreth	Eileen	Independent Member (ICT)	▪ Employed by Cardiff University	3 January 2019
Elsmore	Susan	Independent Member (Local Authority)	▪ Welsh Local Government Association Health and Social care Spokesperson ▪ Cardiff and vale Regional partnership Board Chair ▪ Cabinet Member, Social Care, Health and Well Being	29 January 2019
Hanuk	Akmal	Independent Member	▪ Member of Glas Cymru Holdings Cyfyngedig ▪ Partner IBFC – UK (Islamic Banking & Finance Centre UK)	12 February 2019

		(Community)	▪ Connection to Assadaqaat Community Finance – A not for profit organisation delivering an innovative financial model to encourage enterprise in the communities in Wales ▪ As an Independent member of the UHB developed network of contacts with Corporate Public and Non Public business and non-business organisations offering products and services that would benefit NHS Staff, Patients and their families.	
Imperato	Michael	Independent Member (Legal)	▪ Director Association of Personal Injury Lawyers ▪ Director Bevan Foundation Charity ▪ Director Swansea University Children's Legal Centre ▪ Spouse – Flying Start Manager with Cardiff and Vale University Health Board	10 January 2019
Janczewski	Charles	Vice Chair	▪ WHSSC – Chair of Quality & Patient Safety Committee ▪ Swansea University – Chair of Governance Board for Health & Wellbeing Academy	2 January 2019
Moseley	Sara	Independent Member (Third Sector)	▪ Elected Board Member of WCVA ▪ Executive Director of MIND Cymru ▪ Non-Executive Director of MIND	12 February 2019

Union	John	Independent Member (Finance)	▪ Director John Union Limited ▪ Director Swansea Building Society ▪ Cardiff Business Club Director ▪ Vice chair, Cadwyn Housing Limited ▪ Blake Morgan Solicitors (Ambassador)	3 January 2019
Ward	Dawn	Independent Member (Trade Union)	▪ Nil return declared	10 January 2019
Executive Directors				
Richards	Len	Chief Executive Officer	▪ Advisor to the Life Sciences Hub ▪ Chairman of Improving Chances ▪ Council Member, Cardiff University	25 January 2019
Chadwick	Robert	Executive Director of Finance	▪ Nil return declared	15 January 2019
Curry	Steve	Executive Director of Primary and Community Care, and Mental Health/Chief Operating Officer	▪ Nil return declared	2 January 2019
Driscoll	Martin	Executive Director of Workforce and Organisational Development	▪ Nil return declared	22 February 2019

Foreman	Nicola	Director of Corporate Governance/Board Secretary	▪ Company Secretary of husband's business – Safe Ventures (UK) Ltd	4 March 2019
Harris	Abigail	Executive Director of Planning	▪ Non-executive Director of Social Care Wales ▪ Husband Board Member of Wales Council for Voluntary Action ▪ Uncle Trustee of Teenage Cancer Trust	3 January 2019
Hopkins	Sharon	Deputy Executive Officer/ Director of Transformation	▪ Chair of Public health Advisory Committee for NICE	31 December 2018
Kinghorn	Fiona	Director of Public Health	▪ Husband Director of Public Protection in Rhondda Cynon Taf County Borough Council	24 January 2019
Jenkins	Fiona	Executive Director of Therapies and Health Science	▪ Director JJ Consulting Healthcare Ltd	3 January 2019
Shortland	Graham	Medical Director	Partner Consultant Paediatric Oncologist, Cardiff and Vale University Health Board	1 January 2019
Walker	Ruth	Executive Nurse Director	Council member of the Nursing and Midwifery Council	2 January 2019
Associate Members				

Carver	Lance	Associate Member – Social Services	Director of Social Services - Cardiff	5 March 2019
Thomas	Richard	Chair of Stakeholder Reference Group	▪ Director of Care and Repair Home Improvement Services Ltd	12 February 2019
Martyn	Paula	Chair of Stakeholder Reference Group (*to December 2018*)	▪ Advisor of Care Forum Wales	12 March 2019

Report Title:	**AUDIT AND LEGISLATIVE REQUIEMENTS TRACKER**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	23.04.19	
Status:	**For Discussion**	x	**For Assurance**	x	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Interim Head of Corprorate Governance								

SITUATION

The purpose of this paper is to provide the Audit and Assurance Committee with an update on progress in relation to the implementation of a centralised system for:

- the management and monitoring of compliance with legislative and regulatory requirements, and
- the tracking of the implementation of recommendations and requirements made by audit and inspection bodies.

REPORT

BACKGROUND

As a statutory body that provides care and treatment to the local population, and tertiary and specialist services to the whole of Wales and beyond, Cardiff and Vale University Health Board is required to work within a stringent framework of legislative and quality requirements. It is also subject to audit and inspection by a range of bodies, including:

- Healthcare Inspectorate Wales
- The Cardiff and Vale Community Health Council
- The Cardiff and Vale Local Authorities
- The Health and Safety Executive
- The Human Tissue Authority
- Health Education and Improvement Wales
- The Medicines and Healthcare products Regulatory Agency
- The Fire Service
- The Information Commissioners Office
- The Welsh Language Commissioners Office

Currently, information on future regulatory inspections and the outcome of such visits is received by various departments within the UHB. This means that the Board is not always fully sighted of such activity and the recommendations made. To address this matter the Directorate of Corporate Governance is taking steps to ensure that a centralised systems is put in place to enable the monitoring and tracking of compliance with legislative, regulatory and audit requirements and recommendations. It is also working with Clinical Board's to ensure that where appropriate accreditation and ISO requirements are also captured centrally.

ASSESSMENT

Steps are being taken to ensure that the monitoring and tracking system is proportionate – to risk, scope for improvement, likely benefit and the interests of the UHB and the citizens it serves. In doing so, the process will have regard to:

- inherent levels of risk in the services or activities, in terms of the *likelihood* of detriment to individuals and the gravity or extent of the possible *impact* or *harm* caused;
- views and concerns, as expressed through surveys, consultations, complaints, representative organisations, elected representatives or directly to external review bodies;
- Ministerial concerns and priorities;
- the adequacy of Clinical Board's systems to detect poor compliance, deterioration in performance and actual detriment and harm;
- information already available about service management, performance and outcomes;
- the capacity and record of the Clinical Board's or services in setting service standards, managing performance and accounting publicly for performance;
- the presence and effectiveness of other forms of quality assurance, scrutiny and public accountability;
- the time elapsed since the services concerned were last subject to external review.

Progress

To date three excel spreadsheets have been developed and partially populated by the Directorate of Corporate Governance, these:

- Regulatory and Legislative Tracker: map the key legislative and regulatory requirements with which the UHB has to comply;
- Audit and Inspection Recommendations Tracker: set out all the recommendations made by Internal Audit, Wales Audit and other inspection bodies since April 2017 (*this requires further quality assurance and completeness checks*); and
- Welsh Health Circular Database: map the detail of all Welsh Health Circulars issued by Welsh Government since 2015.

The excel spreadsheets are detailed and going forward will require resource to maintain; also initially a high level of input from Executive Director's and their teams is required to provide an up to date position against the various requirements. A mechanism for their regular update is being developed and implemented.

Developing a Consistent Approach across the UHB

Meetings with representatives of Clinical Board's and Corporate departments have highlighted that various databases/spreadsheets are being maintained and monitored at a local level, but for many areas a mechanism for escalation and reporting to Board is not in place. A consistent and robust approach is needed that enables reporting by:

- UHB
- Executive Director

- Clinical Board
- Service
- Site
- Regulator

The Clinical Diagnostics and Therapeutics Clinical (CDTC) Board have been working on a regulatory and accreditation monitoring system for some time, and have developed a 'Regulatory and Accreditation Dashboard' for their area. Through a series of dials (see example at Appendix 1) the Clinical Board is able to see at a glance its level of compliance with, for example, its readiness for a HTA inspection.

The system developed by the CDT Clinical Board provides a real time view and is forward looking i.e. it assesses current compliance and readiness for a future audit/inspection. The Directorate of Corporate Governance recommends that this model is adopted on a UHB wide basis so that there is consistency and centralised oversight is facilitated. An overview of the system will be presented at the April Audit and Assurance Committee meeting.

RECOMMENDATION

It is recommended that the Audit and Assurance Committee:

AGREES to the UHB adopting the dashboard approach developed by the CDT Clinical Board**.** *If agreed a project plan will be developed taken to Management Executive and the Health System Management Board for consultation and 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

Regulatory and Accreditation Dashboard

Biochemistry ISO15189 inspection readiness

Improvement required on time of longest incident and CAPA

Low likelihood of inspection

Heamatology ISO15189 inspection readiness

Significant delays in incident and capa management

Low likelihood of inspection

Cellular Pathology ISO15189 inspection readiness

Overdue CAPA and incidents of concern

Low likelihood of inspection

Radiopharmacy MHRA inspection readiness

Improvement needed on audit and Capa closure

Estates replacement high priority

High likelihood of inspection

Cellular Pathology/Mortuary HTA inspection readiness

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

SMPU Pharmacy production MHRA

Significantly overdue incidents and CAPA, reflects current escalation postion with the regulator

UHL Pharmacy MHRA inspection readiness

Significantly overdue incidents and CAPA

High likelihood of inspection

BLood Transfusion Laboratory MHRA inspection

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

Stem Cell Processing Unit HTA

long standing capa closure related to change controls

26/4/19

REPORT TITLE:	**Internal Audit Plan 2019/20**								
MEETING:	**Audit Committee**						**MEETING DATE:**	**23rd April 2019**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
LEAD EXECUTIVE:	**Director of Governance**								
REPORT AUTHOR (TITLE):	**Acting Head of Internal Audit**								

PURPOSE OF REPORT:

SITUATION:

Following an extensive planning process and in accordance with the requirements of the Public Sector Internal Audit Standards, the Internal Audit Plan has been prepared which sets out our risk based plan of work for the year 2019/20.

In addition the Plan also includes the Internal Audit Charter which has been prepared as at April 2019.

REPORT:

BACKGROUND:

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

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

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

The Internal Audit Charter has been updated as at April 2019 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

ASSESSMENT:

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

RECOMMENDATION:

The Audit Committee is asked to:

- **APPROVE** the Internal Audit Plan for 2019/20
- **APPROVE** the Internal Audit Charter April 2019.

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention		Long term	x	Integration	x	Collaboration	x	Involvement		
EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable										

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

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

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

Cardiff and Vale University Health Board

Internal Audit Plan 2019/20

April 2019

NHS Wales Shared Services Partnership
Audit and Assurance Services

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2019/20 ('the Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

As a reminder, the Accountable Officer (the Health Board's Chief Executive) is required to certify in the Annual Governance Statement that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards require that "The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities."

Accordingly this document sets out the risk based approach and the Plan for 2019/20. The Plan will be delivered in accordance with the Internal Audit Charter. All internal audit activity will be provided by Audit & Assurance Services, a division of NHS Wales Shared Services Partnership.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- quantification of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering the:

- organisation's risk assessment and maturity;
- coverage of the audit domains;
- previous years' internal audit activities; and
- audit resources required to provide a balanced and comprehensive view.

Our planning also takes into account the NHS Wales Planning Framework 2018/21 and is also mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the

Integrated Medium Term Plan (IMTP) and/or Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

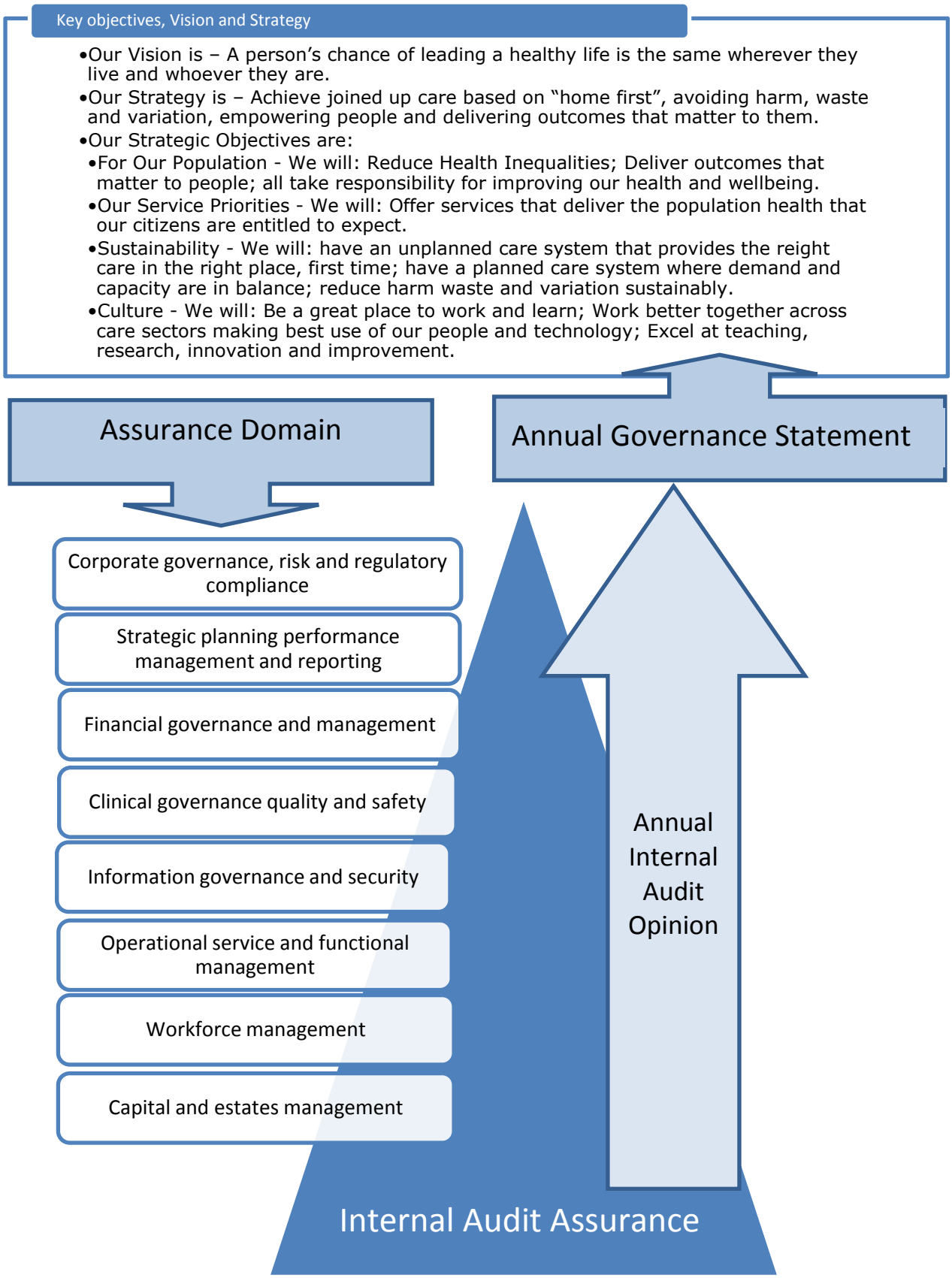
We will ensure that the Plan remains fit for purpose by reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control require annual review, and some work is mandated by Welsh Government, our risk based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe), categorised into eight assurance domains. The risk associated with each domain is assessed and this determines the appropriate frequency for review. As part of this approach we also develop and maintain a 3-year audit strategy to identify when audit areas will be audited.

The eight audit domains are shown in figure 1 which also shows how the cumulative internal audit coverage of them contributes to the Annual Internal Audit Opinion which in turn feeds into the Annual Governance Statement and the achievement of the key objectives for the organisation.

The mapping of the Plan to the eight assurance domains is designed to give balance to the overall annual audit opinion which supports the Annual Governance Statement.

Figure 1 Internal Audit assurance on the domains



2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; thus we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the Corporate Risk Register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and Quality & Safety Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- other assurance processes including planned audit coverage of systems and processes now provided through NHS Wales Shared Services Partnership (NWSSP) and, where appropriate, WHSSC, EASC and NWIS;
- work undertaken by other assurance bodies including the Health Board's Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV)
- work undertaken by other review bodies including Wales Audit Office (WAO) and Health Inspection Wales (HIW); and
- Coverage necessary to provide reasonable assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and / or corresponded with a number of Health Board Executives to discuss current areas of risk and related assurance needs. Meetings have been held with the following key personnel during the planning process:

- Chief Executive Officer;
- Executive Director of Transformation, Improvement & Informatics and Deputy CEO

- Executive Director of Public Health
- Executive Director of Finance;
- Chief Operating Officer;
- Clinical Board Directors of Operations
- Executive Director of Planning;
- Director of Governance;
- Executive Medical Director;
- Executive Director of Nursing;
- Executive Director of Workforce;
- Executive Director of Therapies and Health Sciences
- Director of Capital & Estates.

The draft Plan was then discussed at the full Management Executive meeting to ensure that internal audit effort was best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal control). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, potential for fraud and sensitivity.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2019/20

The Plan is set out in Appendix A and identifies the audit assignment, lead executive officer, outline scope, and proposed timing.

Where appropriate the Plan makes cross reference to key strategic risks identified within the Board Assurance Framework, corporate level risk registers and related systems of assurance together with the proposed audit response within the outline scope.

The scope objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion

with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management and WAO requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

Audit coverage in terms of capital audit and estates assurance will be delivered by our Specialist Services Unit. Given the specialist nature of this work and the assurance link with the all-Wales capital programme we will need to refine with management the scope and coverage on specific schemes. The Plan will then be updated accordingly to integrate this tailored coverage.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above. We will review and update the risk assessment and a rolling 3-year audit plan annually giving definition to the upcoming operational year and extending the strategic view outward.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. Hence, the Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. In particular the Plan will need to be periodically reviewed to ensure alignment with the developing systems of assurance.

Consistent with previous years and in accordance with best professional practice an unallocated contingency provision has been retained in the Plan to enable internal audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with the Wales Audit Office as your External Auditor will take place to co-ordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan indicates an indicative resource requirement of 1250 days to provide balanced assurance reports to the Chief Executive as Accountable Officer in accordance with the Public Sector Internal Audit Standards.

This assessment is based upon an estimate of the audit resource required to review the design and operation of controls in review areas for the purpose of sizing the overall resource needs for the Plan. Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

This total resource available covers the servicing of the local audit plan including capital audit and estates assurance coverage. These numbers are consistent with previous years.

The top-slice funding passed to NWSSP is sufficient to meet these audit resource needs. The inclusive internal provision through NWSSP Audit & Assurance Services represents best value for NHS Wales in comparison with external commercial rates for the equivalent provision of these professional services.

The Public Sector Internal Audit Standards enable internal audit to provide consulting services to management. The commissioning of these additional services by the Health Board is discretionary and therefore not included in the Plan. Accordingly, any requirements to service management consulting requests would be additional to the Plan and will need to be negotiated separately.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2019/20 and:

- Approve the Internal Audit Plan for 2019/20;
- Approve the Internal Audit Charter; and
- Note the associated internal audit resource requirements and key performance Indicators.

Ian Virgill
Acting Head of Internal Audit (Cardiff and Vale University Health Board)
Audit & Assurance Services
NHS Wales Shared Services Partnership

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
(1) Corporate governance, risk and regulatory compliance					
Annual Governance Statement		To provide an opinion and undertake specific areas of review to underpin the completion of the Statement.	Corporate Governance	Q4	Feed into annual report.
Risk, Governance & Assurance		On-going overview of general governance and risk management arrangements. Undertake specific areas of review to support annual opinion.	Corporate Governance	Q1-4	Feed into annual report.
Governance, Leadership & Accountability Assessment		To review the process that has been adopted and evidence supporting the self-assessment.	Corporate Governance	Q4	Feed into annual report.
Health and Care Standards	PR1	Review utilisation of standards within the Health Board and processes for assessing performance against them.	Nursing	Q4	Apr
Claims Reimbursement		Review compliance with Welsh Risk Pool Standard requirements for claims reimbursement.	Nursing	Q3	Feb
Risk Management / BAF development / Risk registers		To review the application and utilisation of the enhanced corporate risk and assurance arrangements currently being developed.	Corporate Governance	Q3	Feb
Management of Health Board Policies		To review the arrangements in place for the creation, management and review of Health Board policies.	Corporate Governance	Q3	Feb
Legislative / Regulatory Compliance Follow-up	PR4	Follow-up of 2018/19 Limited Assurance Report.	Corporate Governance	Q1	Sept

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
Standards of Business Conduct (DoI & G&H) Follow-up	PR5	Follow-up of 2018/19 Limited Assurance Report.	Corporate Governance	Q1	Sept
(2) Strategic planning performance management and reporting					
Continuing Healthcare - Follow up		Follow up of 2017/18 Limited Assurance Report. (This follow up and subsequent report will be split between the Child and Adult service) (Deferred from 18/19 plan)	COO	Q1	Sept
Strategic Planning / IMTP	PR2 / PR3	Review processes for development, delivery and monitoring of the IMTP. Exact scope dependent on outcome the of Welsh Government's review of the draft IMTP.	Planning	Q3	Feb
Brexit Planning		Review adequacy of plans / level of preparedness for the outcome of Brexit.	Planning	Q2	Dec
Engagement Around Service Change	PR3	Review processes for consulting with key stakeholders around service change.	Planning	Q2	Dec
Strategic Performance Reporting	PR2	Review processes for production, presentation and utilisation of strategic performance data. Including accessibility of information & dashboards.	Transformation, improvement & Informatics	Q3	Feb
Data Quality Performance Reporting		Review the accuracy and quality of data recording for a sample key Health Board performance target.	Transformation, improvement & Informatics	Q4	April

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
(3) Financial Governance and management					
UHB Core Financial Systems	PR2 / Fin 01/18	Review a selection of controls in place to manage key risk areas across the range of the main financial systems.	Finance	Q3	Feb
Budgetary Control	PR2 / Fin 02/18	Review processes for provision and utilisation of budgetary information within Directorates and Departments.	Finance	Q3	Feb
Charitable Funds		Review high level governance arrangements including operation of the Charitable Funds Committee.	Finance	Q2	Dec
Management of Long Term Agreements (LTAs)	PR2 Fin 10/18	Review processes for managing delivery against LTAs and receipt of income.	Finance	Q2	Dec
Private and Overseas patients	PR2	Review organisational arrangements for the identification and management of private and overseas patients. (Deferred from 18/19 plan)	Medical	Q1	Sept
(4) Clinical governance quality and safety					
Annual Quality Statement		To provide an opinion on the process that has been adopted and if the evidence recorded supports the self-assessment.	Nursing	Q1	Sept

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
Deprivation of Liberties Safeguards (DoLS)	PR4 /	Review of processes and controls for ensuring compliance with DoLS legislation. (Re-audit following limited assurance report in 15/16 & limited assurance follow-up in 17/18)	Medical	Q1	Sept
Integrated Health Pathways		Review of processes for the development, implementation and utilisation of pathways tool. Establish if benefits are being realised.	Transformation, improvement & Informatics	Q3	Feb
Infection Prevention and Control	PR4 / UHB 25/10	Review the structures and processes in place to ensure that the risk of infection is minimised and the spread of infection is effectively controlled.	Nursing	Q2	Dec
Safeguarding Adults & Children	PR4	Combined review of the systems and procedures in place for ensuring compliance with the Protection of Vulnerable Adults & Protection of Children legislation.	Nursing	Q1	Sept
(5) Information Governance and Security					
Freedom of Information Reviews		Review processes in place to enable the UHB to comply with the legislative requirements of the Freedom of Information Act.	Transformation, Improvement & Informatics	Q3	Feb
IT Strategy	PR6 / IT 6.8.1	Review processes in place for the development and delivery of the IT strategy to ensure it meets the needs of the UHB.	Transformation, Improvement & Informatics	Q1	Sept

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
Departmental IT System	PR6 / IT 6.8.1	Review controls in place to manage a local IT system. System to be agreed with management.	COO	Q2	Dec
IM&T Backlog	PR6 / IT 6.8.2 to 6.8.10	The current IM&T Backlog within the UHB is currently running in excess of £30m. The UHB does not currently have sufficient predictable capital (or revenue) funds to deliver IT equipment management processes to the required standards. The proposed review may review: • the UHB strategy; • the current IM&T risk arrangements; • the prioritisation of investment requirements; and • test the delivery of IM&T infrastructure projects allocated within the discretionary capital programme.	Planning	Q4	April
GDPR Follow-up		Follow-up of 2018/19 Limited Assurance Report.	Transformation, Improvement & Informatics	Q4	April
IT Service Management (ITIL)	PR6 / IT 6.8.1	Review processes in place for the management of IT Service delivery to ensure they are aligned with best practice and meet the needs of the organisation.	Transformation, Improvement & Informatics	Q4 (or Q1 20/21)	April / 20/21

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
(6) Operational service and functional management					
Mental Health CB – Third Sector Contracts		Review local processes in place for the procurement / commissioning of third sector contracts. (Number will be expanding in the near future)	COO	Q1	Sept
C&W CB – Consultant Leave		Review the use of the Intrepid System for managing consultant leave, including notice given before leave is taken	COO	Q3	Feb
Surgery CB – Specialing of ward Patients		Review processes for managing specialling including risk assessments, decision making process, stratification, spend review & tracker.	COO	Q2	Dec
Medicine CB – Specialing of ward patients	Med M4/11	Review processes for managing specialling including risk assessments, decision making process, stratification, spend review & tracker.	COO	Q2	Dec
CD&T CB – Laboratory Turnaround Times (TAT)	CD&T 5.1	Review the effectiveness for clinical practice that the current TATs provide. Focus on Biochemistry and Haematology.	COO	Q3	Feb
Specialist CB – Rosterpro		Review the processes for recording actual hours worked against rosters, managing time balances and working 'catch up' shifts.	COO	Q1	Sept
PCIC CB – Business Continuity		Detailed scope to be agreed with CB management.	COO	Q2	Dec

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
MH CB – Sickness Management Follow-up		Follow-up of 2018/19 Limited Assurance Report.	COO	Q1	Sept
Surgery CB – Medical Staff Governance Follow-up		Follow-up of 2018/19 Limited Assurance Report.	COO	Q1	Sept
Medicine CB – Internal Medicine Follow-up		Second follow-up of 2017/18 Limited Assurance follow-up Report. (2018/19 follow-up remained Limited Assurance)	COO	Q3	Feb
(7) Workforce management					
Medical Staff Study Leave		Review of the application of the new policy across a number of Clinical Boards / Directorates	Workforce	Q3	Feb
Pre–Employment Checks	PR1 / WOD	Review processes for carrying out pre-employment checks on new employees. Currently significant delays in process.	Workforce	Q4	April
Consultant Job Planning Follow-up	PR5	Follow-up of 2017/18 Limited Assurance Report. (Deferred from the 2018/19 plan)	Medical	Q2	Dec
(8) Capital and Estates 5					
Service Improvement Team		Review the establishment and working of the new team. (Deferred from 2018/19 plan)	Planning	Q2	Dec

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
Commercial Outlets		Review arrangements for the management of commercial outlets (Deferred from 2018/19 plan)	Planning	Q3	Feb
Sustainability Reporting	PR4	To establish if the Health Board has robust systems in place to record and report minimum sustainability reporting requirements as required by the Welsh Government.	Planning	Q1	Sept
Carbon Reduction Commitment	PR4	To ensure the Health Board complies with the requirements of the Order and that the information held is accurate, complete and the purchase of the credits is based upon actual usage or informed estimates.	Planning	Q1	Sept
Facilities / Estates Service Board Governance		Review of governance processes around performance management, monitoring and reporting within the service.	Planning	Q4	April
Neonatal and Obstetrics Project	PR6	Recognising the anticipated handover of the circa £40m scheme in July 2019, a review of the completed scheme is proposed. The scope may include: • an assessment of the outturn delivery (cost / programme), • a review of the calculation of Pain / Gain assessment, • assurance that the initial benefits from the delivered scheme have been achieved;	Planning	Q4	April

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
		• a review of the arrangements for ongoing monitoring of anticipated benefits; and • confirmation that lessons are appropriately learnt to apply to future developments.			
Penarth Wellbeing Hub	PR3 / PR6	The development of the Maelfa Wellbeing Hub (est. £10-11m) is a key component of the first tranche of projects within the "Shaping Our Future Wellbeing: In Our Community" Programme Business Case (PBC) submitted to WG in July 2018. Specific areas of audit coverage may include: • the adequacy of project governance and delivery arrangements; • approvals, monitoring and reporting; • design development; and • contract awards etc.	Planning	Q3	Feb
Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	PR6	The Welsh Government announced on 2 November 2018 funding of £30.88m for the new unit, based on a start on site in January 2019 and handover in September 2020. Noting the proposed delivery timetable, the focus of the 2019/20 review may include: • assurance that the project is being delivered within defined cost, time and quality parameters; • assurance that sound project governance arrangements are maintained through construction to project completion, including appropriate reporting, monitoring and approval processes;	Planning	Q4	April

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
		• assurance that adequate processes and procedures are in place to ensure that the contractor is correctly reimbursed in accordance with the contract valuation processes; • to ensure that any changes are processed/ authorised in accordance with the contract and local internal control procedures.			
Control of Contractors	PR4	Estates Assurance reviews test compliance against the processes and procedures put in place by management to control and direct resources deployed to operate the Estate. It is proposed that coverage during 2019/20 will focus on the Management of Contractors operating on the UHB estate (i.e. compliance with HSE and Construction and Design Management Regulations). This review may assess: • the controls and practices in place to ensure that the regulatory requirements are adequately addressed; and • that key risks are identified and appropriate management arrangements are embedded within the organisation.	Planning	Q2	Dec

Cardiff and Value UHB Internal Audit Plan 2019/20 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
Audit Management and Reporting					
Contingency & Assurance and Advisory		This element of the plan allows the flexibility to respond to management requests in order to meet specific Health Board needs throughout the course of the financial year.	Corporate Governance / Finance		
Follow-up		We will conduct follow-up reviews throughout the year to provide the Audit Committee with assurance regarding management's implementation of agreed actions.	Corporate Governance / Finance		
Planning, Management and Audit Committee		An allocation of time is required for the management of the service to the Health Board:- • Planning, liaison and management – Incorporating preparation and attendance at Audit Committee; completion of risk assessment and planning; liaison with key contacts and organisation of the audit reviews; • Reporting and meetings – Key reports will be provided to support this, including preparation of the annual plan and progress reports to the Audit Committee; and • Liaison with External Audit and other stakeholders.	Corporate Governance / Finance		
Head of Internal Audit Annual Report and Opinion	---	Mandatory requirement to comply with the Public Sector Internal Audit Standards and Annual Governance Statement.	Corporate Governance / Finance	Q4	May

The KPIs reported monthly for Internal Audit are:

KPI	SLA required	Target 2018/19
Audit plan 2019/20 agreed / in draft by 30 April	✓	100%
Audit opinion 2018/19 delivered by 31 May	✓	100%
Audits reported vs. total planned audits	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 days]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

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Audit and Assurance Services

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INTERNAL AUDIT CHARTER

April 2019

Contents

1 Introduction

1.1 This Charter is produced and updated regularly to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Cardiff and Vale University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Cardiff and Vale University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Corporate Governance with liaison with the Executive Director of Finance.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Cardiff and Vale University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

Audit work designed to deliver an audit opinion on the risk management, control, and governance arrangements is referred to in this Internal Audit Charter as Assurance Work because management use the audit opinion to derive assurance about the effectiveness of their controls

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective advisory service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such advisory work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit budget and resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Public Sector Internal Audit Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly the Head of Internal Audit has a direct right of access to the Accountable Officer the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance e.g. Quality & Patient Safety Committee, and the Information Governance Committee.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance with Liaison with the Executive Director of Finance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance with Liaison with the Executive Director of Finance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, internal audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

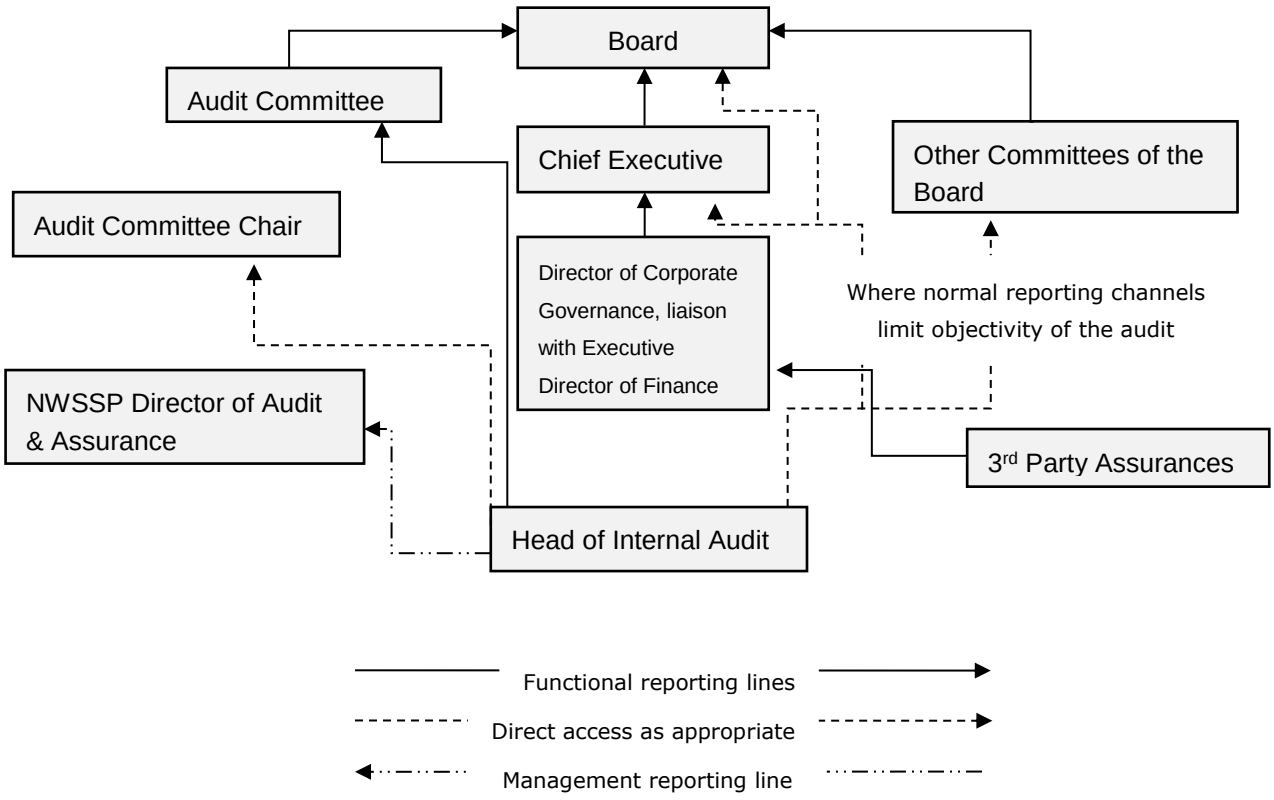
5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, e.g. the NHS Wales Shared Services Partnership, WHCCS, EASC and NWIS.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The key organisational reporting lines for Internal Audit are summarised in Figure 1 overleaf. As part of this, the Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all reports.

Figure 1 Audit reporting lines



6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2018) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- reviewing arrangements for demonstrating compliance with the Health and Care Standards.
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Governance and Accountability modular assessment and the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit, or prejudice the ability of internal audit to deliver a services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

7.4 The scope of the audit coverage will take into account and include any hosted body.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 2 overleaf

Figure 2 Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales to
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance

needs of the organisation will be met as required by the Public sector Internal Audit Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisations objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which "are appropriate, sufficient and effectively deployed to achieve the approved plan";
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information, and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead, and will also be copied to the Director of

Corporate Governance. The key stages in this risk based audit approach are illustrated in figure 3 below.

Figure 3 Risk based audit approach

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement. The process for arriving at the appropriate assurance level for each Head of Internal Audit opinion was subject to a review process during 2013/14, which led to the creation of a set of criteria for forming the judgement that was adopted and used for 2013/14 opinions onwards;

- The Head of Internal Audit opinion will:

a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes, with reference to compliance with the Health and Care Standards;

b) Disclose any qualification to that opinion, together with the reasons for the qualification;
c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and

- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below and presented in flowchart format in Appendix A:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B. The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, stating their agreement or otherwise to the content of the report, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;

- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Director of Corporate Governance and Executive Director of Finance. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance and Executive Director of Finance. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Final reports inclusive of management comments will be issued by Internal Audit to the relevant Executive Director within 10 working days of management responses being received; and
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and Executive Director of Finance and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition any

matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance - NHS Wales Shared Services Partnership
April 2019

Appendix C Audit Reporting Process

Appendix B Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	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	 - + Yellow	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	 - + Amber	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	 - + Red	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.

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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

Delayed Transfers of Care Reporting

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	C&V-1819-13
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Final report issued:	4th April 2019
Auditor/s:	Ian Virgill, Deputy Head of Internal Audit
	Kimberley Rowe, Principal Internal Auditor
Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Judith Hill, Head of Integrated Care
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 Delayed Transfers of Care (DToC) Reporting has been completed in line with the 2018/19 Internal Audit plan for Cardiff and Vale University Health Board.

A Delayed Transfer of Care is experienced by an inpatient in a hospital, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. Timely transfer and discharge arrangements are important in ensuring that the NHS effectively manages emergency pressures. The arrangements for transfer to a more appropriate care setting (either within the NHS or in discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays.

All NHS Local Heath Boards (LHBs) are required to report their monthly DToC activity for inclusion in the NHS DToC Database. The Database is an all-Wales census system operated by the NHS Wales Informatics Service. LHB monthly DToC activity is submitted after validation and agreement with the relevant local authority social services. Figures are signed off by both the LHB and the local authority.

The numbers of delayed transfers of care are used to measure delivery of the NHS Outcomes Framework. The targets for delayed transfers of care in NHS Wales are:

- No less that a 5 per cent reduction in the total number of delayed transfers of care within non-mental health ward when compared to the same period 12 months ago.
- No less that a 10 per cent reduction in the total number of delayed transfers of care within mental-health wards when compared to the same period 12 months ago.

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 Health Board for DToC reporting, 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 the Health Board has appropriate processes in place to ensure the effective recording and reporting of DToC activity in accordance with Welsh Government requirements.

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

- The Health Board has appropriate and up to date documented

procedures and policies in place for the recording and reporting of DToC activity;

- DToC activity is accurately recorded across the Health Board in accordance with local procedures and Welsh Government guidance;
- Robust processes are in place for collating the recorded DToC data and this is accurately and appropriately reported within the Health Board; and
- The Health Board complies with the requirements for reporting DToC data to Welsh Government.

3. Associated Risks

The potential risks considered in this review were as follows:

- Inaccurate reporting of DToC performance;
- DToC issues are not effectively identified, reported and addressed; and
- Non-compliance with Welsh Government reporting requirements.

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 Delayed Transfers of Care 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 a rigorous, detailed process for identifying DToC activity, which is monitored closely on a weekly basis. This process is in line with the Health Boards policy and procedures regarding discharge.

There is active engagement throughout the Health Board in order to validate the DToC data on a monthly basis. The activity data is shared internally with the Clinical Boards, Strategic Leadership Group and Regional Partnership Board; and further to this the Health Board are in compliance with their submissions to Welsh Government.

5. Assurance Summary

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

Assurance Summary					
1	Procedures and Policies				✓
2	Recording DToC Activity				✓
3	Collating and Reporting DToC Data				✓
4	Reporting to WG				✓

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

Design of Systems/Controls

The findings from the review has highlighted no issues that are classified as weakness in the system control/design for Delayed Transfers of Care Reporting.

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 Delayed Transfers of Care Reporting.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Obj 1: The Health Board has appropriate and up to date documented procedures and policies in place for the recording and reporting of DToC activity.

The following areas of good practice have been noted:

- The Health Board has rigorous processes in place to identify DToC patients and validate data, these processes align with the Policy and Procedure in place for Integrated Discharge;
- The Mental Health Clinical Board also have their own discharge and DToC process that has been clearly documented within a flow diagram; and
- The Information team have clear documented procedures for acquiring the DToC data, reconciling it and loading the submitted data into the Data Warehouse.

No significant issues have been identified.

Obj 2: DToC activity is accurately recorded across the Health Board in accordance with local procedures and Welsh Government Guidance.

The following areas of good practice were noted:

- The medically fit patients are reviewed in depth weekly to determine potential DToC and have appropriate validation to ensure record details are an accurate reflection of activity; and
- The Mental Health DToC spreadsheet contains sufficient and readily available information (dates and RAG ratings) to determine length of reasons for delay in order to identify instances of DToC

No significant findings were identified.

Obj 3: Robust processes are in place for collating the recorded DToC data and this is accurately and appropriately reported within the Health Board.

The following areas of good practice are noted:

- There are weekly DToC meetings with Integrated Discharge Service, Local Authorities and Ward representatives where the medically fit patients are scrutinised, and on the Census week, DToCs are identified;
- The preliminary list of DToCs is circulated to all the Clinical Boards via email;
- There is a Get Me Home working Group that meets the week

following the Census date to validate the list, they also have a project plan in place to improve the discharge work stream and support the reduction in DToC; and

- The DToC report is presented to the Strategic Leadership Group and Regional Partnership Board.

No significant findings have been identified.

Obj 4: The Health Board complies with the requirements for reporting DToC data to Welsh Government.

The following areas of good practice are noted:

- The Health Board is in compliance with the Welsh Government requirement for the Census date to take place on the third Wednesday of every month and activity data to be submitted via the All Wales database within three weeks of this date; and
- There is consistency with the DToC codes dictated by Welsh Government and those allocated to principal reasons for Health Board discharge delays.

No significant findings have been identified.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding 1 - Delay Dates (Operating effectiveness)	Risk
The Medically Fit spreadsheet used to identify DToCs weekly is updated using the comments column. However, it is not always clear from this what date certain processes started, eg. funding authorised, housing confirmation, package of care agreement. It therefore makes it difficult to decipher whether a DToC is apparent.	DToC issues are not effectively identified, reported and addressed.
Recommendation	**Priority level**
Each of the principal reasons have an agreed timescale, and divergence from these timescales results in a delayed transfer of care. With these dates listed clearly, there would be clearer evidence to confirm appropriate application of the rules.	**Low**
Management Response	**Responsible Officer/ Deadline**
The date of referral and compliance with time scales is checked verbally within the weekly scrutiny meetings and is often times included in the clinical workstation entries The spread sheet will be altered to include the agreed timescales and any divergence clearly noted	Head of Integrated Care End April 2019

Finding 2 - Clinical Board Reporting (Operating effectiveness)	Risk
The Census data is sense checked by the Clinical Boards based on their current understanding of the bed position, as ward managers are already involved in the detailed weekly validation. DToC numbers are not however formally included in any Clinical Board Reports.	DToC issues are not effectively identified, reported and addressed.
Recommendation	**Priority level**
Due to the patient impact of delayed discharge, it would be beneficial to include DToC in the information presented to the Clinical Board's Quality, Safety and Patient Experience Groups.	**Low**
Management Response	**Responsible Officer/ Deadline**
Clinical Boards will be provided with the monthly DToC report Clinical Board Directors of Operations will be reminded of the necessity to include in Quality and Governance agenda	Head of Integrated Care Beg April 2019 Chief Operating Officer Beg April 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

Ward Nurse Staffing Levels

Final Internal Audit Report

April 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	C&V-1819-21
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Executive sign off:	Ruth Walker, Executive Nurse Director
Distribution:	Jason Roberts, Deputy Executive Nurse Director
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 Ward Nurse Staffing Levels was completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board.

The Nursing Staffing Levels (Wales) Act 2016 (the 'Act') became law in Wales in March 2018. The Act introduced a duty for Local Health Boards and NHS Trusts in Wales to calculate and take all reasonable steps to maintain nurse staffing levels and inform patients of the level.

The nurse staffing level is the number of registered nurses appropriate to provide care to patients that meets all reasonable requirements in the relevant situation. The duty to calculate nurse staffing levels currently applies to adult acute medical inpatient wards and adult acute surgical inpatient wards.

Health Boards and Trusts must make arrangements to inform patients of the nurse staffing levels.

The relevant lead Executive Director for this review was the Executive Director of Nursing.

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 Nurse Staffing Levels, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives were managed appropriately.

The purpose of the review was to establish if the Health Board has appropriate processes in place to ensure that it is complying with the requirements of the Nurse Staffing Levels (Wales) Act 2016.

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

- The Health Board has an appropriate and up to date Nurse Staffing Level standard operating procedure in place and this is made accessible to all relevant staff;
- Nurse staffing levels are appropriately set for all adult acute medical and surgical inpatient wards within the Health Board and these levels are periodically reviewed in accordance with the requirements of the Act;
- The Health Board has identified an appropriate Designated Person to calculate the nurse staffing levels and they formally present them annually to the Board;
- Appropriate actions are taken to enable wards to maintain nurse staffing at the set levels;
- Effective processes are in place to ensure that patients are informed of the nurse staffing levels in accordance with the requirement of the Act; and

- Effective processes are in place for monitoring and reporting on compliance with the set nurse staffing levels.

3. Associated Risks

The potential risks considered in the review were as follows:

- Lack of awareness of the requirements of the Act;
- Harm to patients due to inadequate nurse staffing levels;
- Non-compliance with the requirements of the Nurse Staffing Levels (Wales) Act; and
- Issues relating to nurse staffing levels are not effectively 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.

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 Ward Nurse Staffing Levels 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 findings from the review have identified that Ward Nurse Staffing Levels are being well managed within the Health Board, in accordance with the requirements of the Nursing Staffing Levels (Wales) Act 2016. The Substantial assurance rating reflects the fact that only a small number of issues have been identified.

Information and guidance relating to the Act is readily available via the Health Board's intranet and a local Operating Framework has also been developed.

Robust processes are in place for effectively calculating the ward nurse staffing levels on a 6 monthly basis. The resulting levels are formally reported to the Board by the Executive Director of Nursing, who is the Designated Person for the Health Board.

An adequate process is currently in place for reviewing the actual daily nurse staffing levels against the calculated levels. A monitoring spreadsheet has also been introduced recently to improve the recording and reporting of the review process.

Further work is however required to ensure that each ward's calculated nurse staffing levels are formally approved by all required managers and Executives and the correct levels are then displayed outside all wards.

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:

Assignment Objectives					
1	Health Board has a Nurse Staffing Level SOP				✓
2	Nurse staffing levels are appropriately set			✓	
3	Health Board has identified an appropriate Designated Person				✓
4	Actions are taken to enable wards to maintain nurse staffing at the set levels				✓
5	Patients are informed of the nurse staffing levels			✓	
6	Processes are in place for monitoring and reporting on compliance with the set nurse staffing levels				✓

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weakness in the system control/design for Ward Nurse Staffing Levels.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weakness in the operation of the designed system/control for Ward Nurse Staffing Levels.

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 Nurse Staffing Level standard operating procedure in place and this is made accessible to all relevant staff

The following areas of good practice were noted:

- There is a Nursing section on the Cardiff and Vale UHB Intranet and included is a copy of the Nursing Staffing Levels (Wales) Act 2016 and Frequently Asked Questions (FAQs) on nurse staffing levels.
- The Health Board has developed a local Nurse Staffing Levels Operating Framework. Audit reviewed this against the Nurse Staffing Levels (Wales) Act 2016 and the document was consistent and in compliance with it. The Operating Framework has been approved by the Health Board and is currently with the All Wales Project Lead (along with all the other UHB Frameworks) for consistency checking.

There were no significant findings noted.

Objective 2: Nurse staffing levels are appropriately set for all adult acute medical and surgical inpatient wards within the Health Board and these levels are periodically reviewed in accordance with the requirements of the Act

The following areas of good practice were noted:

- Ward Nurse staffing levels within the Health Board have been reviewed twice; in January and June 2018 and at the time of the Audit they had just undertaken the January 2019 review.
- On a daily basis during the review months of January and June each ward records the acuity of its patients, the number of hours worked by nurses, ward attendees and escorts onto the Health & Care Monitoring system. This information is then utilised, alongside Quality indicators and professional judgement to calculate the ward nurse staffing levels.

  It has been agreed going forward that the recording of patient acuity and nurse hours should be a continual daily process undertaken throughout the year.

- It was identified that, following the review undertaken in June 2018, some wards had changed their skills mix based on the recording of acuity and professional judgement of the nursing team.

The following significant findings were noted:

- Audit reviewed a sample of Nurse Staffing Workforce Templates to ensure that they had been completed and signed off as approved by the appropriate employees. It was identified that the forms had not always been signed as approved by all the required parties.

Objective 3: The Health Board has identified an appropriate Designated Person to calculate the nurse staffing levels and they formally present them annually to the Board

The following areas of good practice were noted:

- The Designated Person for nurse staffing levels within the Health Board is the Executive Nurse Director as detailed in the Health Boards Nurse Staffing Levels (Wales) Act 2016 Operating Framework.
- The Designated Person has formally presented the nurse staffing levels for each ward to the Board following the audits of the nurse staffing levels. The nurse staffing levels were presented and approved at the Board meeting in May 18 for the January 18 acuity audit and November 18 for the June 18 acuity audit.

There were no significant findings noted.

Objective 4: Appropriate actions are taken to enable wards to maintain nurse staffing at the set levels

The following areas of good practice were noted:

- Audit visited a sample of 5 wards to ensure that the establishment levels were correct. It was evident from review of the wards that there were vacancies or staff on sick and Audit were advised that the establishment levels were maintained by the use of bank and agency staff.
- Audit reviewed the Finance report detailing the budget staffing levels against the Summary of Nurse Staffing Levels report for the 5 wards reviewed and for 4 of the wards the staffing levels agreed or there were only minimal, immaterial differences. This evidences that the wards are appropriately funded for their set nurse staffing levels.

There were no significant findings noted.

Objective 5: Effective processes are in place to ensure that patients are informed of the nurse staffing levels in accordance with the requirements of the Act

The following areas of good practice were noted:

- The Health Boards Nurse Staffing Levels (Wales) Act 2016 Operating Framework confirms that the Board are responsible for "specifying the

arrangements for informing patients of the nurse staffing level on each ward along with the date this was agreed by the Board" which is in compliance with the Welsh Governments Nurse Staffing Levels (Wales) Act 2016: Operational Guidance. The arrangements in place within the Health Board are for the staffing levels to be displayed on a board outside each ward.

The following significant findings were noted:

- On three of the 13 sampled wards, the Nurse staffing levels form being displayed outside the ward did not correspond to the latest agreed levels as presented to the Board in October 2018; and
- The ward staffing levels were not displayed on the boards outside a further three of the wards.

Objective 6: Effective processes are in place for monitoring and reporting on compliance with the set nurse staffing levels

The following areas of good practice were noted:

- On a daily basis all the wards advise the Senior Nurses of any shortfalls that they might have with the shifts for that day.
- A daily meeting is held to discuss any staffing shortfalls on the wards and agreements are made for moving staff across wards to address higher risk areas. A template is then sent to the Executive Nurse Director and the Deputy Executive Nurse Director.
- The Deputy Executive Nurse Director has recently developed a spreadsheet for recording the information that is discussed in the daily meetings along with the actual numbers of nursing staff against the agreed ward staffing levels.
- There is a weekly report produced that is presented to the Clinical Board Director of Nursing on hot topics that includes any general staffing issues within the wards.

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**	**2**	**2**	**4**

Finding 1 - Approving ward staffing levels (Operating effectiveness)	Risk
Audit reviewed a sample of 5 wards to establish if the Nurse Staffing Level - Workforce Planning Template had been completed correctly and approved by the appropriate staff. In all cases the form had been completed correctly. The Health Board's Nurse Staffing Levels (Wales) Act 2016 Operating Framework confirms the personnel that should approve the ward staffing levels which includes the Ward Sister / Charge Nurse, Senior Nurse, Head of Finance, Head of Workforce, Executive Nurse Director, Director of Finance and Chief Operating Officer. However, there were instances identified whereby the forms had not been signed by all the required personnel.	Harm to patients due to inadequate nurse staffing levels.
Recommendation	**Priority level**
The Nurse Staffing Levels - Working Planning Template should be signed off by the approved personnel in line with the requirements of the Health Board's Operating Framework, as confirmation that they approve the staffing levels.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The completion of signing off the staffing templates has proved a challenge, given the timescales following validation of data and reporting to Board, due mainly to annual leave of key people during the time required. There have been instances where all signatures are present but have been placed in the incorrect boxes. We continue to learn from each staffing cycle (every 6 months) with an expected improvement.	Jason Roberts, Deputy Executive Nurse Director – May 2019

Finding 2 - Displaying Nursing staff levels (Operating effectiveness)	Risk
The Nurse Staffing Levels (Wales) Act 2016 Operating Guidance confirms that Health Boards are required to inform patients of Nurse staffing levels for each ward. Audit reviewed a sample of 13 wards to establish if the Nurse staffing levels were being displayed and that the information was correct. From the sample of 13 wards visited the findings identified are as follows: • West 6, West 4, East 2, A4, A6N, A1 and B4 - The Nurse staffing levels were being displayed and the establishment agreed to the establishment levels in the Summary of the Nurse Staffing Levels that was taken to the Board on the 25 October 2018; • Ward A7, ward C5 and B1 - The Nurse staffing levels form being displayed outside the ward were checked to the Board report of Nurse Staffing Levels dated 25 October 2018 and there was a difference in the Nurse staffing levels being reported. However, the Nurse staffing levels recorded on the form displayed outside the ward agreed to the Nurse staffing levels report that went to the Board on the 31 May 2018; and • A2, West 1 and ward A5 - The ward staffing levels were not displayed on the board outside the ward. Audit was advised that the ward staffing levels were not being displayed for A2 as staff were previously on A1 Link and moved to A2 and then staff from Heulwen also merged with A2 ward.	Non-compliance with the requirements of the Nurse Staffing Levels (Wales) Act)

Recommendation	Priority level
Management should ensure that all wards display the ward staffing levels to inform the patients of Nurse staffing levels for each ward. Management should ensure that the Nurse staffing levels being displayed are correct and up to date.	**Medium**
Management Response	**Responsible Officer/ Deadline**
We have found that at times, there have been oversights in the ward displaying the correct staffing data. There are a number of reasons for this such as, wards moved, or staffing level amendments agreed with Board, however taking some time for the ward to display the correct information. I note that on three wards the information was not displayed at all. All ward Sisters therefore have been reminded on the importance and expectations to display the appropriate correct data	Jason Roberts, Deputy Executive Nurse Director – July 2019

Finding 3 - Health Board Nurse Staffing Level Standard Operating Procedure (Control design)	Risk
Audit reviewed the Health Board's 'Nurse Staffing Levels (Wales) Act 2016 Operating Framework' against the Nurse Staffing Levels (Wales) Act 2016 and the document was consistent and compliant with the Act. The Nurse Staffing Levels Operating Framework has been approved by the Health Board and is currently with the All Wales Project Lead (along with all the other UHB Frameworks) for consistency checking and therefore it has not yet been published on the Health Board Intranet.	Lack of awareness of the requirements of the Act.
Recommendation	**Priority level**
Management should ensure that following the consistency check of the Operating Framework the document should be published on the Health Board Intranet.	**Low**
Management Response	**Responsible Officer/ Deadline**
The Operating framework is with the All Wales Group for final approval.	Jason Roberts, Deputy Executive Nurse Director – July 2019

Finding 4 - Funded establishments (Operating effectiveness)	Risk
Audit reviewed the Budget reports for staff against the Nurse Staffing Level reports for the 5 selected wards to establish if they corresponded. For 4 wards the staffing on the Finance reports agreed or there was only a minimal, immaterial difference to the Nurse Staffing Level reports. However, on Ward West 4 there was a difference of 6 Whole Time Equivalent (WTE) staff, as the Finance report confirmed the budget for WTE as 21.91 including 0.80 Admin staff whilst the Nurse Staffing levels states 27.32. The Ward Manager advised that the actual nursing establishment is 27.32 WTE for a 22 bedded ward whilst the ward is only funded for 15 beds.	Non-compliance with the requirements of the Nurse Staffing Levels (Wales) Act
Recommendation	**Priority level**
The Finance budgeted report for the WTE staff should be amended to align with the correct Nurse staffing levels and the number of beds on the ward.	**Low**
Management Response	**Responsible Officer/ Deadline**
It is proposed that the finance report will align to the correct Nurse establishment following the completion of the 3rd staffing calculation cycle currently being undertaken	Jason Roberts, Deputy Executive Nurse Director – July 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

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

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

Previous review rating Reasonable Assurance

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Distribution	Geoff Walsh, Director of Capital, Estates and Facilities Jeremy Holifield, Head of Capital Planning
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 project aims to provide accommodation to support the future configuration of specialist neuro and spinal rehabilitation at University Hospital Llandough and elderly care services at St David's Hospital in Cardiff, thus enabling the UHB to progress the decommissioning of Rookwood Hospital.

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

The project was last audited in 2017/18, with Reasonable Assurance determined. At that time, the Full Business Case was being updated to reflect the change in the Contractor.

Subsequently, the Welsh Government has announced on 2 November 2018 funding of £30.88m for the new unit, based on a start on site in January 2019 and handover in September 2020:

	(£)
Works Costs	18,736
Fees	3,342
Non-Works	2,587
Equipment Costs	530
Planning Contingency	1,749
Subtotal excluding VAT	**26,944**
VAT @ 20% less reclaimable	3,937
FBC Total Capital Cost	**30,881**

2. Scope and Objectives

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

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

- **Follow up -** review the status of previously agreed audit recommendations and associated management actions.
- **Governance Arrangements -** assurance that appropriate governance arrangements were in place for the current project phase,

including the operation of effective reporting / accountability lines and that appropriate approvals were in place.

- **Market Testing / Target Cost Production –** assurance that the Project Board was effectively informed on any impact on the value for money assessment.
- **Contract Management –** assurance that contractual costs were robustly agreed and that appropriate contractual documentation was in place.
- **Project Management –** assurance that project management tools and risk control frameworks were employed to deliver the project.

3. Associated Risks

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

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

General compliance was noted with the established control frameworks in each of the objective areas sampled, particularly in relation to project governance.

The overall assurance determined is cognisant of the recommendations made to enhance the control environment and the current stage of the project (i.e. early in the construction programme).

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

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

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

5. Assurance Summary

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

Assurance Summary					
1	Follow Up				✓
2	Governance				✓
3	Market Testing / Target Cost Production				✓
4	Contract Management			✓	
5	Project Management			✓	

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

Design of Systems/Controls

The findings from the review highlighted **1** issue that is classified as a weakness in the system control/design for managing the requirements of the re-provision of Specialist Neuro and Spinal Rehabilitation and Elderly Care Services from Rookwood Rehabilitation Hospital.

Operation of System/Controls

The findings from the review highlighted **2** additional issues that are classified as weaknesses in the operation of the designed system/control for managing the requirements of the re-provision of Specialist Neuro and Spinal Rehabilitation and Elderly Care Services from Rookwood Rehabilitation Hospital.

6. Summary of Audit Findings

Follow Up

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

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

Closed	Outstanding	Superseded	Total
1	-	-	**1**

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

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

Governance

We sought assurance that appropriate governance arrangements were in place for the current project phase, including the operation of effective reporting / accountability lines and that appropriate approvals were in place.

There were no revisions to the governance structure observed at the previous audit; noting the decision was taken to defer the Project Team meetings and for all Rookwood related issues to be discussed at the Capital Management Group meetings, until approval to the revised Full Business Case (FBC) was obtained.

Project team meetings were re-established in November 2018, following FBC approval and had been held monthly to date. Accountability to the Board continued to be demonstrated via the Specialist Services Major Project Board.

The Project Execution Plan (PEP) was updated in January 2019 confirming the structure to achieve the project objectives.

Written approval from the Welsh Government was evidenced with communication to the UHB Board provided on 29 November 2018.

Noting the above, **substantial assurance** has been determined in respect of governance arrangements applied at the project to date.

Market Testing / Target Cost Production

We sought assurance that the Project Board was effectively informed on any impact on the value for money assessment.

The contractor issued a tender for the works in June 2018 for £19,699,190. The Cost Advisor undertook market testing of the packages to ensure value for money in reaching the sum.

The amounts obtained through the market testing were directly reconciled to the cost plan for the works packages. A review of a sample of market tested packages was undertaken:

- 8 relating to UHL works (tested 71% of the works value [£13,045,285]); and
- 6 relating to CRI works (tested 56% of the works value [£3,274,258]).

For all packages, review of the supporting documentation confirmed that value for money had been determined. In the identification of the preferred contractor in all instances bar one the lowest tender that had been selected. There was one package [UHL Groundworks, Site Works & Drainage] where the lowest was not the preferred contractor, however an appropriate explanation for selection was evident.

In view of the above, **substantial assurance**, has been determined in respect of the market testing and cost production exercise.

Contract Management

We sought assurance that contractual costs were robustly agreed and that appropriate contractual documentation was in place.

The procurement strategy was documented within the FBC and agreed for both the contractor and advisers. The procurement route, documented as being followed for the project, was the All Wales Capital Programme utilising the SCAPE Framework.

Full contract documentation was in place for the construction phase of the project prior to the commencement of works; and signed in accordance with delegated limits.

A letter of intent was issued by the UHB's Director of Capital, Estates & Facilities on 20 November 2018 to proceed, ahead of the formalisation of the main contract sum being finalised and a formal contract issued. The letter of intent sought to authorise enabling works associated with the relocation project at University Hospital up to a maximum of circa £571k **(recommendation 1)**.

Noting the project utilises the SCAPE framework, as opposed to Designed for Life framework, Key Performance Indicators (KPIs) will need to be completed allowing effective monitoring and appropriate early corrective action(s) as necessary **(recommendation 2)**.

Noting the above, **reasonable assurance**, has been determined in respect of contract management for the project.

Project Management

We sought assurance that project management tools and risk control frameworks were employed to deliver the project.

Appropriate project management arrangements and tools had been applied to date at the project [refer also to the *Governance* section above].

The Change Management strategy was included within the approved FBC.

The project risk register included in the FBC provided a total quantified risk of £1,750,000 of which £1,167,000 was attributable to the contractor and £583,000 to the UHB. The risk contingency at the latest Welsh Government dashboard report reviewed reflected the above [December 2018].

In the interim, management has updated the risk register [dated February 2019] so that quantified risks reflected only the UHB risks of £583,000 – contractor risks [10 risks in total] are no longer costed and it is assumed that these risk are now included within the agreed contract works costs. The WG dashboard should be adjusted accordingly to accord to the internal reporting **(recommendation 3)**.

In the context of the stage of the project at the point of our review, **reasonable assurance** has been determined.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Current year recommendations	-	2	1	**3**

Finding: Contract Documentation	Risk
A letter of intent was issued by the UHB's Director of Capital, Estates & Facilities on 20 November 2018 to proceed, ahead of the formalisation of the main contract sum being finalised and a formal contract issued. The letter of intent sought to authorise enabling works, associated with the relocation project at University Hospital, up to a maximum of circa £571k. An internal project issues form had been prepared by the Cost Advisor setting out the scope and value of the enabling works. The form had been authorised [15 November 2018] by the Deputy Chief Executive and UHB Chair However, letters of intent do not afford the UHB with the same legal protection as a contract, and in the event of a dispute, are unlikely to provide sufficient detail to enable satisfactory resolution of issues [for example, they do not specify the value of delay damages to be paid]. 'Managing Reality' is produced by the NEC as practical support guidance for the administration and application of the NEC Contract (as utilised at this project). It states: *"Issuing letter of intent should be avoided if at all possible. The Employer should never be in a situation where in order for the works to start, a letter of intent has to be issued because the contract is not in place".*	Letters of intent do not afford the same legal / financial protection as an executed contract.

This view is supported by NWSSP: Specialist Estates Services. Management advised that other options were considered, e.g. separate contract for enabling works), however these were deemed less practical in this instance. Management sought to minimise the risk by capping the value of the works, detailing the full terms of the proposed contract and obtaining executive approval to the approach. It is noted that the cap was not exceeded and that formal contract documentation was in place at the time of the review.	
Recommendation 1	**Priority level**
Letters of intent should only be utilised on an exception basis at future projects **(O)**	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Director of Capital, Estates & Facilities At future projects

Finding: Key Performance Indicators	Risk
As best practice, Health Boards should use the Key Performance Indicators (KPIs) that have been developed for the operative framework. Noting that this procurement is via the SCAPE framework, at the current stage of the project, a formal performance management process was not evident. As set out in the SCAPE Framework Agreement, partners are required to provide performance data on all live projects to SCAPE on a monthly basis. Data will be reviewed by the relevant framework manager to identify any slippage and to work with the partner to take action.	Proactive performance management cannot take place; poor performance goes unaddressed.
Recommendation 2	**Priority level**
A formal SCAPE KPI process should be introduced at the project, to monitor the performance of the contractor. **(D)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Head of Capital Planning With immediate effect

Finding: Dashboard Reports	Risk
The latest version of the 'mandated' Welsh Government dashboard return, available for the project was for the period to December 2018. At the date of this review, whilst it was evident that work had commenced [enabling works] and the risk register had been reviewed and reduced, these were not reflected within the dashboard submission. It is important that the WG dashboard and relevant internal reporting reconciles, to ensure the correct position is reported and assessed.	Poor financial control and risk management over the project.
Recommendation 3	**Priority level**
The monthly Welsh Government dashboard reports should reconcile with internally generated cost, progress and risk reporting. **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed; future returns will be reflective of changes.	Head of Capital Planning April 2019

Previously Agreed Audit Recommendations:

Prior ref	Recommendation	Action / Status	Updated responsibility and timescale	Current year priority rating
Low				
1	At future schemes contract documentation will be signed prior to the commencement of the respective commissions/ works (O)	**Closed** Further to the previous IA report, the contract documentation had been issued to the SCP and Advisors specific to the Construction and Delivery of Rookwood Relocation works at CRI and UHL. As has been stated within this report, the contracts were signed [31 December 2018] prior to the agreed commencement date of the work [7 January 2019].	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*

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

Cardiff and Vale University Health Board

PCIC Interface Incidents

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	C&V-1819-29
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Auditor/s:	Ian Virgill, Deputy Head of Internal Audit
	Kimberley Rowe, Principal Internal Auditor
Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Lisa Dunsford, PCIC Director of Operations
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	Carol Evans, Assistant Director of Patient Safety & Quality
	Helen O'Sullivan, PCIC Quality & Safety Manager
	Rachel Armitage, PCIC Quality & Safety Officer
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 Interface Incidents 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').

It is vital that patient safety incidents that could have harmed or actually did harm a patient are reported so they can be learnt from and any necessary action can be taken to prevent similar incidents from occurring in the future. The Health Board uses the E-DATIX Incident reporting system to facilitate this process.

Unfortunately, Cardiff and Vale General Practitioners (the 'GPs') do not have direct access to the Datix system. Therefore, an Interface Incident Reporting System for recording and monitoring interface incidents was implemented in May 2016. Interface incidents are classed as incidents which have been reported by a GP practice regarding an issue in secondary care. Commonly reported incidents include lost referrals, patient follow up concerns and problematic hospital discharges.

It is noted that GP practices have an alternate Serious Event process in place as part of the contract monitoring arrangements which they follow for the initial recording and management of serious incidents.

In order to improve the efficiency of the interface incidents system and ensure that effective and sustainable actions are taken locally to reduce risk, a continued review of the Interface reporting system will be taking place with stakeholder engagement, from the UHB corporate quality and safety team, LMC, local GP's, Primary Care governance team with involvement of the PCIC Director of Nursing.

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 Interface Incidents, 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 incidents detected by GPs relating to interface incidents are appropriately reported, recorded, communicated and acted upon to reduce the risk of re-occurrence.

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

- There are appropriate local procedures and processes in place for the reporting and management of interface incidents;
- Reported interface incidents are recorded on Datix and appropriately

communicated within the Health Board and externally as required;

- Reported interface incidents are subject to an appropriate investigation within the required timescales;
- Action plans are developed, approved and implemented where issues have been identified and feedback is provided to relevant individuals;
- Reporting of interface incidents complies with all external requirements (including Welsh Government);
- Periodic reports on the management of interface incidents, including identification of trends and lessons learned, are produced and shared with appropriate management/groups; and
- Robust plans are in place for reviewing, updating and improving the interface incident reporting process.

3. Associated Risks

The potential risks considered in this review were as follows:

- Incidents occurring within GPs are not effectively reported and managed;
- Lessons are not learned and actions are not taken to prevent re-occurrence of incidents; and
- Required improvements to the interface incident reporting process are not identified or implemented.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with PCIC Interface Incidents Reporting 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.

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

The audit notes that the management of the interface incidents reporting process prior to the time of our review, had been adversely effected by the loss of the dedicated Admin support for over a year. However, the filling of the PCIC Quality and Safety Officer role, in conjunction with support from the Patient Safety team, means that the backlogs of logging incidents in Datix have been cleared.

Despite this improvement, there is recognition that there remains little engagement and communication with General Practitioners and this can be seen as a recurring theme throughout the findings in Appendix A.

It is acknowledged that the interface incident reporting system was put in place as an additional, voluntary process introduced to monitor incident trends and highlight potential improvements. GP practices are required to manage their own incidents through the GMS contract and report any significant events through the Health Board's Assistant Medial Director (AMD). However, interface incidents are currently only being regularly reported by a minority of GP practices which creates the risk that the Health Board is not aware of all interface incidents occurring. Whilst the level of reporting needs to increase, achievement of this would have a significant impact given the current resource available to manage the process.

The current interface incident reporting process was introduced as a temporary system and there was an intention to commence scoping the roll out of Datix to GPs in the autumn of 2018, in order to make the reporting and management of incidents within Primary Care more efficient. Whilst preliminary scoping has been undertaken, the Health Board is still utilising the current system for managing interface incidents.

Whilst the audit has highlighted a number of weaknesses in the current interface incidents process, the overall assurance rating of reasonable assurance reflects the lower level of risk associated with the stated purpose of the system.

5. Assurance Summary

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

Assurance Summary					
1	Reporting and Management		✓		
2	Recording on Datix and Communication within Health Board			✓	
3	Investigation of Reported Incidents				✓
4	Action Plans for Issues and Feedback			✓	
5	Periodic Reports are Produced and Shared				✓
6	Reviewing, Updating and Improving the Process		✓		

** 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 PCIC Interface Incidents Reporting.

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 Interface Incidents Reporting.

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 the reporting and management of interface incidents.

The following areas of good practice have been noted:

- The recently recruited Quality and Safety Officer is responsible for managing the recording and reporting of incidents on a weekly basis; and

- Considerable efforts have been made between the PCIC Q&S team and Patient Safety to ensure the backlog of interface incident reported to date have been cleared and logged on Datix.

The following significant findings have been noted:

- PCIC currently act as a conduit of communication flow between primary and secondary care, which is not deemed effective and is intensive to manage. Out of approximately 64 practices, only 6 are regularly using the interface incident reporting process and the volumes of incidents reported therefore have the potential to increase substantially with the engagement with more practices;
- Currently General Practitioners are using the interface incidents process to raise administration issues that are not necessarily patient safety or incidents that would usually be reported within Datix. Whilst these are sanctioned by the Welsh Health Circular, the volumes could potentially overshadow reports of serious incidents;
- There is currently little engagement with the GPs regarding the interface incidents process.

Obj 2: Reported interface incidents are recorded on Datix and appropriately communicated within the Health Board and externally as required.

The following areas of good practice were noted:

- All sampled reported incidents from Primary Care were found to be recorded within the Datix system; and
- 14 out of 15 of these reports were done using the standard interface incidents form or the agreed style communication letter.

No significant findings were identified.

Obj 3: Reported interface incidents are subject to an appropriate investigation within the required timescales

The following area of good practice was noted:

- Once an incident has been recorded within Datix, they are either closed by the PCIC Q&S Officer if it is clear that no further investigation is required, or they are assigned an incident manager within Secondary care to deal with. From the sampled testing of 15 reports, 3 were closed by the PCIC Q&S Officer, and the remaining 12 were assigned an incident manager within the hospital.

No significant findings were identified.

Objective 4: Action plans are developed, approved and implemented where issues have been identified and feedback is provided to relevant individuals.

The following area of good practice was noted:

- Once a report is sent to the PCIC mailbox, the sender receives an automated response to instruct them of the ongoing procedure for investigating and feeding back results.

The following significant finding was identified:

- The commentary provided in Datix by the Directorates following investigations of individual incidents is brief and therefore it is difficult to decipher how incidents have been resolved, what lessons have been learnt and improvement changes made for the future.
- The process for tracking interface incidents in Datix and providing feedback to Primary Care following closure of the incident needs to be strengthened.

Obj 5: Periodic reports on the management of interface incidents, including identification of trends and lessons learned, are produced and shared with appropriate management/ groups.

The following areas of good practice were noted:

- The Quality and Safety team have been undergoing theme and trend work to identify potential areas of improvement and have begun working on this with secondary care directorates. This work predominantly revolves around tightening the controls of discharge summaries within Emergency teams and respective Women and Children directorates;
- E-Datix has been customised to include a suite of readily available reports and dashboards to enable indicators to be monitored and user work lists easily accessible; and
- Interface incidents are included in the Quality and Safety dashboard that forms a key agenda item at the PCIC Quality, Safety and Experience Committee and therefore has regular exposure to management.

No significant issues were identified under this objective.

Obj 6: Robust plans are in place for reviewing, updating and improving the interface incident reporting process.

The following area of good practice was noted:

- The Patient Safety team have worked alongside the PCIC Q&S team to help embed the current interface incidents process and clear the backlog of reporting onto Datix.

The following significant finding was identified:

- There has been no progress on designing implementation plans for the roll out of Datix to the GPs. The PS team intend to draw on experience of secondary care Datix implementation to plan the primary care roll out. To date there has been no engagement with the GPs on this subject or any firm training or education plans for the new interface incidents process. Initial conversations indicated a timescale for Datix to commence scoping the roll out in autumn 2018; however, further progress due to current vacancies within the PS team, means this has been delayed until 2019.

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**	**4**	**4**	**9**

Finding 1 - EDatix rollout to GPs (Control design)	Risk
PCIC currently act as a conduit of communication flow between primary and secondary care, which is not deemed effective. There have been approximately 300 reports since the process began (81 incidents have been reported in the past 6 months) and it is therefore labour intensive to manage. Out of approximately 64 practices, only 6 are regularly using the interface incident reporting process. The Patient Safety team have worked alongside the PCIC Q&S team to help embed the current interface incidents process and clear the backlog of reporting onto Datix. There has however, been limited progress on designing implementation plans for the roll out of Datix to the GPs. The PS team intend to draw on experience of secondary care Datix implementation to plan the primary care roll out. To date there has been no engagement with the GPs on this subject or any firm training or education plans for the new process. Initial conversations indicated a timescale to commence scoping the requirements for Datix roll out in Autumn 2018; however, due to current vacancies within the PS team and other system developments required on other modules, for example, the complaints module, initial scoping has been limited and further work was delayed until 2019.	Required improvements to the interface incident reporting process are not identified or implemented

Recommendation	Priority level
Plans should be devised for the proposed roll out of Datix to GPs, this should include, but not be limited to: • Establishing realistic timescales for implementation; • Engagement with GPs; • Communication with other Health Boards who have already rolled out Datix to their Primary Care providers; • Developing a training and education plan for use of the system; and • Consideration of access levels and role assignments.	**High**
Management Response	**Responsible Officer/ Deadline**
The Patient Safety team (PST) have already carried out some preparatory work which has included: • Work with IT to explore Firewall issues • Visits to ABMUHB and BCUHB to share learning from their experiences of rolling this out • Consultation with All Wales Datix administrators group. November 2018 – the Patient Safety team is currently recruiting to a key vacancy in the Datix team. Once the vacancy has been filled, the PST can review the current Datix workplan and re-commence an implementation plan for the roll out of the incident reporting module of Datix to GP'S by December 2020.	Head of Patient Safety / March 2019 Review September 2019

Finding 2 - Errors categorised as Interface Incidents (Operating effectiveness)	Risk
Currently General Practitioners are using the interface incidents process to raise administration issues that are not necessarily patient safety or interface incidents that would usually be reported within E-Datix. Whilst these are sanctioned by the Welsh Health Circular, the volumes could potentially overshadow reports of serious incidents.	Incidents occurring within GPs are not effectively reported and managed
Recommendation	**Priority level**
There should be continued engagement and education with GPs to ensure they are categorising issues correctly within the interface incidents remit and are highlighting those reports that contain a major risk or potential harm.	**Medium**
Management Response	**Responsible Officer/ Deadline**
In July 2018 the PST in partnership with PCIC have undertaken work to develop an incident trigger list, to improve the quality of and the appropriateness of what is reported on the system. Regular contact is made with practices and the LMC relating to patient safety issues.	PCIC Clinical Board / Complete

Finding 3 - Completeness and Time lag (Operating effectiveness)	Risk
The interface incident process was introduced to monitor incident trends and highlight potential improvements. The effective operation of the process is reliant on the timely reporting of interface incidents. Review of a sample of 15 reported interface incidents identified that 3 were reported to the PCIC over 30 days from the incident occurring (7/15 tested an incident date could not be determined, 5/15 tested were less than 30 days).	Incidents occurring within GPs are not effectively reported and managed
Recommendation	**Priority level**
PCIC should communicate the importance of reporting interface incidents in a timely manner.	**Low**
Management Response	**Responsible Officer/ Deadline**
Practices already deal with serious issues relating to interface incidents by contacting the secondary care dept themselves and dealing with the matter direct, this is supported by the LMC and GMC in their guidance for Independent contractors working within the GMS contract.	PCIC Patient safety Manager / Complete

Finding 4 - Reliance on one officer (Control design)	Risk
The interface incidents process is predominantly managed by one member of staff, the PCIC Quality and Safety Officer. The incoming reports are not monitored during periods of absence and there is currently no standard operating procedure to document the processes followed in this role. Due to the volume of incidents reported, during testing it was found that 6/15 of the incidents were entered into Datix over 7 days after they were reported to PCIC.	Incidents occurring within GPs are not effectively reported and managed
Recommendation	**Priority level**
In addition to the recommendation to consider future workforce plans, a Standard Operating Procedure should be written that encompasses the entire Q&S Officer role in relation to Interface Incidents.	**Low**
Management Response	**Responsible Officer/ Deadline**
An agreed pathway is already in place that has been supported by the LMC, staffing pressures sometimes result in delays inputting the information into Datix from PCIC staff, however the risk of the delay affecting patient care or patient outcomes is extremely low as practices will have already dealt with the incident and are sending the information to PCIC for information and recording in the Interface incident process.	C Evans, Head of Primary Care Operations and Delivery / Complete

Finding 5 - Formal Action Plans (Control design)	Risk
The commentary provided in Datix by the Directorates following investigations of individual incidents is brief and therefore it is difficult to decipher how incidents have been resolved, what lessons have been learnt and improvement changes made for the future.	Lessons are not learned and actions are not taken to prevent re-occurrence of incidents
Recommendation	**Priority level**
The Patient Safety team should remind Clinical Boards and Directorates of the requirement to ensure that interface incident reports within Datix contain sufficient detail of actions taken and outcomes are clear.	**Medium**
Management Response	**Responsible Officer/ Deadline**
This would not be the role of the PST. The UHB Incident, Hazard and near miss Reporting procedure clarifies the roles and responsibilities of the Clinical Boards: 'The **Clinical/Service Board Management teams** are responsible for ensuring that staff within their Board are briefed on their individual and collective responsibilities within the incident reporting process. They must ensure that all incidents are reported, investigated and analysed, so that learning and improvements can be embedded in practice' The **Patient Safety Team** and **Health, Safety and Environment Unit** are responsible for supporting the implementation of this procedure. They will also undertake to raise staff awareness and training on incident reporting and investigation.	

PCIC Clinical Board work closely with the Patient Safety team and have developed robust incident management processes through training and awareness as sessions and the development of operational guidance documents for circulation to internal and external stakeholders.	PCIC Clinical Board/ Head of Patient Safety/ as required Complete

Finding 6 - Engagement with GPs (Operating effectiveness)	**Risk**
Despite initial efforts to establish an interface working group, there is little engagement with the GPs regarding the interface incidents process. There is currently no training or education program in place.	Incidents occurring within GPs are not effectively reported and managed
Recommendation	**Priority level**
Efforts should be made to engage with all GP practices, especially those that do not regularly report interface incidents. Consideration should be given to developing a training and education plan to improve the quality, timeliness and completeness of reporting from GPs.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The patient Safety team will work with PCIC as part of the Datix implementation plan to provide an appropriate training and education programme to GPs and other practice staff	PST / review Sept 2019

Finding 7 - Investigations drop off to do lists (Operating effectiveness)	Risk
Once an incident has been assigned an incident manager within Datix, it no longer appears on the Q&S officer to do list, therefore, there is no tracking of investigations or recognition of incident closures by PCIC. However, the incidents remain visible to the Q&S officer within their permissions on the system. Due to directorates then following the normal Datix procedure for secondary care, and little understanding of the specific interface incidents process, this results in no feedback to Primary Care when the incident has been closed.	Incidents occurring within GPs are not effectively reported and managed
Recommendation	**Priority level**
The Q&S Officer should review the list of Datix Reports opened by themselves, paying particular attention to those with overdue flags, to monitor that interface incidents are being progressed and closed. Engagement with Secondary Care directorates to ensure they are aware of the benefit of feeding back investigation results to Primary Care.	**Medium**
Management Response	**Responsible Officer/ Deadline**
PST – the way that permissions and profiles are set up in Datix means that once the incident is assigned to another user (e.g if an incident which involves the laboratories is passed on to the Laboratory manager) it remains visible to staff within the reporting area but also to those who need to respond and investigate the issue.	Patient Safety Manager and Patient Safety Officer Daily Review process Mon-Friday Complete

Presentations about the interface reporting process have been given at the UHB wide Datix super-user group so that Clinical Boards are aware of the process. Information was also included in the December 2018 Patient Safety and Quality Department newsletter.	

Finding 8 - Lack of Feedback to Primary Care (Operating effectiveness)	**Risk**
There is very little feedback provided from Secondary to Primary care in relation to incidents that have been reported. The PCIC Q&S team had intended to include an update to GPs through the Primary Care newsletter; however, this is no longer an option. Following audit fieldwork and as an alternative to the newsletter, an email was sent to all practice managers that contained the themed issues that emerged from reported incidents and the resulting investigation/improvement work undertaken. This is the first feedback that has been provided to GPs and in order to be effective, this needs to become a regular communication.	Lessons are not learned and actions are not taken to prevent re-occurrence of incidents
Recommendation	**Priority level**
Regular communication with GPs should be undertaken to make them aware of the actions taken following their reporting of interface incidents. This will inform them of improvements to processes as a result and encourage future engagement.	**Low**

Management Response	Responsible Officer/ Deadline
A paragraph in relation to the Interface process was included in the winter Patient Safety and Quality Newsletter. The UHB Medical Director and LMC are kept up to date with the interface incident process through the regular Primary/Secondary Care interface meetings.	Head of Patient Safety / Complete December 2018

Finding 9 - Secondary Care to Primary Care (Control design)	Risk
Whilst this report predominantly focusses on reporting interface incidents from Primary to Secondary care, it is noted that the current mechanism to report interface incidents from Secondary to Primary care is through Datix with the Q&S Manager listed as the Incident Manager. However, this process is reliant on Secondary care assigning these issues to PCIC and the current volume of reports are low.	Lessons are not learned and actions are not taken to prevent re-occurrence of incidents
Recommendation	**Priority level**
Consideration should be given to how feedback and incident reporting can be made a two-way process with continued engagement between Primary and Secondary care. This will need to include training of Secondary Care professionals in the current process of interface incidents reporting.	**Low**

Management Response	Responsible Officer/ Deadline
PCIC does receive incident notification from internal departments within the UHB which are managed in line with the agreed UHB process for incident management. PST –this issue has also been presented at the Datix Super user Group. Further information will be included on the Datix Intranet page.	PCIC Clinical Board Head of Patient Safety / 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.

Cardiff and Vale University Health Board

Medicine Clinical Board – Sickness Absence Management

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditor/s: Sharon Edwards, Principal Internal Auditor

Executive sign off: Steve Curry, Chief Operating officer

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Barbara Davies, Interim Lead Nurse

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 Absence Management within the Medicine 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 overall sickness absence rates within the Medicine Clinical Board are above the current Welsh Government Target percentage. Over the last 2 years the Clinical Board, supported by the Workforce Department, have been working to identify sickness absence 'hot spots'. The Workforce Department have then undertaken 'Deep dive' sickness audits within the identified areas and interventions have been introduced with the aim of reducing sickness absence levels.

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 Medicine Clinical Board for the management of Sickness Absence, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the 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, including the reasons for sickness being recorded on ESR;
- Managers are taking required action at the appropriate stages of sickness absence in accordance with the All Wales Sickness Management policy.
- Appropriate actions have been identified and effectively implemented within the Clinical Board to enable improved management of sickness absence and a reduction in sickness absence rates; and
- Effective processes are in place within the Clinical Board for recording and reporting sickness absence rates.

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 6 wards within the Clinical Gerontology Directorate:

- West 2 ward, University Hospital Llandough (UHL);
- East 6 ward, UHL;
- East 8 ward, UHL;
- A6 South ward, University Hospital of Wales (UHW);
- Elizabeth ward, St Davids; and
- Sam Davies ward, Barry Hospital.

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 Medicine Clinical Board Sickness Absence Management is **Reasonable Assurance**.

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

The audit has identified that the sampled wards had a good level of awareness of the All Wales Sickness policy and appropriate processes are in place to enable effective control and management. However, there is variation in the consistency with which those controls are being applied in practice. There is also a need to ensure all managers are fully aware of the new All Wales Managing Attendance at Work Policy.

It was identified that the required documentation is not always being completed for all episodes of sickness absence. Also, episodes of frequent, short term sickness absence are not always being effectively monitored to ensure that the required sickness interviews are identified and undertaken.

A number of the sampled wards have sickness absence levels above the current target levels. This is mainly due to the numbers of staff on long term sickness absence. However our review identified that the appropriate meetings, support and other interventions are being undertaken to manage instances of long term sickness.

Sickness absence management training is provided to key managers and the Workforce department provide additional training and support to identified hot spot areas. The findings of the audit have however highlighted the need to ensure that additional training is provided when there are changes in ward management and further interventions are targeted at those wards where a lack of compliance has been identified.

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.			✓	

Assurance Summary					
2	Sickness absence is appropriately recorded, monitored and managed.		✓		
3	Management taking required actions at appropriate stages.			✓	
4	Clinical Board actions to improve sickness absence management.			✓	
5	Recording and reporting of sickness absence.			✓	

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for Medicine 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 Medicine CB – Sickness Management.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: There are appropriate sickness absence management policies and procedures in place and these are available to all staff.

The following areas of good practice were noted:

- Discussions with the Ward Managers from each of the 6 wards reviewed confirmed that they were all aware of the previous All Wales Sickness Management Policy.
- Each ward has processes in place for managing sickness absence in accordance with the requirements of the All Wales Policy.

- Copies of the All Wales Sickness Management Policy and associated sickness absence procedure documents are readily available to all staff members on the wards.

The following significant finding was noted:

- Managers across the 6 sampled wards were unaware that a new All Wales Managing Attendance at Work Policy was replacing the previous All Wales Sickness Management Policy.

Objective 2: Sickness absence is appropriately recorded, monitored and managed in accordance with local procedures and the All Wales Sickness Management Policy, including the reasons for sickness being recorded on ESR

The following areas of good practice were noted:

- Within 4 of the 6 wards reviewed, the majority of sickness absence episodes tested were effectively managed, in accordance with the requirements of the All Wales policy. Only a small number of individual instances of non-compliance were identified.
- Where reasons for absence are recorded on the self-certificate forms these are effectively recorded into ESR.

The following significant findings were noted:

- Within wards A6 at UHW and East 8 at Llandough, more significant issues were identified around the management of sickness absence episodes. Self-certificates and Return to work interviews were not completed for all episodes and the reasons for absence were not always recorded on self-certificates.

Objective 3: Managers are taking required action at the appropriate stages of sickness absence in accordance with the All Wales Sickness Management policy.

The following areas of good practice were noted:

- Frequent short term sickness is being effectively managed within wards East 6 at UHL, A6 at UHW and Sam Davies at Barry. Triggers for all the sampled staff were appropriately monitored and any required informal or formal interviews were completed.
- Long term sickness absence is being effectively managed across all of the sampled wards with required interviews completed, referrals to Occupational Health where required and appropriate support from Workforce colleagues.
- It is noted that the levels of sickness absence were particularly high within Elizabeth ward at St David's. This is due to a number of members of staff being on long term sickness absence. Our review identified that

all required interventions were being appropriately undertaken in order to manage these absences.

The following significant findings were noted:

- Instances were identified across 3 of the sampled wards where employees frequent short term sickness absence wasn't being effectively managed. A number of triggers weren't identified and informal or formal interviews were not therefore undertaken when required

Objective 4: Appropriate actions have been identified and effectively implemented within the Clinical Board to enable improved management of sickness absence and a reduction in sickness absence rates.

The following areas of good practice were noted:

- Sickness management training sessions have been held for ward managers and assistant ward managers.
- Monthly and / or quarterly discussions on sickness levels are held between each ward and the relevant Senior Nurse / Directorate Lead Nurse; and
- Ward staff will contact Workforce for advice and support when dealing with specific sickness absence episodes.

The following significant findings were noted:

- A number of the sampled wards would benefit from additional training and support in order to ensure that sickness absence is consistently and effectively managed.

Objective 5: Effective processes are in place within the Clinical Board for recording and reporting sickness absence rates.

The following areas of good practice were noted:

- The Workforce department produce regular reports on Directorate and wards sickness absence levels.
- Managers are able to access information on their sickness absence levels through the ESR system.

The following significant findings were noted:

- A number of the sampled ward managers stated that they do not consistently receive sickness absence reports from Workforce.

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**	**3**	**1**	**5**

Finding 1 – Management of individual sickness absence 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 employee sickness absence episodes from each of the 6 wards (60 in total) to establish if self-certificates and Return to Work documentation were available, completed correctly and within a timely manner. Minor findings were noted across 4 of the sampled wards but more significant issues were identified within East 8 and A6 South as follows: **Ward East 8 UHL** Review of the ten sampled staff identified the following issues: • There was no self-certificate on file for 2 of the episodes; • There was no reason for absence recorded on 7 of the 8 completed self-certificates; • There was no copy of a completed return to work interview form on file for 2 of the episodes; and • A further 2 return to work interviews were completed more than 7 days after the employee actually returned to work. **Ward A6 South UHW** Review of the ten sampled staff identified the following issues: • There was no self-certificate on file for 4 of the episodes;	Increased sickness absence levels due to inappropriate management of sickness absence episodes.

• There was no copy of a completed return to work interview form on file for 4 of the episodes; and • A further 5 return to work interviews were completed more than 7 days after the employee actually returned to work.	
Recommendation	**Priority level**
Management must ensure that all future sickness episodes are managed and documentation is completed in accordance with the requirements of the All Wales Managing Attendance at Work Policy. Management should ensure that a self-certificate is completed correctly and a return to work interview is held with the employee including the completion of the return to work form. Clinical Board management should consider introducing further periodic training on the sickness management process in order to increase awareness and compliance levels.	**High**
Management Response	**Responsible Officer/ Deadline**
• Re-circulate the All Wales Managing Attendance at Work Policy. • Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. • Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Ward Managers, Senior Nurses & Clinical Board Representative / 12th March 2019

Finding 2 – Management of frequent short term sickness absence (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 the numbers of sickness absence episodes for the sampled staff to establish if the sickness triggers had been monitored correctly and required interviews carried out in compliance with the All Wales Sickness Management Policy. The following issues were identified across the sampled wards: **Ward West 2 UHL** • One trigger was missed and a required informal interview was therefore not conducted. **Ward A6 UHW** • Triggers were missed for 6 of the 10 employees sampled and therefore required informal and / or formal interviews were not conducted **Elizabeth ward St David's** • One trigger was missed and a required informal interview was therefore not conducted.	Underlying causes of sickness absence may not be identified or addressed leading to increased sickness absence levels.

Recommendation	Priority level
Management should ensure that the sickness triggers are being managed correctly and all future required informal discussions and formal sickness interviews are carried out in accordance with the requirements of the All Wales Managing Attendance at Work Policy.	**Medium**
Management Response	**Responsible Officer/ Deadline**
• Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. • Confirm management expectations with Ward Managers in following the All Wales Managing Attendance at Work Policy. • Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Ward Managers & Senior Nurses / 1st April 2019

Finding 3 – New All Wales policy (Control design)	Risk
The testing carried out on the management of sickness absence episodes was completed against the requirements of the All Wales Sickness Management Policy in place prior to October 2018. However, at the time of testing the new All Wales Managing Attendance at Work Policy had recently been published and formally adopted by the Health Board. None of the 6 ward managers were aware that the new policy was being introduced. It is noted that the new policy includes changes to the triggers for managing frequent short term sickness absence.	Sickness absence is not managed in accordance with the latest All Wales policy requirements.
Recommendation	**Priority level**
Management must ensure that all wards are aware of the new All Wales policy and copies are available to all staff, Future changes in policy must be effectively communicated to all relevant staff.	**Medium**
Management Response	**Responsible Officer/ Deadline**
• Re-circulate the All Wales Managing Attendance at Work Policy. • Any changes to policy to be circulated via email and then to be s hared with ward staff.	Ward Managers & Senior Nurses / 1st April 2019

Finding 4 – Sickness absence training and information (Operating Effectiveness)	Risk
The Workforce department identify 'hot spot' sickness management areas within the Clinical Board, based on levels of sickness absence. These areas are then provided with additional support and advice in order to assist with the management of sickness absence with the aim of reducing levels. The issues identified as part of our review suggest that a number of wards would benefit from further intervention in order to ensure consistently effective management of sickness absence. It is acknowledged that a number of wards have had changes in ward managers which may have led to a loss of previously gained experience. Workforce also produce regular reports on Directorate and ward sickness absence levels. A number of the sampled ward managers however identified that they did not receive this information on a regular basis.	Ineffective processes are in place within the Clinical Board for recording and reporting sickness absence rates.
Recommendation	**Priority level**
Management should ensure that all current ward managers are provided with appropriate training to enable them to effectively manage sickness absence. A robust process should also be implemented to ensure that timely training is provided to any new ward managers.	**Medium**

Regular information on sickness absence levels should be consistently provided to all ward managers.	
Management Response	**Responsible Officer/ Deadline**
• Within Stroke Services, engaged with Human resources to provide further training for all members of the Leadership team. • Discussed with HR and now regularly circulating sickness data. • HR currently undertaking deep dives with high rate areas to provide useful supportive information about absence.	Ward Managers & Senior Nurses / 1st April 2019

Finding 5 – Recording of Sickness dates (Operating effectiveness)	**Risk**
It was evidenced from our testing that there were a number of inconsistencies across all six 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.	Incorrect / inconsistent recording of sickness absence dates.

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**
• Within Stroke Services, engaged with Human resources to provide further training for all members of the Leadership team. • Through Support and appraise, challenge can be placed upon the ward staff to ensure that appropriate input of data is reconciled.	Ward Managers / 1st 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.

CRI Safeguarding Works

Final Internal Audit Report

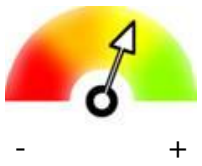
Cardiff & Vale University Health Board

2018/19

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance


CONTENTS

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Distribution	Geoff Walsh, Director of Capital, Estates and Facilities Jeremy Holifield, Head of Capital Planning
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 CRI Safeguarding project addresses remediation and stabilisation works on blocks 14 and 14A, and the Chapel, at the Cardiff Royal Infirmary (CRI). The work entailed protecting the fabric of the listed buildings, making the area suitable to accommodate therapy services as part of the re-provision of the Specialist Neuro and Spinal Rehabilitation Services from Rookwood Hospital; and to provide accommodation that is suitable for any longer term developments aligned to the UHB's 'Shaping Our Future Well-Being in the Community' programme.

Welsh Government funding was approved in the sum of £2.149m in January 2017. Subsequent to this, the project experienced a change in main contractor (following the decision of the original contractor to withdraw from this and related projects), and also an increase in scope, bringing the total project cost to £2.928m.

The funding shortfall was met in part (£280k) by disposal proceeds from Longcross House, with the remainder (£499k) supported by discretionary capital.

Work commenced on site in January 2018, with completion in September 2018.

The project was delivered within budget and to the revised programme completion date (adjusted by three weeks from the original contract completion date, due to additional work instructed by the UHB).

2. Scope and Objectives

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

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

- **Client Brief/ Approvals** – The client brief was adequately defined at the project outset and appropriate approvals to the progression of the development were obtained.
- **Selection & Appointment of the Contractor** – Appropriate arrangements were applied in the selection and appointment of the main contractor and advisers, and contract documentation was executed by all parties in a timely manner.
- **Cost and Programme Management –** Assurance that appropriate funding was in place. Arrangements were in place to monitor and review the financial performance and progress of project delivery

(including delays/extensions to the contract period etc.) and the management of project changes. All of the above contributing to the formulation of the final account.

- **Valuation/ Final Account** – Assurance that adequate processes and procedures were in place to ensure that the contractor was correctly reimbursed in accordance with the contract.
- **Project delivery (PPE/Benefits Realisation)** – determine whether there were any relevant issues that limited the successful delivery of the project and lessons learnt are captured to inform future developments e.g.:
    - Procurement approach;
    - Resource requirement;
    - Project management e.g. site issues, performance control issues (including advisers' performance); and
    - Quality e.g. defects.
- **Other** – Any other issues identified at the project affecting delivery.

3. Associated Risks

The potential risks considered in the review are as follows:

- Project may not have been effectively managed;
- Project over-runs on time and cost;
- Failure to achieve the required quality or anticipated benefits;
- Failure to apply lessons learned to future 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 following positive aspects were noted at the project:

- The project was delivered within budget and to the agreed revised programme;
- Appropriate business case and funding approvals were in place; and

- The final account was reviewed and confirmed to be appropriately calculated and supported.

However, it was noted that works were instructed on a letter of intent, the value of which was exceeded by March 2018. The project continued without corresponding contractual documentation. This was addressed two months after completion in December 2018.

Further enhancements have been recommended in respect of:

- the risk assessment of progressing work prior to full Listed Building Consent being received;
- the absence of a Project Execution Plan; and
- the approach to post project evaluation and benefits realisation assessment.

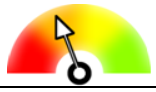
However, noting the largely positive delivery arrangements at the project, the effectiveness of the system of internal control in place to manage the risks associated with the delivery of the CRI Safeguarding project has been assessed as providing **Reasonable Assurance**.

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	Client Brief/ Approvals			✓	
2	Selection & Appointment of Contractor			✓	
3	Cost & Programme Management				✓
4	Final Account				✓
5	Post Project Evaluation / Benefits Realisation			✓	

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

Design of Systems/Controls

The findings from the review highlighted **one** issue that is classified as a weakness in the system control/design for managing the requirements of the CRI Safeguarding project.

Operation of System/Controls

The findings from the review highlighted **four** issues that are classified as weaknesses in the operation of the designed system/control for managing the requirements of the CRI Safeguarding project.

6. Summary of Audit Findings

Client Brief/ Approvals

We sought assurance that the client brief was adequately defined at the project outset, and appropriate approvals to the progression of the development were obtained.

The project was initially approved in 2016/17, by both the Health Board and Welsh Government, in the sum of £2.149m.

Subsequent to this approval, the original main contractor (appointed from the Designed for Life Framework) withdrew from the project, and a replacement contractor was appointed under the SCAPE framework (Note:

this contractor also withdrew from the related Rookwood Relocation project, which was reviewed in more detail in that project's 2017/18 audit report).

Following the change in contractor, the Health Board identified the opportunity to extend the client brief to encompass additional areas of building 14/14a and also the chapel, to benefit from the contractor's presence on site and the similarity of work required at these locations. Accordingly, the cost of the project increased to £2.928m.

A detailed report was prepared by the external cost adviser, setting out the benefits and costs of the increased scope of works. We confirmed the appropriate approval of this increased funding requirement, utilising disposal proceeds from Longcross House and discretionary capital funding.

Whilst listed building planning consent was initially secured in relation to the original scope of the project in December 2016, further formal consent in relation to the additional areas of work was not granted until July 2018; after work had commenced on these areas. Management advised that the risk here was considered to be low, noting the wider, ongoing discussions with the Local Authority in relation to works on the CRI site, and that the work undertaken did not alter the design of the original buildings in any way. Whilst recognising this, the risk was not noted to have been formally documented, approved or captured at the project risk register (**recommendation 1**).

A Project Execution Plan is an expected control set out in the Health Board's Capital Projects Manual, but was not utilised at the project. Such a document is beneficial in providing a central reference for detail such as the project scope and budget, organisation structure, risks and project management arrangements (**recommendation 2**).

However, noting that the required business case and funding approvals were in place, albeit with some timeliness issues, and the above are minor points of enhancement, **reasonable assurance** has been determined.

Selection & Appointment of the Contractor

We sought assurance that appropriate arrangements were applied in the selection and appointment of the main contractor and advisers, and contract documentation was executed by all parties in a timely manner.

As noted above, following withdrawal of the original contractor from the project, an alternative procurement route utilising the SCAPE framework was identified. The revised procurement and contract strategy was developed with input from NWSSP: Specialist Estates Services and found to have been appropriately reported and approved.

Works were instructed to commence in January 2018 under a Letter of Intent, to a maximum value of £212,600. Whilst noting that Letters of

Intent do not generally represent good practice, in that they do not afford the same legal protection as a full contract, management confirmed that this was an exceptional situation exacerbated by delays and the pressing need for the project to commence as soon as possible.

However, the main contract was not subsequently executed until after works had completed (works completed in September 2018, and the contract was executed in December 2018). The maximum value authorised under the Letter of Intent had been exceeded by March 2018.

Further issues with contractual arrangements were noted at the adviser delivery agreements, both being executed after the contract period had commenced (circa one month delay at each). Additionally, the construction phase agreement was signed by the Chair and Director of Corporate Governance, who are not in fact detailed in the Scheme of Delegation with regards to contract authorisation authority. It is recognised, however, that the financial commitment was additionally controlled via the delegated authorities in place within the UHB's financial system.

See **Recommendation 3** with regards the above issues.

Noting that the associated risk has now passed and a contract is in place a **reasonable assurance** has been determined. However, this issue is not insignificant and should be considered at future projects.

Cost & Programme Management

We sought assurance that appropriate funding was in place, and that arrangements were in place to monitor and review the financial performance and progress of project delivery (including delays/extensions to the contract period etc.) and the management of project changes.

The project was delivered within the overall funding envelope of £2.928m. Within this, an underspend of £90k was achieved against the Welsh Government (WG) contribution; with the WG approving the retention of this sum to offset against the discretionary capital commitment.

Contractual changes of £57,682 were observed, representing only 2.4% of the original contract sum. A sample of three of the largest changes were reviewed, and found to be appropriately authorised and supported.

Works were completed three weeks after the original contract completion date (with practical completion on 14th September 2018), with the revised completion date having been appropriately amended via adjustments to the programme end date, to accommodate the additional works requested by the UHB. The financial impact was funded from available contingencies.

Robust progress and cost reports were prepared by the external advisers on a monthly basis, with internal progress reporting via the Capital Highlight

reports presented on a monthly basis to the Capital Management Group (CMG).

In view of the above, **substantial assurance** has been determined in respect of cost and programme management for the project.

Final Account

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

The final account was signed-off on 16th January 2019, in the sum of £2,398,987.89.

As the project applied a NEC Option A contract, the final account comprised the fully complete costed activity schedule plus any agreed compensation events.

The final account and supporting documentation was reviewed, and found to appropriately substantiated. All compensation events had been appropriately authorised, and were supported by quotations where necessary.

Accordingly, **substantial assurance** has been determined in respect of the final account.

Post Project Evaluation & Benefits Realisation

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

Whilst a comprehensive post project evaluation procedure was documented at the business case (aligned to the Designed for Life Framework requirements), management subsequently determined that a dedicated evaluation exercise in respect of CRI Safeguarding works would not be undertaken. However, this has not been formally documented or approved.

It is recognised, however, that a workshop had recently been held to inform the delivery of the wider Rookwood Relocation project (in respect of working relationships and procedures), and management advise that lessons learnt from work on site during the CRI Safeguarding work were informally fed into the wider project.

Whilst a number of benefits were identified in the business case, as with the post project evaluation exercise, a benefits realisation exercise has not yet been undertaken. We are advised that management consider this to be more appropriate to undertake after completion of the wider project. Noting this, the benefit in relation to reduced maintenance costs did not

define the baseline measure, or the targeted reduction to be achieved from the investment.

(**Recommendations 4 & 5**).

Accordingly, it is acknowledged that it is planned to undertake a full post project evaluation and benefits realisation exercises at the completion of the main Rookwood Relocation work. Issues raised here relate to the formal agreement of the required approach. Accordingly, **reasonable assurance** has been determined at this stage.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	0	2	3	**5**

Finding 1 : Listed Building Planning Consent	Risk
Listed Building Consent for the original scope of work was provided in December 2016. Subsequent to this, as discussed elsewhere in this report, the scope of work was increased to include additional areas of the CRI site, including the Chapel. Work commenced on site in January 2018, and progress reports note that by June 2018 work to the Chapel was substantially progressed (e.g. *"Stained Glass Windows to Chapel ongoing (85%/75%), Chapel roof repairs and guttering (80%/75%)").* However, formal Listed Building Consent for these additional areas of work was not provided until July 2018. Management advised that the risk here was considered to be low, noting the wider, ongoing discussions with the Local Authority in relation to works on the CRI site, and that the work undertaken did not alter the design of the original buildings in any way. Whilst recognising this, the risk was not noted to have been formally documented and approved, or captured at the project risk register.	Project risks may not be appropriately assessed, approved and reported.
Recommendation 1	**Priority level**
Progression at risk should be fully documented, approved and recorded at the risk register (O).	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed.	Director of Capital, Estates and Facilities At future projects

Finding 2: Project Execution Plan	Risk
The NHS Capital Investment Manual, (which provides project management best practice guidance), defines a Project Execution Plan (PEP) as a: *"… core document for the management of a project. It is a statement of policies and procedures defined by the project director… It sets out in a structured format the project scope, objectives and relative priorities."* The UHB's Capital Projects Manual states: 2.2.4 Project Execution Plan It is the responsibility of the Project Manager to complete the *Project Execution Plan* during Stage 1. This document provides a full and firm foundation by defining/including the following project elements and documents ; ▶ Project Background ▶ Project Definition (including the *Stage Deliverables Checklist*) ▶ *Scoping Document for Major Capital Group* ▶ User Group Quality Expectations ▶ Project Organisation Structure ▶ Budget and forecast cost ▶ *Risk Register* ▶ *Project Programme* ▶ Communications Plan (captured within the *Schedule of Meetings* document) ▶ Procurement (of consultants, contractor and equipment) Once completed during stage 1, it is the Project Manager's ongoing responsibility to update the *Project Execution Plan* at the end of each Stage. A PEP was not prepared for the project, with management advising this was due to the size and nature of the project.	Lack of an up to date central reference point for project officers may reduce project control.

Noting that some project arrangements varied in practice from those set out in the Business Justification Case, a PEP would have been beneficial to define the actual arrangements at the project. Such changes included the project reporting and accountability structure, which was originally intended to be managed via the Specialist Rehabilitation and Clinical Gerontology Project Team (CGPT) and Specialist Services Major Projects Board (SSMPB). In practice, noting the nature of the project, and that the CGPT was stood down for the majority of the CRI works period, reporting was via monthly Capital Highlight Reports to the Capital Management Group.	
Recommendation 2	**Priority level**
A Project Execution Plan should be prepared at the outset of a project, in accordance with the Capital Projects Manual and best practice (O).	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Director of Capital, Estates and Facilities At future projects

Finding 3: Contractual Arrangements	Risk
Letter of Intent A letter of intent (LoI) was utilised at the main works, in advance of the full contract being executed. Letters of intent are not generally recommended, as they do not afford the Health Board with the same legal protection as a contract, and in the event of a dispute are unlikely to provide sufficient detail to enable satisfactory resolution of issues. It was further noted that the contract start and end dates were incorrectly detailed within the letter. It is recognised that management advise that the use of LoIs is not general practice within the UHB, with this being an exceptional situation due to the significant delays already experienced at the project and the pressing need for works to commence within the financial year. It was confirmed that the use of the LoI to the stated financial value of £212,600 was appropriately authorised by the Chief Executive, Director of Planning and Project Director. *Main Contract Documentation* The works contract was not fully executed until December 2018, whilst works had completed in September 2018. Therefore, there was no contractual agreement in place after the above sum of £212,600 was expended.	Letters of intent do not afford the same legal / financial protection as an executed contract. Longer term liabilities are not adequately addressed until the main contract is finalised and executed.

Adviser Appointments The pre-construction and construction delivery agreements with the external advisers were also executed after the contract start dates (both circa one month after the contract period had commenced). The construction phase delivery agreement with the external advisers does not appear to have conformed to the delegated remit set within the Scheme of Delegation. The agreement was signed by the Chair and Director of Corporate Governance, who are not listed as having delegated authority to complete contracts. It is recognised, however, that financial commitment would be additionally controlled by the delegated authorities within the UHB's financial system (ORACLE).	
Recommendation 3	**Priority level**
Sufficient contractual arrangements should be in place to safeguard the Health Board interests (O).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. This was an exceptional situation and the use of letters of intent is not standard practice within the department. We also accept that the contract should have been executed sooner. However, progression without a fully executed contract was considered to be a low risk to the Health Board.	Director of Capital, Estates and Facilities At future projects

Findings 4 & 5: Post Project Evaluation & Benefits Realisation	Risk
The approved BJC documented the intended post project evaluation approach, including benefits realisation at the time the document was prepared. This aligned to the Designed for Life Framework requirements, noting this was the procurement approach at the time. The identified benefits were primarily to be measured via completion of the works to the required listed building standards, to safeguard the buildings and provide a suitable base for future development. A further benefit related to reduced maintenance costs. However, the business case did not state any baseline measure, or reduction targets, against which the final position could be measured. It also did not clarify at what stage the benefit would be measured. The Welsh Government approval letter stated: *"Funding is provided on the understanding that further evidence on the impact of the investment will be provided by 31 March 2018* [noting this date would have moved back following the delay to project commencement] *or as part of a wider benefits realisation exercise associated with investment on the site. The evaluation requirements will be discussed and agreed at a future Capital Review Meeting."* However, as the project was subsequently delivered via an alternative framework (SCAPE), management advised that there are now no plans for a distinct post project evaluation exercise to be undertaken specific to the CRI Safeguarding works.	Potentially beneficial lessons may be missed. Improvements may not be gained at future projects. Approved benefits resulting from the investment may not be able to be confirmed.

It was also confirmed that no benefits assessment had been undertaken to date, with the intended approach not yet discussed and agreed with the Welsh Government We acknowledge that a workshop had recently been held with the UHB, Contractor and advisers, focusing on the relationships and working practices between the key parties. Further, management advised that knowledge gained from the CRI Safeguarding work has benefited the wider Rookwood relocation project, however, this could not be formally evidenced. It is further recognised that, with the CRI Safeguarding works forming part of wider ongoing investment on the site, it would not be practical to measure achievement of such benefits until the site has been redeveloped and the buildings are in use. Management confirmed that supporting baseline data would be available against which to measure future performance. However, it is noted that the revised approach had not been formally documented and approved.	
Recommendations 4 & 5	**Priority level**
4) Project benefits should be clearly identified and documented in the business case, including: • Baseline value; • Method of measurement; • Target improvement; • Timing of when the benefit would be achieved; and • Lead responsibility for the benefit (D). ***(This recommendation being for implementation at future projects).***	**Low**

Post project evaluations should be delivered in accordance with agreed Business Case requirements, or a revised approach should be appropriately approved (O). 5) The required approach to post project evaluation and benefits assessment should be agreed with the Welsh Government, in relation to the CRI Safeguarding project and wider investment at the CRI site (O).	
Management Response	**Responsible Officer/ Deadline**
Agreed.	Director of Capital, Estates and Facilities 4) At future projects 5) June 2019

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

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Cardiff and Vale University Health Board

Commissioning

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Sharon Hopkins, Director of Transformation, Improvement & Informatics.
Distribution:	Melanie Wilkey, Head Of Outcomes Based Commissioning
	Eleri Probert, Commissioning Programme 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

A review of Commissioning was completed in line with the 2018/19 Internal Audit plan for Cardiff and Vale University Health Board.

The UHB is an integrated commissioner and provider organisation which means that it is responsible for planning what services are required to meet the health and wellbeing needs of its population.

Effective commissioning is essential to ensure that appropriate services are provided, either internally by Clinical Boards or by organisations external to the UHB, and that they are effectively monitored and evaluated.

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

2. Scope and Objectives

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

The purpose of the review was to establish if the Health Board has an appropriate Commissioning framework in place that is being consistently applied to ensure that the health needs of the population are being met.

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

- The Health Board has an appropriate, approved and up to date Commissioning Framework in place that is in line with relevant best practice and Welsh Government guidance;
- The Framework is effectively publicised and widely available to relevant parties;
- The Health Board has a current set of Commissioning Intentions in place that identify the services required to meet the needs of the population and the organisation's strategic objectives and Integrated Medium Terms Plan (IMTP);
- Effective governance processes are in place corporately for the management of the commissioning process;
- Effective processes are operating within Corporate Commissioning team for the management of areas such as Individual Patient Funding Requests (IPFR) and European Economic Area (EEA) requests;
- Clinical Boards have a good awareness of the UHB Commissioning Framework and Commissioning Intentions and are effectively utilising them to identify their commissioning requirements as part of their planning processes, in line with their respective IMTPs.

3. Associated Risks

The potential risks considered in this review are as follows:

- The Health Board fails to effectively identify the health needs of its population;
- Services are not provided to meet the identified population health needs;
- The Health Board fails to deliver its strategic objectives.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Commissioning is **Reasonable assurance**.

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

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

The UHB has a Commissioning Framework in place that reflects Welsh Government requirements and best practice, although the iteration provided at the time of the review was not dated and did not state its duration of applicability. The Framework was compiled as a wholly collaborative exercise involving internal and external stakeholders and is published on the Commissioning pages of the UHB intranet site. There has however been no publicity undertaken to promote its existence nor are there any public facing commissioning pages via the UHB internet site.

The UHB Commissioning Intentions document is current and its content aligns with that of the Commissioning Framework and the UHB IMTP. There is a formal UHB Strategic Commissioning Group that meets regularly, is

well attended and reports to Executive Board. These meetings are also supported by informal monthly commissioning meetings that review and provide progress updates. However, the Group's Terms of Reference document is not dated, does not state quoracy attendance levels and its listed membership was out of date and does not include any Clinical Board representation.

Sample testing undertaken to establish the level of compliance with the policies and procedures in place relating to the management of Individual Patient Funding Requests (IPFR) and European Economic Area (EEA) funding requests established that all the required checks, documentation, evaluation and approval processes were effectively undertaken and outcomes were provided to clinicians and patients accordingly.

Furthermore, the three sampled Clinical Boards (Mental Health, PCIC and Children & Women's) have a good awareness of the Commissioning Framework and Commissioning Intentions documents and are effectively utilising to identify and support their own commissioning requirements and arrangements in line with the content of their respective IMTPs.

5. Assurance Summary

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

Assurance Summary					
1	Commissioning Framework			✓	
2	Publication & Availability of Commissioning Framework			✓	
3	Commissioning Intentions				✓
4	Commissioning Governance			✓	
5	Management of IPFR & EEA Funding Requests				✓
6	Clinical Board Awareness & Utilisation of Commissioning Documentation				✓

** 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 three issues that are classified as weakness in the system control/design for Commissioning.

Operation of System/Controls

The findings from the review did not highlight any issues that are classified as weakness in the operation of the designed system/control for Commissioning.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: The Health Board has an appropriate, approved and up to date Commissioning Framework in place that is in line with relevant best practice and Welsh Government guidance.

The following areas of good practice were noted:

- The UHB has a current Commissioning Framework in place that includes and reflects internal and external commissioner stakeholder needs and guidance and is in accordance with Welsh Government strategic approaches.

There were no significant findings noted.

Objective 2: The Framework is effectively publicised and widely available to relevant parties.

The following areas of good practice were noted:

- UHB Commissioning Framework was compiled as a wholly collaborative exercise involving internal and external stakeholders, was subject to stakeholder feedback and revision, and its final iteration is published on the UHB Intranet site.

The following significant findings were noted:

- There has been a lack of internal publicity and awareness raising to promote the UHB Commissioning intranet pages and an absence of similar pages on the UHB internet site to provide information on the Commissioning Framework to the public and external stakeholders.

Objective 3: The Health Board has a current set of Commissioning Intentions in place that identify the services required to meet the needs of the population and the organisations strategic objectives and Integrated Medium Term Plan (IMTP).

The following areas of good practice were noted:

- The UHB Commissioning Intentions is current and its content aligns with that of the Commissioning Framework and the Health Board IMTP.

There were no significant findings noted.

Objective 4: Effective governance processes are in place corporately for the management of the commissioning process.

The following areas of good practice were noted:

- The UHB Strategic Commissioning Group meets quarterly, reports to Executive Board and is supported by a formal Terms of Reference (ToR) document outlining its membership, purpose and objectives.
- All Strategic Commissioning Group meetings are well attended.
- A monthly Commissioning Meeting is also held between Strategic Commissioning Group meetings to review and follow up on progress actions.

The following significant findings were noted:

- The Strategic Commissioning Group Terms of Reference document is not dated, does not state the quoracy attendance level and its listed membership was out of date at the time of the review.
- The current Strategic Commission Group membership does not included any Clinical Board representation that could actively inform, support and expedite the Group's mandate and objectives.

Objective 5: Effective processes are operating within the Corporate Commissioning team for the management of areas such as Individual Patient Funding Requests (IPFR) and European Economic Area (EEA) funding requests.

The following areas of good practice were noted:

- All 8 sampled Individual Patient Funding Requests (IPFR) were subject to the appropriate residency and clinical history checks, appropriately documented by the clinician in accordance with Welsh Government Policy and Guidance and the decision outcomes were recorded in the IPFR Panel Minutes and provided to the clinician and patient.
- All 5 sampled European Economic Area (EEA) funding requests were subject to the appropriate residency and clinical history checks, appropriately documented by the patient including full evidence of treatment provided and payment receipts in accordance with Welsh Government Policy and Guidance and the reimbursement decision outcomes were provided to the patient and recorded in the IPFR Panel Minutes.

There were no significant findings noted.

Objective 6: Clinical Boards have a good awareness of the Health Board's Commissioning Framework and Commissioning Intentions and are effectively utilising them to identify their commissioning requirements as part of their planning processes, in line with their individual IMTPs.

The following areas of good practice were noted:

- The Mental Health Clinical Board, PCIC Clinical Board and Children & Women's Clinical Board all have a good awareness of the Health Board's Commissioning Framework and Commissioning Intentions and are effectively utilising them to identify their commissioning requirements as part of their planning processes, in line with their individual IMTPs.

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	**1**	**1**	**1**	**3**

Finding 1 - Strategic Commissioning Group Terms of Reference and Membership (Control design)	Risk
Good practice is noted that there is a Strategic Commissioning Group that meets quarterly, reports to Executive Board and is supported by a formal Terms of Reference (ToR) document outlining its membership, purpose and objectives. However, the ToR does not state the quorate membership attendance levels to ensure appropriate and effective decision making when membership attendance is low. Additionally, the Strategic Commissioning Group does not include within its membership any representatives from any of the Clinical Boards and as such its objectives are at risk of failure without their contribution into the strategic processes outlined within their mandate stated in the Terms of Reference. Furthermore, the current Terms of Reference document is outdated in that one of the stated members has left UHB employment in the past 12 months and it does not include the Assistant Director of Patient Safety and Quality.	The Health Board fails to deliver its strategic objectives.
Recommendation	**Priority level**
Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference.	**High**

Management Response	Responsible Officer/ Deadline
The Strategic Commissioning Groups Terms of Reference, including membership was reviewed at a facilitated workshop on 20th Feb 2019. The first draft of a refreshed Terms of reference is scheduled for discussion at the May 2019 meeting of the Strategic Commissioning and Finance Group. Clinical Board representation will be fully considered.	Melanie Wilkey May 2019

Finding 2 - Publication and Availability of the UHB Commissioning Framework (Control design)	Risk
Good practice is noted that a great deal of internal and external collaborative work was undertaken to produce the Commissioning Framework, and that there is evidence of its existence for use both inside and outside the organisation. However, this has not followed through into any awareness or publicity exercises to promote the commissioning intranet pages that hold the Commissioning Framework and Commissioning Intentions documents. Additionally, there are currently no Commissioning pages on the UHB internet site to provide wider awareness of commissioned services and the Commissioning Framework to the public and external stakeholders.	The Health Board fails to deliver its strategic objectives.
Recommendation	**Priority level**
The Commissioning Team should as part of its ongoing programme of work publicise their presence via their intranet pages and create an internet page thereby promoting the Commissioning Framework and Commissioning Intentions	**Medium**

so as to maximise awareness of content to both internal/external stakeholders and the wider general public.	
Management Response	**Responsible Officer/ Deadline**
The development of the commissioning intranet pages, alongside commissioning toolkits, and awareness raising remains on the Commissioning Team's work plan. These actions were not progressed following publication of the Framework due to capacity of the team, and other urgent priorities. Progression of these actions will be included in the team's work plan for 2019-20, but capacity to implement remains an issue.	Melanie Wilkey April 2020

Finding 3 - Commissioning Framework (Control design)	**Risk**
Good practice is noted that the Commissioning Framework is current and its content reflects internal and external guidelines and stakeholder needs and those stated by Welsh Government. Additionally, the Framework was subject to scrutiny and approval by the UHB Strategic Commissioning Group in September 2018. However, at the time of the review the Framework was not dated, was not subject to any version control and did not state any timescale as to its applicability, use and future review.	The Health Board fails to deliver its strategic objectives.

Recommendation	Priority level
The Commissioning Framework document should be updated to reflect its creation date and should be subject to version control stating a timescale of applicability and use.	**Low**
Management Response	**Responsible Officer/ Deadline**
The Commissioning Framework has been amended, and now includes version control, and timescale of applicability, which is 5 years. The Framework will be reviewed for currency and accuracy on an annual basis.	Eleri Probert April 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Cardiff & Vale University Health Board

e – IT Training

Final Internal Audit Report

2018/19

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Distribution:	Nigel Lewis, Assistant Director of IT
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. Introduction and Background

A review of the management of e-IT Learning within the Health Board was completed in line with the Internal Audit Plan.

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

2. Scope and Objectives

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

The purpose of the review was to provide assurance that learning is appropriately developed to provide knowledge to the user base, is subject to review and is delivering according to user needs.

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

- learning package creation;
- review and update of learning packages;
- uptake of learning and its impact; and
- post learning support.

3. Associated Risks

The potential risk considered in the review was as follows:

- Users do not develop the knowledge to use the systems appropriately.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with e-IT Learning 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.

Overall the UHB has a good system in place for developing and delivering training on the key IT systems used. Learning packages are appropriately developed in consultation with managers and are available for online and classroom learning. Feedback is sought after training provision, and the results of this are positive. Post learning support in the form of handouts and guides are available and there are service leads in place for assistance.

The audit identified a small number of areas for improvement specifically relating to reduced service delivery due to lack of staff availability and the use of a training system that had not been updated to match the live version.

5. Assurance Summary

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

Assurance Summary					
1	Learning package creation				✓
2	Review and update of learning packages			✓	
3	Uptake of learning and its impact			✓	

Assurance Summary					
4	Post learning support				✓

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weakness in the system control/design for e-IT Learning.

Operation of System/Controls

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

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: Learning package creation

The following areas of good practice were noted:

- learning packages are created for three database systems operated in the UHB including the Welsh Clinical Portal (WCP), Patient Management System (PMS) and Paris system;
- the needs of the audience are considered in the sense that both online and classroom options are offered for all the systems;
- learning packages articulate the learning objectives at the outset and the packages are constructed to ensure that these objectives are met in a concise and relevant way;
- learning packages including workbooks and lesson plans contain document control information; and
- quick guide handouts are provided which also contain contact details for PMS Training and PMS Support. In addition flash cards are provided for new WCP features.

There were no significant findings identified under this objective.

Objective 2: Review and update of learning packages.

The following areas of good practice was noted:

- learning packages are reviewed before they are commissioned;

- review is a consultative process including trainers and managers;
- the PMS and Paris packages also include review and sign off procedures involving the service coordinators who represent the training customers (attendants); and
- feedback is sought at the end of training to identify areas for improvement.

The following significant findings were identified:

- The Paris training system was not updated to the latest version which resulted in the relevant learning package being out of sync with the current version of the Paris system. Attendants are therefore learning an older version of the system and not the one that is currently implemented.

Objective 3: Uptake of learning and its impact.

The following areas of good practice were noted:

- the uptake of learning is controlled by the service coordinators and department managers who represent the users of all three systems;
- system users must attend relevant training before they can access the systems. User accounts are only set up on completion of training, this ensures 100% uptake of learning;
- the impact of the learning is assessed by requesting attendants to leave feedback at the end of a training session; and
- the records of the booking system show that an average negative feedback equates to 1.5% of all responses.

The following significant findings were identified:

- Due to a lack in the availability of training staff at the end of 2018 and the beginning of 2019 a decision was made to temporarily reduce the course content for the Paris system to "Central Index and Referral" only. It was appreciated at the time that "this would diminish quality/comprehension, and place more onus on the service support delivered to new staff/users by managers/peers post classroom training".

Objective 4: Post learning support.

The following areas of good practice were noted:

- post learning support is provided via helpdesk and contact information is given at the end of the classroom training;

- service coordinators, department managers and IT champions are available to provide advice;
- modifications implemented through system updates are documented and made available on the Intranet meaning that those who have attended past training sessions are kept up to date with system changes; and
- handouts and pocket guides have been developed and are given to attendants to take away from training.

There were no significant findings 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**	**2**	**5**	**7**

Finding 1: Temporarily reduced training content (Operating Effectiveness)	Risk
Due to a lack in the availability of training staff at the end of 2018 and the beginning of 2019 a decision was made to temporarily reduce the course content for the Paris system to "Central Index and Referral" only. It was appreciated at the time that "this would diminish quality/comprehension, and place more onus on the service support delivered to new staff/users by managers/peers post classroom training". The actual negative impact on services is not being evaluated, thus training quality may suffer to such an extent that it could result in the inadequate usage of the systems by poorly trained staff.	Users do not develop the knowledge to use the systems appropriately.
Recommendation 1	**Priority level**
An assessment of the impact of these measures should be carried out and procedures developed for actions in similar circumstances in the future.	**Medium**

Management Response	Responsible Officer/ Deadline
An assessment of the reduced course duration is to be undertaken by the PARIS training senior officer at the point the team regain their second training staff member (long term sick, meant the two person PARIS training complement was reduced by half). The PARIS programme has service representation embedded in its 'change structure'. These staff have been asked for concerns and feedback regularly (to the fortnightly MHCS team meetings) since this 'new training model' was made necessary (due to long term loss of staff). No operational risks or concerns have been raised from scoped services to date.	MHCS Programme Manager / IT Trainer September 2019, depending on staff return to work

Finding 2: Learning package update (Operating Effectiveness)	Risk
The Paris training system was not updated to the latest version which resulted in the relevant learning package being out of sync with the current version of the Paris system. Attendants are therefore learning an older version of the system and not the one that is currently implemented. Thus the training being delivered is not appropriate and without proper controls and agreed procedures this could affect the quality of training resulting in the inadequate use of the system.	Users do not develop the knowledge to use the systems appropriately.
Recommendation 2	**Priority level**
Relevant policies and procedures should be put in place to set out the circumstances under which this kind of drift can be allowed (if at all), any mitigation measures, how many versions the training system can be allowed to be behind and any other provisions to ensure adequate quality levels of training are preserved.	**Medium**

Management Response	Responsible Officer/ Deadline
The 'relevance' of the PARIS training system is under *constant* review through both the fortnightly PARIS team meeting and the fortnightly PARIS Technical Design Team (TDT). The functionality that is 'trained' upon is a hugely limited subset of all the capability of PARIS 'live' (as there are, for example, c400 assessment types on PARIS LIVE, and c50 casenote types etc…). As such the Health Board trains on one or two examples, thus negating the necessity for 'LIVE' and 'TRAIN' systems to be 'identical'. Approximately 6000 changes have been made to the PARIS 'live' system over a decade, including c20 PARIS 'version' changes. An assessed evaluation is constantly undertaken by the PARIS senior trainer to assure that what we 'train' upon, is 'suitably reflective' of what is currently (or sometimes due) to be on the LIVE system. As an example, in any 'version' change to PARIS there will be a range of changes. These changes may have no bearing upon what is 'trained' upon, and as such there would be no purpose in upgrading the training system. Further, doing so would reduce delivery capacity, leading to a greater wait for training, and inducing unnecessary 'training issues'.	MHCS Programme Manager / IT Trainer This review is ongoing and assessment is documented at team meeting, else TDT minutes. As such the issue is mitigated and considered closed.

Finding 3: Pre-assessment for learning difficulties (Design)	Risk
It was noted from review of customer feedback given by a member of staff at the end of a training session that comments had been made in respect of the difficulties in completing the training as follows: ”my dyslexia causes me issues” and “… my dyslexia impacts on my learning”. There is no pre-assessment in place to determine if any training attendants have learning difficulties. The means that attendants with learning difficulties are disadvantaged in the class room and therefore the training is not effective and they may not be able to use the systems properly.	Users do not develop the knowledge to use the systems appropriately.
Recommendation 3	**Priority level**
To introduce a relevant pre-assessment process and procedures to ensure that staff with learning difficulties are able to learn the systems to the required level.	**Low**

Management Response	Responsible Officer/ Deadline
The Health Board will: 1. Agree a process for ensuring any LD is captured. 2. Develop the Training Booking system to include a mandatory Learning Difficulties field within the user profile screen. The LD will automatically display against the user when booking them in for training sessions. Initially the LD field will default to NONE however the IT Trainers are to check/update the LD field when requests for training received.	Implementation and Training Manager / Informatics Support officer /IT Trainers Deadline – end of June 2019

Finding 4: Document control (Operating Effectiveness)	Risk
The training material contains document control information including version, sign off and reason for update. It was noted that version information was inconsistent and some fields were left blank (sign off and user acceptance fields). This may result in the wrong version of training material being used in training sessions.	Users do not develop the knowledge to use the systems appropriately.
Recommendation 4	**Priority level**
Document control information to be standardised and completed in full on training documents.	**Low**
Management Response	**Responsible Officer/ Deadline**
Training documents are currently version controlled but not standardised. Standardising them would be a very low priority within the current resource.	Implementation and Training Manager / senior IT Trainer September 2019, depending on staff availability

Finding 5: Sign off (Operating Effectiveness)	Risk
Learning packages are reviewed before they are commissioned and a consultative process is in place which includes trainers and managers. The PMS and Paris systems also includes a review and sign off procedure involving the service coordinators who represent the training customers (attendants). However, a sign off of training packages by service customers is not carried out for Welsh Clinical Portal training, instead user feedback is used to identify issues. Issues that can be identified and corrected before the training is delivered are therefore only addressed after staff have been trained.	Users do not develop the knowledge to use the systems appropriately.
Recommendation 5	**Priority level**
A sign off process should be introduced involving training customers for the Welsh Clinical Portal	**Low**

Management Response	Responsible Officer/ Deadline
A review and sign off procedure for the Welsh Clinical Portal involving the service coordinators who represent the training customers (attendants) will be considered and discussed with the WCP trainer on return to work from Work Life Balance absence. This could take the form of a WCP 'super user' group who review and comment on new versions of the training package before they are made available for general use.	NWIS Programme Manager /NWIS Project Manager / IT Training Officer September 2019

Finding 6: Learning impact assessment (Operating Effectiveness)	Risk
Training attendants' feedback is collected at the end of the session. There is no impact assessment process in place to evaluate the training attendants' opinions once they have had a chance to use their acquired knowledge in the work environment. In addition the mailbox containing feedback emails from attendants in relation to onscreen WCP and PMS training has not been reviewed from July 2018. Constructive comments provided by attendants are not reviewed and training quality is not improved due to a lack of feedback from those who have had the chance to test their knowledge in the work environment.	Users do not develop the knowledge to use the systems appropriately.
Recommendation 6	**Priority level**
An impact assessment process should be introduced in order to gather and evaluate the feedback from training attendants after they have had the opportunity to use the relevant systems. The feedback emails should be reviewed on a regular basis.	**Low**

Management Response	Responsible Officer/ Deadline
An impact assessment process is in draft but has been suspended due to the Work Life Balance absence of the WCP trainer. This and the regular review of feedback emails will recommence once the trainer has returned to post.	NWIS Programme Manager / NWIS Project Manager / IT Training Officer September 2019, depending on staff return to work

Finding 7: Post learning support (Operating Effectiveness)	Risk
Post learning support information is restricted to helpdesk contact information and attendants are not informed as to who the IT champions and service co-ordinators are that they could contact with any queries once they are actually using the systems. Attendants are therefore not aware of the full range of help and support that is available. Some staff queries may go unanswered. In addition there is lack of a standard programme of refresher sessions, with service co-ordinators noting that these would be of use.	Users do not develop the knowledge to use the systems appropriately.

Recommendation 7	Priority level
The training material should be updated to include a range of options for post learning support other than just helpdesk contact information. The need for refresher sessions should be reviewed in conjunction with service customers.	**Low**
Management Response	**Responsible Officer/ Deadline**
It would not be appropriate to provide Service Coordinator details since these will be subject to change at effectively no notice. Training materials include contact information for the "IT User Support" team which is managed by the IT Trainers and Implementation Officer. Both e-mail and telephone contact details are included. Users are able to contact for advice, refresh and support to meet their requirements. If e-learning material is available the link to the learning is also included. As such full support is demonstrably available post training from the user's perspective. Refresh sessions have previously been included into a rolling schedule however take up from end users (and support from managers to ensure attendance) was so poor that it was deemed a waste of the limited resource within the training team. Refresh sessions can be (and are) delivered on request by the service customers.	Implementation and Training Manager / IT Trainers Completed.

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.