Bundle Audit and Assurance Committee 23 May 2019

Agenda attachments

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AUDIT AND ASSURANCE COMMITTEE

Thursday, 23 May 2019 at 9.00am
Executive Meeting Room, Woodlands House, Heath

AGENDA

1.		Welcome and Introductions	*Oral* *John Union*
2.		Apologies for Absence	*Oral* *John Union*
3.		Declarations on Interest	*Oral* *John Union*
4.		Minutes of the Committee meeting held on 23 April 2019	*John Union*
5.		Action log following meeting held on 23 April 2019	*John Union*
6.		Any Other Urgent Business: To agree any additional items of urgent business that may need to be considered during the meeting.	*Oral* *John Union*
7.		**Items for Review and Assurance**	
8.	*10 mins*	Internal Audit Progress and Tracking Reports: **Assignment** — **Assurance Rating** Cyber Security — Limited	*Ian Virgil*
9.		**Items for Approval / Ratification**	
10.	*5 mins*	Report of the Losses and Special Payments Panel	*Robert Chadwick*
11.		**Items for Information**	
12.		Internal Audit reports for information: **Assignment** — **Assurance Rating** 1. Strategic Planning and IMTP — Substantial 2. Core Financial Systems — Reasonable 3. Estates Statutory Compliance - Water — Reasonable 4. E-Advice — Reasonable 5. UHB Transformation Process — Reasonable 6. MHRA Compliance — Reasonable 7. Health and Care Standards — Reasonable	*Ian Virgil*

13.		**Review and Final Closure**	
14.		Items to be deferred to Board / Committee	*Oral* *Chair*
15.		To note the date, time and venue of the next Committee meeting: • **Special Audit Committee - Thursday, 30 May 2019 – 10.00am** Nant Fawr 1 & 2, Ground Floor, Woodlands House	

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

UNCONFIRMED MINUTES OF AUDIT COMMITTEE
HELD ON 23 APRIL 2019
CORPORATE MEETING ROOM, HEADQUARTERS,
UNIVERSITY HOSPITAL WALES

Present:		
John Union	JU	Chair - Audit
Eileen Brandreth	EB	Independent Member - ICT
Charles Janczewski	CAJ	UHB Vice Chair
Dawn Ward	DW	Independent Member – Trade Union
In attendance:		
Stuart Bodman	SB	Internal Office
Michael Bond	MB	Director of Operations – Surgery (*For item 19/04/007*)
Robert Chadwick	RC	Director of Finance
Steve Curry	SC	Chief Operating Officer
Rhodri Davies	RD	Wales Audit Office
Nicola Foreman	NF	Director of Corporate Governance
Craig Greenstock	CG	Counter Fraud Manager
Geraldine Johnston	GJ	Director of Operations – Medicine (*For item 19/04/007*)
Mike Usher	MU	Wales Audit Office
Ian Virgil	IV	Interim Head of Internal Audit
Secretariat:		
Glynis Mulford	GM	Corporate Governance Officer
Observer:		
Urvisha Perez	UP	Wales Audit Office

AC: 19/04/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
AC: 19/04/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
AC: 19/04/003	**DECLARATIONS OF INTEREST** Charles Janczewski declared his interest as Chair of the Quality and Patient Safety Committee at WHSCC.	
AC: 19/04/004	**MINUTES OF THE AUDIT COMMITTEE HELD ON 26 FEBRUARY 2019** The Minutes from the meeting held on 26 February 2019 were reviewed. **Resolved - that:**	

	The Committee approved the minutes of the meeting held on 26 February 2019.	
AC: 19/04/005	**ACTION LOG FOLLOWING THE LAST MEETING HELD ON 31 JANUARY 2019** The Committee received the Action Log from the meeting held on 26 February 2019, which were as follows: **AC: 18/071 – Wales Audit Report on Medical Equipment:** The Chair had spoken with the Director of Therapies and Health Sciences who reported she was working with the team on the inventory which held an enormous number of items. Also the Chair had spoken to the Clinical Lead, Professor Colin Gibson and the Managing Director, All Wales Genomics Service. The group was looking to bring two IT systems together to try and gather a list of items procured that cost under £5k. The data would be put into a workable format to provide more information. A report would be brought back to a future meeting and continue to liaise with the Wales Audit Office. **Resolved – that:** a) A report be brought to a future meeting b) The Chair would continue to liaise with the Wales Audit Office	FJ
AC: 19/04/006	**CHAIRS ACTION TAKEN SINCE LAST MEETING** The Chair provided a summary of the discussions of the private session of the Committee held on 26 February 2019. The following comments were made: ▪ Discussed the Procurement Compliance Report and considered the Single Tender Actions and was assured that all STAs were challenged and reviewed. ▪ Received the Counter Fraud Progress Report where the high risk areas were reviewed and provided an overview of the draft Annual Plan. ▪ Discussed the Workforce and Organisational Compliance Report and agreed measures put in place were to ensure Agenda for Change arrangements were complied with.	
AC: 19/04/007	**INTERNAL AUDIT PROGRESS AND TRACKING REPORT** The Interim Head of Internal Audit provided an overview against the Internal Audit 2018/19 plan. The following comments were made:	

	• There were a number of planned audits delayed but these would be finalised in time for the Annual Report. A final report would be presented at the May meeting. No concerns had been highlighted and the remaining reports neared the draft stage. This would not affect the overall opinion. • Eight reports had been finalised with two substantial and six achieving a reasonable rate. • The remainder of the plan was highlighted with eight reports from 2018/19 plan being deferred to the 2019/20 plan. This was deemed appropriate to do so. The remaining 46 reports were split across the eight domains. • Regarding Limited reports, one report was in draft relating to compliance with water. Further discussion would be held with the Executive lead for this area which could move it from a limited assurance through discussion and final agreement. • The other seven audits were likely to be reasonable assurance for the year end opinion. This would be in line with previous years. • The plan for 2019/20 had been produced and gone through the Management Executive team for discussion. • The Health Board needed to improve its timeliness in responding to signing off the reports and to provide assurance from the Executive Team for the turnaround to be more efficient. Although this area had improved and were moving in the right direction. • The Internal Audit team was commended for the layout of the report. Members stated they received assurance from report as it was very balanced to read. **Surgery Clinical Board – Medical Finance Governance Report:** The Director of Operations for Surgery informed the Committee there had been real learning from the audit undertaken. Processes had been put in place such as Standard Operating Procedures. The following comments were made: • Regarding group Job Planning it was raised whether there were set processes to monitor and record the consultant's activities. • There had been issues around consultants not undertaking clinics and there was a change in job planning with junior doctors covering clinics. • A group job plan with a 'buddy up' scheme was in place for upper GI surgeons and colectoral surgeons so there would always be someone available on call. Although there had been challenges with changes in management there was good governance and a SOP developed so that people would know what to do when someone was on leave. • It was encouraging to see the level of engagement and motivation from Clinical Directors across all departments who had taken this seriously and was designing decisions to go forward. This would be addressed further through formal performance reviews.	HOIA

- The main lessons learnt for this not to be repeated was good governance and good documentation and incorporating a standardised approach.
- There was a detailed follow-up report but time would be needed to give the Clinical Board time to embed the new procedures.
- The Committee was assured from the views of Clinical Directors and the need to have procedures embedded.

Internal Medicine Follow-up Final Report: The Chief Operating Officer introduced the report and informed the Committee that the first audit was undertaken in November 2017 with changing arrangements within the Clinical Board including the Director of Operations. The Clinical Board was more stable and maturity was seen coming through. The Director of Operations for Medicine stated the Clinical Board was on a better footing and did not carry on unacceptable behaviours and actions.

- Things were moving forward with 71% of staff completing their PADR. As from March an improved governance structure was in place for director reviews. In addition, more robust process and procedures had been developed and embedded with the team. This provided people with meaningful opportunities and enabled staff to realise their value. Opportunities for training were available for staff.
- The cultural shift was significant and the directorate had good leadership capability and processes to hold people to account.
- The internal audit report had been discussed at the operational meeting and Clinical Board.
- Measures were in place with more due diligence around tracking and there was confidence this would improve significantly, acknowledging there were some milestones to complete but was moving in the right direction.
- The Director of Operations for Medicines was commended for her reputation and the work the team had undertaken.
- The Committee asked for assurance this would be put right with suitable timescales for follow up review and more frequent updates.
- There was the opportunity to link in with the Chair on a monthly basis.
- Monitoring would be kept in place and intervention with the lead nurse should be able to demonstrate month on month improvement.

Resolved - that:

a) The Committee considered the internal progress report.

AC: 19/04/008 **WALES AUDIT OFFICE PROGRESS REPORT**

Mike Usher, Wales Audit Office, presented an overview of the report. This incorporated updates on the financial audits. He stated that there would be increased testing on fixed assets this

	year. Work underway was also highlighted and Wales Audit Office would be working on a project with the Director of Public Health on the Future Generations Wellbeing Act. In addition, work being scoped would commence towards the end of the year around quality governance and quality work. There was a Discharge Planning checklist on line to help with assurance and the UHB may want to have a discussion on how best to use this service. This was across the board but excluded operating theatres. The Future Generations Wellbeing Act was covered by 44 bodies and work would be undertaken across all of them. This would be to ensure the principles of the act were embedded in the organisation. A reflective piece of work would take place with a series of workshops. The outcome of the workshop would be to produce improvement actions. Regarding the workplan for the IMT follow-up the WAO would liaise with the Director of Corporate Governance on timescales. **Resolved – that:** a) The Committee noted the Wales Audit Office update	
AC: 19/04/009	**POST PAYMENT VERIFICATION REPORT** The Committee reviewed the report and queries were raised in the appendices as to the number of error rates and claim rates that were very high for some practices and what the PPV were doing regarding these. A report on these to be provided to the September meeting. **Resolved – that:** a) The PPV Report be noted and an update to be provided on the error rates and claim rates to the September meeting of the Audit Committee	SC
AC: 19/04/010	**DRAFT UNIVERSITY HEALTH BOARD ANNUAL REPORT AND ANNUAL GOVERNANCE STATEMENT** The Director of Corporate Governance provided an update on the Annual Report. This would be presented in three parts with the performance report and accountability report submitted together. The Annual Report would be circulated for members to provide input into the document which would go forward for approval by the Board at the end of May. **Resolved – that:** a) The Committee noted the update on Annual Report	NF

AC: 19/04/011	**DECLARATIONS OF INTEREST AND GIFTS AND HOSPITALITY** The Director of Corporate Governance presented the report and amendments were noted. This would go forward to the senior management team within clinical boards and was described as work in progress. A communications plan was also needed to raise awareness among staff and improve declarations of interest reporting. **Resolved – that:** a) The Committee approved the declarations of interest report at Appendix 1 and b) Agreed to the declarations of interest made by Board members being published on the UHB website	NF
AC: 19/04/012	**TRACKING REPORT FROM RECOMMENDATIONS FROM REGULATORY BODIES** The Director of Corporate Governance presented an update on the report which had previously received a rating of Limited Assurance. Comprehensive work was being undertaken on the reports starting from April 2017. The following comments were made: • A tracker had been developed for Welsh Health Circulars, Internal Audit Reports and Wales Audit Office Reports which had been agreed with the Executive Directors and would be tracked centrally through the Governance Department. The Committee would have sight of the dashboard and what was needed from each Director. • A high level dashboard would be presented in September to see how this worked. The dashboard would be tested with set parameters which could be pulled off the spreadsheet. • This was a positive piece of work and the governance arrangements were looking more robust. **Resolved – that:** a) The Committee agreed to the UHB adopting the dashboard approach developed by the CDT Clinical Board. A project plan would be developed taken to Management Executive and the Health Systems Management Board for consultation and approval	NF NF
AC: 19/04/013	**ANNUAL AUDIT PLAN** The interim Head of Internal Audit presented the above report which showed a detailed plan for the year as well as detail on the resource requirement and responsibilities of the Health Board. The	

following comments were made on the key issues:

- To highlight how the plan was developed. This linked in to public sector standards to comply with when producing the plan and the process to go through those standards.
- There was a risk based approach highlighted through the Board Assurance Framework which was linked into ensure Internal Audit plan was achieving its objectives.
- Meetings were held with Executives and key management to discuss high risks and obtain granular information where assurance was weak.
- The eight assurance domains ensured it was covered and the plan spread across to provide the annual opinion for next year.
- The plans were incorporated with Wales Audit Office processes so there would not be duplication of work.
- The report highlighted the planned internal audit coverage and agreement from Executives on these areas had been received. Any amendments had been discussed with the Executives at time of review.
- The plan showed the audits that had been deferred and what was achieved through the number of days allocated. There was a contingency built into the plan if there was a need to do further assurance work or needed urgent cover the plan could be adjusted to accommodate this.
- The key performance indicators for Internal Audit were measured against the Internal Audit Charter.
- The report presented details of the audit reporting process and timescales and responses to be received.
- The Corporate Governance tracking system could be built in to monitor whether Internal Audits were behind.
- The team was thanked for their contribution.

Resolved – that

b) The Committee approved the Internal Audit Plan for 2019/20

AC: 19/04/014 **ITEMS FOR NOTING AND INFORMATION**

The Committee resolved that the Internal Audit Reports for noting and information be received:

- Delayed Transfers of Care
- Ward Nurse Staffing Levels
- Capital Project - Rookwood Relocation
- PCIC Clinical Board – Interface Incidents
- Medicines Clinical Board – Sickness
- Absence Management Report
- Capital – CRI Safeguarding Works Report
- Commissioning Report
- E-IT Learning Report

AC: 19/04/015	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE** There were no items to report to the Board / other Committees	
AC: 19/04/016	**DATE OF THE NEXT MEETING OF THE AUDIT COMMITTEE MEETING:** Corporate Meeting Room, Woodlands House, Heath	

ACTION LOG
FOLLOWING AUDIT COMMITTEE MEETING
23 APRIL 2019

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	|STATUS/COMMENTS
Actions Completed					
Actions in Progress					
AC 19/04/012	Tracking Report from Recommendations from Regulatory Bodies	A high level dashboard to be presented in September. A project plan on the dashboard would be taken to Management Executives and HSMB for consultation and approval	N Foreman N Foreman	24/09/19	On agenda for September 2019 meeting.
AC 19/04/011	Declarations of Interest and Gifts of Hospitality	To publish Declarations of Interest on UHB website	N Foreman		
AC 19/04/010	Draft UHB Annual Report and Annual Governance Statement	Report to be circulated for members input into document.	N Foreman		To go forward to Board at end of May 2019.
AC 19/04/009	Post Payment Verification Report	To provide an update on error and claim rates.	S Lavendar	24/09/19	On agenda for May meeting 2019.
AC 19/04/007	Internal Audit Progress & Tracking Report	Final Internal Audit Annual Report to be presented at May meeting	I Virgil	24/09/19	On agenda for September 2019 meeting.
AC 18/071	Wales Audit Report on Medical Equipment	Investigate how other Health Boards deal with equipment <£5k inventory	Fiona Jenkins		The data would be formatted to provide more information. A report to be provided at a future 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 18/079	Losses and Special Payments	Job titles to be added to the appendices of future reports.	C Lewis	23/04/19	On agenda for May meeting. Will be actioned when the next losses 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 May 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 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

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee May 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 May Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
MHRA Compliance	Draft	Reasonable	Delay in commencing fieldwork.
e-advice	Draft	Reasonable	Completion of fieldwork took longer than planned.
UHB Transformation Process	Draft	Reasonable	Delay in commencing fieldwork.
Performance Reporting Data Quality – RTT	Planning		Availability of Internal Audit resource

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	
Strategic Planning / IMTP	Substantial	
Health & Care Standards	Reasonable	
UHB Core Financial Systems		
Estates Statutory Compliance – Water		
Specialist CB – Medical Finance Governance		
Cyber Security	Limited	

4. DELIVERY OF INTERNAL AUDIT PLAN

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

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

4.2. 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 Strategic Planning / IMTP

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 made appropriate progress towards delivering the key commitments within its one year plan for 2018/19 and there is evidence that monitoring of the Plan and the Clinical Board IMTPs is carried out and therefore we consider the review to be of substantial assurance. In addition, at the time of the review the Health Board's IMTP for 2019-2022 was approved by Welsh Government.

There were a number of core actions that were included within the Annual Plan for 2018/19 and the progress of these were monitored and updates provided on them via the Operational Planning Group and the monthly Performance Reviews. 'Delivering On Our Commitments' was reported within the IMTP 2019-22, giving an update on the core actions from the Annual Plan 2018/19 including whether they had been delivered, were in progress or not implemented. It was evident that significant progress had been made on delivery of the key commitments from the Annual Plan 2018/19.

The Health Board produced a Mid-Year Review report for the Welsh Government and the Executive providing an update on the Annual Plan and there are monthly meetings held with Welsh Government to discuss the IMTP.

There were a number of processes in place within the Clinical Boards to monitor and report delivery of the core actions and other priorities within their individual IMTPs. However, these were inconsistent and of a varied standard. It has been agreed to update the process going forward with there being individual plan priorities for each of the Clinical Boards that will come from the Shaping Our Future Wellbeing - Annual Plan for 2019-20 (An X-Matrix Document will be in place to set out priorities for the organisation and clinical boards). This will enable the Clinical Boards to consistently monitor each of their projects and effectively report on the progress and any issues and ensure appropriate Management Executive Oversite.

5.2 Health & Care Standards

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

The current review has confirmed that the Health Board continues to make good progress with the embedding of the Standards across the organisation. The further development of the process for continuous monitoring of performance against the Standards through existing Groups and Committees is leading to more effective utilisation of the Standards to drive improvements in service delivery.

Review of a sample of the 17 aligned standards has confirmed that the agendas of the respective Groups / Committees are appropriately set up to reflect the criteria dictated in the Standards to which they are aligned. Continued work is however needed to ensure that all the Groups / Committees are regularly monitoring Clinical Board performance against the standards and effectively driving required improvements.

Self-assessments of the Health Board's performance against the Standards for 2018/19 have been appropriately completed.

The Health Board has an appropriate timetable in place for the finalisation and sign-off of the 2018/19 self-assessments and subsequent reporting of the outcomes to the Quality, Safety and Experience Committee. The planned process for completing this is in line with that undertaken for the 2017/18 standards.

However it is noted that a number of the current self-assessments are provisionally scored as 'getting there' which illustrates that the Health Board has further work to do to ensure that all the standards are being fully utilised throughout the organisation.

5.3 UHB Core Financial Systems

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

The current review has identified that there are generally good processes in place for the management of the Health Board's Fixed Asset Register. An up to date Financial Control Procedure is in place and available via the intranet and a specific Capital Asset booklet along with bespoke training has been provided to relevant Clinical Board staff.

The annual asset verification exercise was undertaken by the Finance Department. However, a number of asset transfers or adjustments identified by the Clinical Boards had not been updated on the Asset Register at the time of our review.

There is currently a lack of any standard process for validating and updating the Oracle Hierarchy lists across the individual Clinical Boards and also the Corporate Finance team. The substantive testing completed as part of the review identified a number of errors within the Oracle Hierarchy. Issues were also identified around the retention of Budget Holder – Financial Limit Forms within the e-Enablement team.

5.4 Estates Statutory Compliance - Water

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

We noted strong controls in the areas of governance, structures and procedures. The Water Policy and the Water Safety Plan (WSP) were well

defined, in terms of the requirements of the WHTM 04-01 and the HSE Approved Code of Practice (ACOP) L8.

There was insufficient evidence of required flushing activities in the sampled wards at University Hospital Wales (UHW) and University Hospital Llandough (UHL), including a number of wards classed as high risk. The Water Safety Group should ensure it receives assurance that improvements are made in respect of the specific ward areas with non-compliance identified during the audit, to ensure this high risk area is better controlled.

Substantial improvements have been made in recent years in terms of surveying the infrastructure across the UHB, and producing schematics and risk assessments for the estate, as required by the HSE ACOP and WHTM. This work forms a part of a wider, ongoing statutory compliance programme within the UHB.

However, further work remains to be completed to ensure the identified risks and required remedial actions are appropriately prioritised, with a full action plan in place to manage these risks. In the meantime, we recognise that significant investment has already been made to address the highest risk areas.

Noting the ongoing nature of this work, but recognising the substantial improvements already achieved, we have chosen to reserve our assurance opinion in respect of "Risk management" at this point in time; recognising that further improvements will be achieved within the next 6-12 months on completion of this work.

In view of the number of positive areas identified, and ongoing improvement in respect of risk management, we have accordingly determined **reasonable assurance** as to the effectiveness of the system of internal control in place for safe water management within the UHB at the time of the current audit.

However, noting the marginal nature of this positive assurance, and that the opinion is reserved in respect of risk management, this is subject to the agreement of further follow up during 2019/20. The follow up will affirm whether the intended action has been taken in a timely manner and whether it has been effective as evidenced at a new sample of wards / sites to those considered at this audit.

5.5 Specialist CB – Medical Finance Governance

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

The current review has identified that processes are in place for managing Medical Finance Governance within each of the two sampled Directorates.

The consultants in post are appropriately working their core contracted Direct Clinical Care (DCC) sessions and consultant time is being effectively planned around the requirements of the services.

Issues were however identified around the current level of consultant staff within the Critical Care Directorate and the potential adverse impact this may have on the future delivery of the service.

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	Complete – May 19 (The outcome of this review feeds into the Annual Opinion and no separate report was issued)	N/A - feeds into Annual Opinion	May

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Health & Care Standards	1		Corporate Governance	Q4	Final – Issued May 19	Reasonable	May
UHB Core Financial Systems	14	6.7	Finance	Q3/4	Final – Issued May 19	Reasonable	May
Estates statutory compliance – Water		6.4.1	Planning	Q2	Final – Issued May 19	Reasonable	May
Strategic Planning/IMTP	7	5	Planning	Q3/4	Final – Issued May 19	Substantial	May
Specialist CB – Medical Finance Governance	37		COO/Clinical Board	Q4	Final – Issued May 19	Reasonable	May
Cyber Security	27	6.8	Therapies	Q3/4	Draft – Issued April 19	Limited	May
UHB Transformation Process	12	10	Public Health	Q3/4	Draft – Issued May 19	Reasonable	Sept 19
e-advice	26	6.8	Therapies	Q2/3	Draft – Issued May 19	Reasonable	Sept 19
MHRA Compliance	22	8	COO	Q3/4	Work in Progress	Reasonable	Sept 19
Performance Reporting Data Quality RTT	9	5.3	Public Health	Q3	Scheduled to start May 19		Sept 19
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*		

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Consultant Job Planning Follow-up	*40*	*6.2*	*Medical*	*Q3*	*Deferred to 19/20 At request of Medical Director. – Agreed at Dec AC*		
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		● Risk Management		● Standards of Behaviour ● Legislative / regulatory Compliance	● Contract Compliance ● H&CS	● Claims Re-imbursement		
Financial Governance and Management	4					● Core Financials	● Charitable Funds ● CIPs		● Private & Overseas patients
Clinical Governance, Quality and Safety	5					● *MHRA Compliance (Draft)*	● Annual Quality Statement ● Ombudsman Reports ● Ward Nurse Staffing Levels		● DoLS Follow-up
Strategic Planning, Performance Management and Reporting	8					● Commissioning ● *UHB Transformation (Draft)*	● Performance Reporting Non RTT ● DToC Reporting ● Strat Plan IMTP	● Performance Reporting RTT (Won't be completed for opinion)	● CHC Follow-up ● Public Health Targets
Information Governance and Security	6				● Information Governance – GDPR ● Cyber Security	● Renal It system ● e-IT Training ● *e-advice (Draft)*	● Neuroscience It System follow up		

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 Sessions ● 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					● Shaping Our Future Wellbeing – Capital Projects ● Environmental Sustainability Reporting ● Cleanliness Standards Follow up ● Carbon Reduction Commitment (SSU) ● Estates Time Recording System – Kronos ● Capital Project – Rookwood			● Commercial Outlets ● Service Improvement Team

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**		
						● Capital – Safeguarding Work CRI ● Estates Statutory Compliance Water			

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	
Estates Statutory Compliance - Water	Reasonable	Draft	19/04/19	10/05/19	14/05/19	15/05/19	A	
Health & Care Standards	Reasonable	Final	10/05/19	03/06/19	14/05/19	15/05/19	G	
UHB Core Financial Systems	Reasonable	Final	01/05/19	23/05/19	14/05/19	15/05/19	G	
Strategic Planning / IMTP	Substantial	Draft	29/04/19	21/05/19	15/05/19	15/05/19	G	
Specialist CB – Medical Finance Gov	Reasonable	Draft	13/05/19	06/06/19	16/05/19	17/05/19	G	
Cyber Security	Limited	Draft	30/04/19	22/05/19	17/05/19	17/05/19	G	
e-advice	Reasonable	Draft	02/05/19	24/05/19				
UHB Transformation Process	Reasonable	Draft	07/05/19	29/05/19				
MHRA Compliance	Reasonable	Draft	22/05/19	13/06/19				
Performance Report Data Quality RTT								

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	**G**	98% 45 from 46	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	**A**	89% 40 from 45	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	**R**	56% 23 from 41	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	**G**	100% 41 from 41	80%	v>20%	10%<v< 20%	v<10%

Audit and Assurance Services
Cardiff and Vale / South Central Team
Second Floor, Cardiff Royal Infirmary
Glossop Road
Cardiff
CF24 0JT
Contact details: ian.virgil@wales.nhs.uk

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

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

Cardiff & Vale University Health Board

Cyber Security

Final Internal Audit Report

2018/19

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

Contents **Page**

Review reference:	CUHB1819.27
Report status:	Final
Fieldwork commencement:	April 2019
Fieldwork completion:	April 2019
Draft report issued:	April 2019
Management response received:	May 2019
Final report issued:	May 2019
Auditors:	Martyn Lewis

Executive sign off:	Sharon Hopkins, Executive Director of Transformation, Improvement & Informatics
Distribution:	David Thomas, Director of Digital & Health Intelligence
	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

The review of the management of Cyber Security within the Health Board has been completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Hospital Board ('the Health Board').

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

Cyber security is the protection of information assets by addressing threats to information processed, stored, and transported by internetworked information systems. It is the protection of computer systems from the theft or damage to their hardware, software or information, as well as from disruption or misdirection of the services they provide.

Cyber-security includes controlling physical access to the hardware, as well as protecting against harm that may come from malware, viruses and unauthorised or inappropriate software.

A strong cyber awareness culture is one of the best defences against cyber-attacks. Regulations such as the Network and Information Security (NIS) Directive have increased the burden on organisations to ensure they have effective cyber-security strategies and culture in place, in addition to robust controls and policies, to prevent and remediate attacks.

In October 2017, Stratia Consulting was commissioned by Velindre Trust, on behalf of NHS Wales, to carry out external cyber security assessments for its organisations.

For each organisation, a cyber-security assessment report and security improvement plan (SIP) was produced. Additionally, an overarching security assessment and SIP for NHS Wales as a whole was produced.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place for cyber security, 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 to the Audit Committee that a process is in place for ensuring cyber security which provides protection from malicious software and appropriately protects the UHB information.

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

- governance: An appropriate governance and management structure is in place to ensure cyber-security;

- external review awareness: Information contained within the UHB's cyber-security assessment report and SIP has been discussed and monitored by an appropriate group or committee; and
- implementing actions: any actions contained within the previous cyber-security report and SIP have been completed within the agreed timeframes.

3. Associated Risks

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

I. poor or non-existent stewardship in relation to cyber-security;

II. failure to comply with regulations such as the NISD;

III. loss of data and inappropriate access to information from entities internal to the organisation;

IV. risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities; and

V. inappropriate unauthorised software installed / increased risk of infection from introduction of malware.

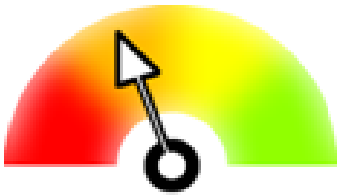
OPINION AND KEY FINDINGS

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 cyber security is **Limited assurance**.

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

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

It is worth noting that this review of cyber-security arrangements within the Health Board focused on the governance and visibility of the Stratia assessment report and SIP. We evaluated evidence to support the organisation's current positional statement on its action plan developed from the SIP; as such, our follow-up work was limited to the areas contained in the original Stratia report.

There is a high level structure for monitoring cyber security with a formal Committee in place and with cyber security related risks being included on the IM&T risk register. However at a lower level there is a lack of structure, with no operational group extant and no defined resource or lead for cyber security within the organisation. In the main the actions contained within the Stratia report have not been progressed, in general due to a lack of resource within IM&T. This has led to vulnerabilities not being addressed, in particular related to the use of old software and patching delays. This combined with the lack of any active monitoring or vulnerability scanning means the UHB is potentially unaware of its security position.

There is guidance available for staff on the intranet in terms of policies and procedures, although it should be noted that the IT Security Policy is out of date, however there is no ongoing programme of reminders being sent to staff regarding cyber security good practice.

5. Assurance Summary

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

Assurance Summary					
1	Governance		✓		
2	External review awareness			✓	

Assurance Summary					
3	Implementing actions		✓		

** 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 cyber security.

Operation of System/Controls

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

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: An appropriate governance and management structure is in place to ensure cyber-security.

The following areas of good practice were noted:

- Cyber security is reported to the Information Technology and Governance (IT&G) committee and is included within the risk register; and
- There is guidance available for staff on IT security and cyber security.

The following significant findings were identified:

- There is no current operational lead for cyber security and no structured programme to improve the UHBs position with respect to cyber security. Without this role being extant and operational the UHB will not be able to fully reduce its cyber security risks.
- Due to the lack of a cyber security lead, cyber security is dealt with in a reactive and ad hoc manner without any structure as there is no formal / operational cyber security group and currently no reporting process for cyber security or KPI reporting on this.
- Although there is an Information Security Policy, together with other related policies, there is no structured mechanism for providing regular updates / reminders to staff on good practice related to cyber security. Studies have shown that in general, employee actions / mistakes have led to approximately 50% of breaches. As such, this leads to an increased risk to the Health Board.

- The IT Security Policy is out of date as it dates from 2015 with the next review date given as 31 march 2018. The policy still refers to the Data Protection Act 1998 and not the GDPR.

Objective 2: Information contained within the Health Boards' cyber-security assessment report and SIP has been discussed and monitored by an appropriate group or committee.

There were no noted areas of good practice or significant findings identified within this objective.

Objective 3: Any actions contained within the previous cyber-security report and SIP have been completed within the agreed timeframes.

The following areas of good practice were noted:

- Anti-virus is running within the UHB;
- The UHB network is segmented;
- The UHB uses firewalls to protect the network;
- Patching of desktops is automatic, and there are reports on status available.

The following significant findings were identified:

- The Stratia report identified the need for investment in cyber security staff in order to improve the UHBs position. However this has not been provided and the majority of the actions defined within the Stratia report have not been completed with the main reason for the lack of action being a lack of resource within IM&T. This has been exacerbated by key staff having left, which has led to the organisation struggling to meet the day to day demands with little scope for improvements.
- Although the Health Board has security tools in place, due to a lack of resource available it has not maximised the benefits of these with Nessus (a vulnerability scanner) not being used.
- In addition, the organisation does not have the ability to efficiently deal with a cyber incident as it has not yet enacted the national Security Incident and Event Management (SIEM) product, and there is no incident response plan in place. As such the organisation is not fully able to quantify and fix its vulnerabilities, and would find it difficult to identify and deal with a malicious actor gaining access to the network.

- The organisation continues to use a number of devices running old software (operating system, servers, databases), and is also using old hardware such as switches. Although these are known to IM&T, there is no formal, resourced plan to remove all of these.
- There are weaknesses within the patching regimen for the organisation:
  - for desktops, although patching is automatic, there are some where this process is not working and so the pc is not getting the patch;
  - for servers, patching is manual, with the timing of patching varying dependant on the nature of the server. Some can be patched and restarted, however some that are running clinical systems cannot be taken down, and are therefore patched opportunistically. However there is no formal patch plan / process that sets this out;
  - for firmware / network hardware, this is also on an ad hoc basis without a formalised structure.

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	**4**	**4**	**0**	**8**

Finding 1–Resource and Actions (Operating effectiveness)	Risk
The Stratia report identified the need for investment in cyber security staff in order to improve the UHBs position. However this has not been provided and the majority of the actions defined within the Stratia report have not been completed with the main reason for the lack of action being a lack of resource within IM&T. This has been exacerbated by key staff having left, which has led to the organisation struggling to meet the day to day demands with little scope for improvements. This leads to an increased risk of vulnerabilities existing and being exploited within the organisation.	Poor or non-existent stewardship in relation to cyber-security.
Recommendation	**Priority level**
A review of the resources available within IM&T and the requirements of the organisation should be undertaken to ensure that the department can appropriately meet the demands. Additional investment should be considered in order to provide a cyber security function.	**High**

Management Response	Responsible Officer/ Deadline
A review of the current IT and Information departments has been completed and a restructure proposal created. This includes additional cyber security resources to manage and deliver the NESSUS and SIEM requirements, utilising the additional funding being made available by Welsh Government.	David Thomas July 2019

Finding 2–Management Process (Design)	Risk
Due to the lack of a cyber security lead, cyber security is dealt with in a reactive and ad hoc manner without any structure as there is no formal / operational cyber security group and currently no reporting process for cyber security or KPI reporting on this. This means that the UHB is not fully sighted on its cyber security position.	Poor or non-existent stewardship in relation to cyber-security.
Recommendation	**Priority level**
An active monitoring process which feeds into KPI reporting should be developed and maintained within IM&T.	**High**
Management Response	**Responsible Officer/ Deadline**
The restructure of the directorate includes additional resource to manage cyber security issues. A key role for this function will be the development of a monitoring system that supports the KPI reporting against cyber security.	David Thomas Sept 2019

Finding 3–Lead Role (Operating effectiveness)	Risk
There is no current operational lead for cyber security and no structured programme to improve the UHBs position with respect to cyber security. Without this role being extant and operational the UHB will not be able to fully reduce its cyber security risks.	Poor or non-existent stewardship in relation to cyber-security.
Recommendation	**Priority level**
Resources should be provided to allow for a cyber security role to be properly defined and operating appropriately.	**High**
Management Response	**Responsible Officer/ Deadline**
The restructure of the IT and information functions being proposed will result in the establishment of cyber security roles which will monitor and respond to cyber incidents and will develop policy, processes and procedures to reduce the likelihood of a cyber security incident.	David Thomas Sept 2019

Finding 4– Active Monitoring (Operating effectiveness)	Risk
Although the Health Board has security tools in place, due to a lack of resource it has not maximised the benefits of these with Nessus (a vulnerability scanner) not being used. In addition, the organisation does not have the ability to efficiently deal with a cyber incident as it has not yet enacted the national Security Incident and Event Management (SIEM) product, and there is no incident response plan in place. As such the organisation is not fully able to quantify and fix its vulnerabilities, and would find it difficult to identify and deal with a malicious actor gaining access to the network.	Risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities.
Recommendation	**Priority level**
Active monitoring should be established. A Cyber response plan should be developed.	**High**
Management Response	**Responsible Officer/ Deadline**
The creation of new cyber security roles in the restructured directorate will mean that a proactive stance on monitoring of cyber security is created as part of a wider Cyber response plan, which will also incorporate use of the NESSUS and SIEM solutions.	David Thomas Sept 2019

Finding 5– Old Software (Operating effectiveness)	Risk
The organisation continues to use a number of devices running old software (operating system, servers, databases), and is also using old hardware such as switches. Although these are known to IM&T, there is no formal, resourced plan to remove all of these. Until these are updated / removed the organisation will be at increased risk of a cyber attack, or a that a cyber attack becomes more widespread within the UHB as older devices contain security vulnerabilities and no longer have manufacturer support.	Risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities.
Recommendation	**Priority level**
A formal, resourced plan for the removal of old software and devices should be established.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A formal plan is in the early stages of production and will address removal of aged and insecure software as well as devices. This will be implemented by the cyber security team proposed in the new directorate structure.	David Thomas Sept 2019

Finding 6– Patching (Operating effectiveness)	Risk
There are weaknesses within the patching regimen for the organisation: • for desktops, although patching is automatic, there are some where this process is not working and so the pc is not getting the patch; • for servers, patching is manual, with the timing of patching varying dependant on the nature of the server. Some can be patched and restarted, however some that are running clinical systems cannot be taken down, and are therefore patched opportunistically. However there is no formal patch plan / process that set this out; • for firmware / network hardware, this is also on an ad hoc basis without a formalised structure. Without a formal procedure that defines the patching mechanism for all items within the UHB, there is a risk that vital updates will be missed and the UHB will be exposed to unnecessary risk.	Risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities.
Recommendation	**Priority level**
A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board.	**Medium**

Management Response	Responsible Officer/ Deadline
Patching of PCs is being investigated as time allows to identify the scale of the risk. A patch management procedure will be developed to address patching of all devices. This procedure will describe how patches and updates will be managed, with reference to the national standards and alerts managed through NWIS.	David Thomas Sept 2019

Finding 7– Staff Awareness (Operating effectiveness)	Risk
Although there is an Information Security Policy, together with other related policies, there is no structured mechanism for providing regular updates / reminders to staff on good practice related to cyber security. Studies have shown that in general, employee actions / mistakes have led to approximately 50% of breaches. As such, this leads to an increased risk to the Health Board.	Poor or non-existent stewardship in relation to cyber-security.
Recommendation	**Priority level**
Regular cyber security "bulletins" should be published via the intranet, with reminders of good practice.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The profile of cyber security will be raised via the creation of regular proactive bulletins, available to all staff via the intranet, which will remind staff of good practice.	David Thomas July 2019

Finding 8– Security Policy (Operating effectiveness)	Risk
The IT Security Policy is out of date as it dates from 2015 with the next review date given as 31 march 2018. The policy still refers to the Data Protection Act 1998 and not the GDPR.	Poor or non-existent stewardship in relation to cyber-security.
Recommendation	**Priority level**
The IT Security Policy should be reviewed and updated.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The current IT security policy is scheduled to be reviewed to reflect changes in legislation, IT architecture and national policy.	David Thomas Sept 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.

Report Title:	Report of the Losses and Special Payments Panel								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	23.05.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**x**	**For Information**	
Lead Executive:	Executive Director of Finance								
Report Author (Title):	Head of Financial Accounting and Services								

SITUATION

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

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

BACKGROUND

The Losses and Special Payments Panel last met on 13th May 2019 to consider the 6 month period October 1st 2018 to March 31st 2019. This report informs the Audit and Assurance Committee of the items considered at this meeting and the recommendations made for formal Audit and Assurance Committee approval. The minutes of the last meeting of the Losses and Special Payments Panel are attached as Appendix 1. These minutes give more detail about the issues discussed at the meeting, including those items that have been recommended to the audit committee for approval.

ASSESSMENT

The following losses have been identified for write off:

- Clinical negligence claims of £19.851m and personal injury claims of £0.321m for the period 1st October 2018 to 31st March 2019. For noting the income & expenditure charge suffered by the UHB in respect of such incidents was £0.751m;

- £86,927 in respect of bad debt write offs for the period 1st October 2018 to 31st March 2019;

- Small Claims Panel Losses of £9,199 for the period 1st October 2018 to 31st March 2019;

- £25,208 in respect of Ex Gratia Payments made during the period 1st October 2018 to 31st March 2019;
- £500 regarding one incident of theft for the year 1st April 2018 to 31st March 2019;
- £442,289 re obsolete or lost/damaged stock for the year 1st April 2018 to 31st March 2019.

ASSURANCE is provided by:

- The detailed minutes of the Panel meeting attached at Appendix 1.

RECOMMENDATION

The Audit and Assurance Committee is asked to:

- **APPROVE** the write offs outlined in the Assessment Section above.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS PANEL HELD ON 13th MAY 2019.

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

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

1. Minutes of Last Meeting

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

2. Clinical Negligence and Personal Injury Losses

Mr Monk presented the financial report on Clinical Negligence and Personal Injury losses for the twelve month period ending 31st March 2019.

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

SUMMARY OF LOSSES

	2018/2019 £'000	2017/2018 £'000
Clinical Negligence	22,700	52,476
Personal Injury	359	811
Total Loss	23,059	53,287
Less WRP Receipts Due	-21,456	-50,913
Total Net Cost to the UHB	1,603	2,374

With respect to clinical negligence claims, Mr Monk advised that there had been a reduction in gross expenditure (before reimbursal from the Risk Pool) of £29.776m. This was largely as a result of the decrease in quantums of existing cases which had fallen by £29.764m in comparison to the previous year. This was largely due to the significant increase in the value of provisions that had occurred in 2017/18 because of the revised discount rate which the Lord Chancellor announced in February 2017. No such adjustment had been required in 2018/19, though Mrs Wicks noted that the discount rate was due to change again in 2019/20. The result of this change was expected to be a reduction in the gross value of claims in 2019/20.

The impact of all recorded Personal Injury claims had been a gross I&E charge of £0.359m. This was a relatively low figure, which was £0.452m lower than in 2017/18. Again this was linked to the change in the discount rate in 2017/18 and also because fewer cases had moved from being possible to succeed to likely to succeed this year than last.

Recommendation

The Panel recommended that the Audit and Assurance Committee note that following expected reimbursement from the WRP, the net expenditure incurred by the UHB on these Clinical Negligence and Personal Injury claims was £1.603m for the year to March 31st 2019. Of this £0.852m relating to the period 1st April 2018 to 30th September 2018 had been noted at the December Audit Committee meeting.

Finalised Clinical Negligence (including Redress) Claims

During the six months ending 31st March 2019, there were 68 claims (where liability had been conceded and settlements paid) which had concluded at a total settlement cost of £19.876m (which are treated as a loss). The UHB also incurred £0.539m in legal fees re these cases and was successful in recovering £19.285m from the Welsh Risk Pool and Welsh Government for these claims, resulting in a net cost to the UHB of £1.130m.

Finalised Personal Injury Claims

During the six months ending March 31st 2019, 21 claims where liability had been conceded and settlements paid have concluded at a total settlement cost of £0.321m (which are treated as a loss). The UHB had also incurred £0.036m in defence fees and was successful in recovering £0.142m from the WRP for these claims, resulting in a net cost to the UHB of £0.215m.

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

In response to a question from Mr Lewis, Mr Hurton said that the amounts settled over any six month period could be volatile, being influenced by both the change in the discount rate applied and by the existence of any abnormally large cases (which usually were in respect of infants). For comparison the amounts recommended for write off in previous panel meetings had been:

November 2018 Clinical Negligence £11.777m, Personal Injury £0.292m

May 2018 Clinical Negligence £4.457m, Personal Injury £0.636m

November 2017 Clinical Negligence £2.983m, Personal Injury £0.260m

May 2017 Clinical Negligence £15.380m, Personal Injury £0.470m

November 2016 Clinical Negligence £9.768m, Personal Injury £0.255m

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of the settlement costs of claims finalised in the period 1st October 2018 – 31st March 2019. The value of these claims finalised was - Clinical Negligence - £19.851m. Personal Injury - £0.321m.

3. Debt Write Offs

Mr Williams presented a report on proposed invoice write offs for the period 1st October 2018 to 31st March 2019.

These were as follows:

Dental	112	8
Medical Records	472	24
Payroll	8,019	26
Accommodation	2,408	5
O/Seas Patients	67,641	20
Private Patients	2,887	27
Misc	5,388	44
Total	**86,927**	**154**

The total value of write offs actioned for the first six months of this financial year had been £53,606.59 giving a total of £140,534.01 for the year 2018/19.

Mr Williams stated that two relatively large invoices re overseas patients had contributed significantly to the value to be written off:

The first invoice for £0.032m related to a British National who had resided in Portugal for a number of years and had returned to the UK with the express intention of obtaining hospital treatment. Upon arrival in Accident and Emergency, the Overseas Patients Team informed the patient's family that he may not be entitled to free hospital treatment, since British Nationals of a non-pension age living in another EEA country are chargeable for treatment. A reciprocal agreement does not apply here because the patient specifically arrived in the UK for NHS treatment. Hence an invoice was issued for the NHS treatment, however the patient returned to Portugal and therefore the debt was referred to the Health Board's debt collection agency. Despite the efforts of the debt collection agency they were unable to locate the patient.

The second invoice for £0.025m related to a patient living in the UK with an expired visa and therefore not entitled to free NHS treatment. The patient had very complex medical needs and required lifelong treatment. Originally two invoices were raised to the value of £29k and monthly instalments were received to the value of £4k.The debt was not referred to the Debt Collection Agency as not deemed collectable due to the family's poor financial situation.

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

	2014/15		2015/16		2016/17		2017/18		2018/19	
	Value	No	Value	No	Value	No	Value	No	Value	No
Accommodation	0	0	8	1	1,049	8	0	0	2,668	6
Dental	90	7	130	10	81	6	203	15	401	16
Medical Records	1,182	48	360	22	650	35	1,070	47	672	42
Payroll	15,229	18	2,004	7	20,025	53	12,639	26	11,262	31
Private Patients	4,573	18	4,578	32	24,325	28	23,764	63	2,887	27
O/Seas Patients	24,761	38	53,011	48	16,475	10	58,632	40	74,450	26
IVF Wales	0	0	0	0	31,026	24	0	0	0	0
Misc	122,466	68	17,787	50	78,685	61	35,847	54	48,194	524
	168,301	**197**	**77,877**	**170**	**172,315**	**225**	**132,155**	**245**	**140,534**	**672**

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of £86,927 in respect of Bad Debts for the period 1st October 2018 to 31st March 2019.

4. Permanent Injury Losses

Mr Monk presented a report on permanent injury costs for the final six months of the financial year 2018-19. He explained that permanent injury allowances were approved by the NHS Pensions Agency and the long term costs were picked up by the UHB. The costs must be treated as losses and should be noted by the Panel. The UHB made payments on a quarterly basis to the Pensions Agency based on bills received from them.

There were a total of 27 cases ongoing, which in expenditure terms had resulted in a net benefit over the 6 month period to the UHB of £0.107m. The benefit was due to a change in the prescribed discount rate that is applied to such cases. There were payments made in the same period of £0.118m.

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

5. Employment Tribunal Costs

Mr Crook presented a paper outlining the claims and costs for the period 1st October 2018 to 31st March 2019.

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

All ten of these cases were live as at March 31st 2019. Nine of the cases had previously been reported to the Losses and Special Payments Panel, and the remaining case had been submitted to the Employment Tribunal since 1st November 2018.

No Employment Tribunal Cases were won, lost or settled during the period and therefore there was no loss for the panel to consider.

6. Ex Gratia Payments and Other Losses

Mr Monk presented a report on relevant costs for the period 1st October 2018 to 31st March 2019. Mr Monk noted that there were 18 ex-gratia losses totalling £25,208 made in the six months under consideration.

Eleven of the cases (£13,750) were the result of the independent review/ombudsman process. Two of the cases involved the receipt by UHB departments of counterfeit bank notes (£40) and one related to a court fee re an overdue invoice (£90). One incidence related to a loss of cash from a safe at Y Gegin Restaurant (£660). The incident had been reported to the police and money was now being kept in a more secure room which has had CCTV

installed. Three cases (£10,668) related to interest charged by HMRC in respect of VAT it had deemed to be recovered in error.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of the losses incurred in the period 1st October 2018 to 31st March 2019 amounting to £25,208

7. Small Claims Panel Losses

Mr Monk presented a report on costs for the period 1st October 2018 to 31st March 2019. During that period 16 claims had been settled at a total cost of £9,199.

Lack of accurate record keeping had resulted in 5 claims being paid as the resulting investigation has shown that they are unable to account for the loss.

4 claims had been paid as items were lost whilst changing bed sheets or clothing items were accidently sent to the laundry.

Accidental damage had resulted in 5 supported claims and travel expenses were paid to 2 patients who had suffered unnecessary costs due to maladministration by the Board.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of the £9,199 in respect of compensation payments which had been paid during the final six months of the Financial Year 2018/19.

8. Voluntary Early Release Payments

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

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

The Panel was asked to note the total payments figure. However no

recommendation for approval was required, since these have been approved by the appropriate committee.

The panel noted that there had been 5 payments during the final 6 months of the year totalling £0.211m.

9. Report of the Counter Fraud Manager

A report on fraud investigations undertaken during the year ended March 31st 2019 was received in the absence of Mr Greenstock.

The panel noted that all potential fraud and irregularity investigations were regularly discussed with the Finance Director and then reported to the Audit and Assurance Committee. An update on the current position of fraud cases under investigation was reported to the Audit and Assurance Committee on 23rd April 2019.

As at 31st March 2019, there are no cases reported, which have been closed in the period, from which the Health Board were then not able to recover any of its costs. However, there are a total of eighteen cases still under investigation and which have an estimated potential total loss of approximately £85k.

10. Security Losses

Mr Cockayne was not able to attend the meeting but had prepared a report for consideration. Only one incident had been reported to the security department during the year ending 31st March 2019. The incident was classified as a theft by the police and was investigated as such. The approximate cost of the item (a communications display monitor) lost was £500.

The Panel recommended that the Audit and Assurance Committee approve the write off of the £500 in respect of security losses which had been incurred during the Financial Year 2018/19.

11. Stock Write Offs

Mr Hurton presented a report on stock identified for write off during the year to March 31st 2019. During this period there were 17 instances of obsolete stock totalling £0.355m (2017/18 £0.097m) and 8 instances of lost or damaged stock totalling £0.087m (2017/18 £0.044m).

Mr Hurton stated that the 2017/18 figures had been significantly lower than in other years and the 2018/19 figures were more in line with historic levels. For information he said that the overall write offs in past years had been:

2016/17 £0.362m
2015/16 £0.339m

Part of the increase in the year was connected to write offs of environmental monitoring equipment issued to patients by ALAS. The stock which had been reusable after being reclaimed from patients but was now obsolete due to its software no longer being supported by the manufacturer.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of the £442,289 in respect of lost, damaged or obsolete stock during 2018/19.

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

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

Cardiff and Vale University Health Board

Strategic Planning/IMTP

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	C&V-1819-07
Report status:	Final Internal Audit Report
Fieldwork commencement:	12th March 2019
Fieldwork completion:	11th April 2019
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Management response received:	15th May 2019
Final report issued:	15th May 2019
Auditor/s:	Lucy Jugessur, Principal Internal Auditor Ian Virgill, Deputy Head of Internal Audit
Executive sign off:	Abigail Harris, Executive Director of Planning
Distribution:	Christopher Dawson-Morris, Corporate Strategic Planning Lead Lee Davies, Operational Planning Lead Lisa Dunsford, PCIC Director of Operations Rachel Burton, Children & Women Director of Operations Mike Bond, Surgery Director of Operations
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 Strategic Planning - IMTP was completed in line with the 2018/19 Internal Audit Plan.

The Health Board was unable to produce a balanced Integrated Medium Term Plan (IMTP) for the three year period 2018-2021. The IMTP could not therefore be approved by Welsh Government and the Health Board was required to produce and submit a one year plan for 2018/19.

The processes around the production of the 2018-2021 IMTP and resultant one year plan have been subject to previous Internal Audit review in March 2018.

The current review therefore focussed on the processes for the on-going delivery and monitoring of the one year plan.

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

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the Management of the Strategic Planning - IMTP process, in order to provide assurance to the Health Board's Audit Committee that risks to the achievement of the system's objectives are managed appropriately.

The purpose of the audit was to establish if adequate processes were in place to ensure effective on-going monitoring and delivery of the Health Board's 2018/19 one year plan.

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

- The Health Board has made appropriate progress towards delivering the key commitments within its one year plan for 2018/19;
- Robust processes are in place for monitoring and recording the progress made against the key commitments;
- Effective processes are in place for periodic reporting of the level of progress to appropriate groups and / or committees within the Health Board;
- Regular reports on progress are submitted to Welsh Government in line with required timescales;
- Effective processes are in place within the Clinical Boards for monitoring and reporting the delivery against the key objectives within their agreed IMTPs; and
- Clinical Board performance is effectively reported up to the Executive Team / Board and issues are escalated as required.

3. Associated Risks

The potential risks considered in this review are as follows:

- The Health Board fails to deliver the key commitments within its one year plan;
- Clinical Boards fail to deliver the key commitments within their IMTPS; and
- Issues of non-delivery are not identified and / 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 Strategic Planning/IMTP is **Substantial assurance**.

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 made appropriate progress towards delivering the key commitments within its one year plan for 2018/19 and there is evidence that monitoring of the Plan and the Clinical Board IMTPs is carried out and therefore we consider the review to be of substantial assurance. In addition, at the time of the review the Health Board's IMTP for 2019-2022 was approved by Welsh Government.

There were a number of core actions that were included within the Annual Plan for 2018/19 and the progress of these were monitored and updates provided on them via the Operational Planning Group and the monthly Performance Reviews. 'Delivering On Our Commitments' was reported within the IMTP 2019-22, giving an update on the core actions from the Annual Plan 2018/19 including whether they had been delivered, were in

progress or not implemented. It was evident that significant progress had been made on delivery of the key commitments from the Annual Plan 2018/19.

The Health Board produced a Mid-Year Review report for the Welsh Government and the Executive providing an update on the Annual Plan and there are monthly meetings held with Welsh Government to discuss the IMTP.

There were a number of processes in place within the Clinical Boards to monitor and report delivery of the core actions and other priorities within their individual IMTPs. However, these were inconsistent and of a varied standard. It has been agreed to update the process going forward with there being individual plan priorities for each of the Clinical Boards that will come from the Shaping Our Future Wellbeing - Annual Plan for 2019-20 (An X-Matrix Document will be in place to set out priorities for the organisation and clinical boards). This will enable the Clinical Boards to consistently monitor each of their projects and effectively report on the progress and any issues and ensure appropriate Management Executive Oversite.

5. Assurance Summary

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

Assurance Summary					
1	Health Board has made appropriate progress towards delivering key commitments				✓
2	Robust processes are in place for monitoring and recording progress				✓
3	Effective processes are in place for periodic reporting of the level of progress				✓
4	Regular reports on progress are submitted to Welsh Government				✓
5	Effective processes are in place within the Clinical Boards for monitoring and reporting			✓	

Assurance Summary					
	the delivery against the key objectives				
6	Clinical Board performance is effectively reported up to the Executive Team / Board			✓	

** 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 Strategic Planning/IMTP.

Operation of System/Controls

The findings from the review have highlighted no issues that are classified as weakness in the operation of the designed system/control for Strategic Planning/IMTP.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: The Health Board has made appropriate progress towards delivering key commitments within its one year plan for 2018/19

The following areas of good practice were noted:

- The Annual Plan for 2018/19 included fourteen core actions detailing the major developments that were to be delivered within the 2018/19 year. At the time of the Audit, the IMTP for 2019-2022 had been produced and within the document is a section on 'Delivering on our Commitments' detailing the previous actions and any progress. Six of the original core actions had been delivered and the results of these were reported. Two of the core actions were in progress and updates were provided. One core action had not been implemented as further scoping was required.
- The other five core actions within the 2018/19 Annual Plan were detailed elsewhere in the IMTP for 2019-2021. Progress had been made on these core actions and updates were provided on them.

There were no significant findings noted.

Objective 2: Robust processes are in place for monitoring and recording the progress made against the key commitments

The following areas of good practice were noted:

- There is a Mid-Year Review undertaken which is a monitoring review of progress on the IMTP which is provided to the Welsh Government and also internally to the Management Executives. There were updates provided within the Mid-Year Review on the Core Actions detailed in the Annual Plan 2018/19.
- There was also a section titled 'Outcomes that matter to people' which included Obesity, Population health, Prevention and health improvement, Substance Misuse and Wellbeing of Future Generations. For each of these areas there was detail confirming what the Annual Operating Plan Actions were, the Current Status and Actions Being Taken to Recover Progress.

There were no significant findings noted.

Objective 3: Effective processes are in place for periodic reporting of the level of progress to appropriate groups and / or committees within the Health Board

The following areas of good practice were noted:

- The Strategy and Delivery Committee were provided with updates on the commitments within the Annual Plan 2018/19.
- Reports and updates were provided to the Operational Planning Group which is a group that includes the Chief Operating Officer and all the Directors of Operations for the Clinical Boards and IMTP is discussed within this group.
- There are monthly performance meetings with the Chief Operating Officer and the individual Director of Operations and any updates on any of the projects within the Clinical Board were discussed and reported at this meeting.
- Quality & Delivery meetings are held which include staff within the Health Board and Welsh Government and they discuss commitments within the IMTP.

There were no significant findings to note.

Objective 4: Regular reports on progress are submitted to Welsh Government in line with required timescales

The following areas of good practice were noted:

- There are no regular reports provided to Welsh Government apart from the Mid-Year Review which is provided on a 6 monthly basis. However, the Director of Planning and the Corporate Strategic Planning Lead meet with Welsh Government to discuss the IMTP and letters are sent from Welsh Government confirming the meeting and the discussions that were held.

- PCIC reported to the Welsh Government on some of their IMTP priorities whereby they have received funding, outlining any progress with results/ benefits planned, any issues since the last report and how they will be addressed and the amount spent to date.

There were no significant findings noted.

Objective 5: Effective processes are in place within the Clinical Boards for monitoring and reporting the delivery against the key objectives within their agreed IMTPs

The following areas of good practice were noted:

- It was identified within the PCIC Clinical Board that there are Clinical Board IMTP Development Sessions which reviewed progress to date for IMTP priority schemes for 2018/19. In addition, there is a PCIC Service Delivery Group and updates were provided on the core actions within the IMTP.
- Within the three sampled Clinical Boards there were processes in place for monitoring the core actions within the agreed IMTPs as follows:
  - PCIC - There were a number of Prevention Priority Deliverables detailed within the PCIC IMTP and updates were provided to the Welsh Government on the priorities. There was evidence of updates being provided on Primary Care Sustainability;
  - Surgery - Audit selected four of the Core Actions from the Annual Plan 2018/19 that were related to the Surgery Clinical Board. Progress of the Core Actions were discussed within the Clinical Board meetings. There was a specific Programme Group for one of the Core Actions that met on a monthly basis to discuss the progress.
  - Children and Women - There was only one Core Action relating to this Clinical Board and a project board was in place to manage and monitor the repatriation of CAMHS and regular updates were provided on the project. In addition, Audit selected a sample of priorities that were included within the IMTP and there was evidence of monitoring of these.

The following significant findings were noted:

- There was a lack of consistency in place within the sampled Clinical Boards for monitoring and reporting the delivery against key objectives within their IMTPs. As identified, PCIC had specific groups in place to review the progress against the IMTP but there weren't any such overarching review groups in place within the Surgery or Children and Women Clinical Boards.

Objective 6: Clinical Board performance is effectively reported up to the Executive Team / Board and issues are escalated as required

The following areas of good practice were noted:

- There is an Operational Planning Group in place which is attended by all the Clinical Board Directors of Operations with the Chief Operating Officer, Deputy Chief Operating Officer and the Operational Planning Director. Performance against the agreed IMTPs was discussed within this agenda.
- There are monthly Executive Performance reviews held within each of the Clinical Boards and updates were provided on the IMTP.
- The Planning Department have implemented a Shaping Our Future Wellbeing - Annual Plan for 2019-20 which details all the major projects including the IMTP projects and which Clinical Board is responsible for them.

The following significant findings were noted:

- It has been agreed that there will be individual plans produced for each of the Clinical Boards that will come from the Shaping Our Future Wellbeing - Annual Plan for 2019-20. These will enable the Clinical Boards to consistently monitor each of their projects and report on the progress and any issues. At the time of the review the documents had not been produced.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - Monitoring and reporting of projects by the Clinical Boards Design)	Risk
It was evident from our review that there are a number of ways that the Clinical Boards are able to report on their IMTPs to the Executive Team / Board, including the Operational Planning Group and the monthly Executive Performance reviews. There was however a lack of consistent processes in place within the three sampled Clinical Boards for monitoring and reporting delivery against key objectives within their 2018/19 IMTPs. The Planning Team have now produced a Shaping Our Future Wellbeing - Annual Plan for 2019-20 (X-Matrix Document) which details all the major projects, including the IMTP projects and how they will fit in with the KPIs and which Clinical Board are responsible for them. It has been agreed that there will also be individual plans produced for each of the Clinical Boards to enable them to monitor each of their projects and report on the progress and any issues. This will allow there to be a consistent and standardised process for monitoring and reporting on the individual projects.	Issues of non-delivery are not identified and / or addressed
Recommendation	**Priority level**
Management should ensure that the plans for Clinical Boards are produced on a timely basis to enable the Clinical Boards to report on their projects in a consistent manner and allow them to monitor them appropriately.	**Medium**

Management Response	Responsible Officer/ Deadline
A revised monitoring process for reporting clinical board progress on IMTPs will be in place for 2019/20. This will utilise the Shaping Our Future Wellbeing- Annual Plan (X-Matrix) methodology to provide clarity on performance and accountability arrangements. Progress against key IMTP priorities as captured in the annual plan document will be reported to Management Executives on a monthly basis as agreed at Management Executives on 09/05/19.	Chris Dawson-Morris, Corporate Strategic Planning Lead. 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.

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Cardiff and Vale University Health Board

Health and Care Standards

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

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Auditor/s:	Ian Virgill, Deputy Head of Internal Audit
Executive sign off:	Ruth Walker, Executive Nurse Director
Distribution:	Carol Evans, Assistant Director Patient Safety and Quality Alexandra Scott, Patient Safety and Quality Assurance Manager
Committee:	Audit Committee

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

1. Introduction and Background

The review of the Health and Care Standards was completed in line with the Internal Audit Plan.

The relevant lead Executive for the assignment is the Executive Nurse Director.

The new Health & Care Standards came into force on 1st April 2015 and incorporate a revision of Doing Better: Standards for Health Services in Wales (2010) and the 'Fundamentals of Care Standards' (2003).

The new standards provide a consistent framework that enables health services to look across the range of their services in an integrated way to ensure that all that they do is of the highest quality and that they are doing the right thing, in the right way, in the right place at the right time and with the right staff.

The Health and Care Standards have been designed so they can be implemented in all health care services, settings and locations. They establish a basis for improving the quality and safety of healthcare services by providing a framework which can be used to identify strengths and highlighting areas for improvement.

Health services are expected to understand where they currently are in relation to meeting these standards through honest self-assessment well tested through the use of mechanisms such as internal audit and clinical audit.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the Health & Care Standards, 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 establish if the Health Board has adequate procedures in place to ensure that the standards are effectively utilised to improve clinical quality and patient experience and that appropriate processes are in place to assess performance against the standards.

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

- The Health & Care Standards are effectively implemented across the whole Health Board and are being utilised to improve the quality and safety of services;
- An appropriate process is in place to assess performance against the standards during 2018/19; and
- The Health Board has appropriate processes in place to oversee, monitor and report the utilisation and assessment of the standards.

3. Associated Risks

The potential risks considered in the review were as follows:

- The standards are not effectively utilised across the Health Board; and
- The Health Board is not aware of its performance against the standards.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Health and Care Standards 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 current review has confirmed that the Health Board continues to make good progress with the embedding of the Standards across the organisation. The further development of the process for continuous monitoring of performance against the Standards through existing Groups and Committees is leading to more effective utilisation of the Standards to drive improvements in service delivery.

Review of a sample of the 17 aligned standards has confirmed that the agendas of the respective Groups / Committees are appropriately set up to reflect the criteria dictated in the Standards to which they are aligned. Continued work is however needed to ensure that all the Groups / Committees are regularly monitoring Clinical Board performance against the standards and effectively driving required improvements.

Self-assessments of the Health Board's performance against the Standards for 2018/19 have been appropriately completed.

The Health Board has an appropriate timetable in place for the finalisation and sign-off of the 2018/19 self-assessments and subsequent reporting of the outcomes to the Quality, Safety and Experience Committee. The planned process for completing this is in line with that undertaken for the 2017/18 standards.

However it is noted that a number of the current self-assessments are provisionally scored as 'getting there' which illustrates that the Health Board has further work to do to ensure that all the standards are being fully utilised throughout the organisation.

5. Assurance Summary

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

Assurance Summary					
1	Effective implementation and utilisation of the Standards across the Health Board.			✓	
2	Assessment of performance against the standards during 2018/19.			✓	
3	Oversight and monitoring of the utilisation and assessment of the standards.				✓

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

6. Summary of Audit Findings

From a review of the processes underpinning the utilisation, embedding and assessment of the Health and Care Standards in 2018/19 the following points can be noted under the individual objectives:

Objective 1 - The Health & Care Standards are effectively implemented across the whole Health Board and are being utilised to improve the quality and safety of services:

- The Health Board has made further progress during 2018/19 towards ensuring that the Health and Care Standards are effectively embedded across the organisation and are being appropriately utilised.
- As part of its on-going 3 year plan, the Health Board has aligned a further 4 of the standards to existing Groups or Committees who are then responsible for the effective utilisation and assessment of the Standards. This means that 15 of the 22 Standards have now been aligned to Groups or Committees with the plan being that the remaining 7 are aligned over the next year.
- Testing carried out on a sample of the groups or committees confirmed that their agendas are appropriately set up to reflect the criteria dictated in the Standards to which they are aligned.
- The Health Board will however need to ensure that all the identified groups and committees are receiving regular reports on individual Clinical Board performance against the standards and are using these to effectively drive the utilisation of the Standards across the organisation.

Risk 2 - An appropriate process is in place to assess performance against the standards during 2018/19:

- An appropriate timetable is in place for the completion, review, sign-off and reporting of SBAR self-assessments against the standards.
- Draft SBAR self-assessments have been completed for the standards that have been aligned to relevant groups or committees. Review of a sample of the SBAR self-assessments confirmed that they had been appropriately completed with an overall score, details of supporting assessment and key improvement actions for 19/20.
- The Clinical Boards are actively engaged in the completion of self-assessments against the 7 Standards that have not yet been aligned to Specific Groups / Committees. Review of a sample of 3 of these Standards confirmed that all 8 Clinical Board's had completed an appropriate self-assessment of their position against the Standard during 2018/19. A Corporate SBAR self-assessment had also been completed by each of the relevant corporate leads.

  The sampled 3 Standards were:

  - Standard 1.1 Health Promotion, Protection & improvement;

- Standard 3.5 Record Keeping; and
- Standard 6.3 Listening and Learning from Feedback.

Objective 3 - The Health Board has appropriate processes in place to oversee, monitor and report the utilisation and assessment of the standards:

- The completed 2018/19 SBAR self-assessment will be subject to formal sign-off by Executive and Independent member leads but this was not scheduled to be completed until after the current review.

  Review of the process undertaken during June / July 2018 for sign-off of the 2017/18 self-assessments confirmed that a robust and effective process was carried out. This provides additional assurance for 2018/19 given that the planned process is the same.
- Details of the UHBs compliance against the Standards is scheduled to be reported to the September meeting of the Quality, Safety and Experience Committee.
- Details of the proposed approach to the utilisation and assessment of the Standards and monitoring of progress were reported to and agreed by the Quality, Safety and Experience Committee.

Appendix A - Assurance opinion ratings

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.

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UHB Core Financial Systems

Final Internal Audit Report

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Executive sign off:	Bob Chadwick, Director of Finance
Distribution:	Chris Lewis, Deputy Director of Finance Richard Hurton, Assistant Finance Director Rhian Selwood, Financial Accounting Manager David Maddocks, Shared Financial Information Manager Paul Emmerson, Principal Finance Manager
Committee:	Audit Committee

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

1. Introduction and Background

The review of the Core Financial Systems has been completed in line with the 2018/19 Internal Audit plan for Cardiff and Vale University Health Board.

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

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

2. Scope and Objectives

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

The purpose of the review was to establish if the Health Board has appropriate processes in place to ensure the effective management of the Asset Register and the General Ledger Approval Hierarchies.

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

Asset Register

- Procedure guidance is in place and is appropriate and up to date;
- The Health Board has an up to date asset register in place that accurately records all assets;
- New assets and asset disposals are accurately identified and promptly recorded on / removed from the register; and
- Assets are appropriately accounted for including valuation, depreciation and indexation.

General Ledger Approval Hierarchy

- Approval hierarchies within the general ledger are appropriate and are in line with the Health Board's Scheme of Delegation; and
- Robust processes are in place for reviewing and maintaining the approval hierarchies within the general ledger.

3. Associated Risks

The potential risk considered in this review were as follows:

- The capital asset register may be inaccurate and assets may be incorrectly recorded or valued; and
- Unauthorised expenditure may be incurred.

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 establishment controls within the Core Financial Systems is **Reasonable assurance.**

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

The current review has identified that there are generally good processes in place for the management of the Health Board's Fixed Asset Register. An up to date Financial Control Procedure is in place and available via the intranet and a specific Capital Asset booklet along with bespoke training has been provided to relevant Clinical Board staff.

The annual asset verification exercise was undertaken by the Finance Department. However, a number of asset transfers or adjustments identified by the Clinical Boards had not been updated on the Asset Register at the time of our review.

There is currently a lack of any standard process for validating and updating the Oracle Hierarchy lists across the individual Clinical Boards and also the Corporate Finance team. The substantive testing completed as part of the review identified a number of errors within the Oracle Hierarchy. Issues were also identified around the retention of Budget Holder – Financial Limit Forms within the e-Enablement team.

5. Assurance Summary

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

Assurance Summary					
1	Procedure guidance is in place and is appropriate and up to date				✓
2	An up to date asset register in place that accurately records all assets			✓	
3	New assets and asset disposals are accurately identified and promptly recorded on / removed from the register			✓	
4	Assets are appropriately accounted for including valuation, depreciation and indexation				✓
5	Approval hierarchies within the general ledger are appropriate and in line with the Health Board's Scheme of Delegation			✓	
6	Robust processes are in place for reviewing and maintaining the approval hierarchies		✓		

** 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 UHB Core Financial Systems.

Operation of System/Controls

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

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: Procedure guidance is in place and is appropriate and up to date.

The following areas of good practice were noted:

- An Asset Register Financial Control Procedure (FCP) is in place and up to date. It reflects the current processes regarding asset additions, disposals, physical verification, depreciation and indexation.
- The FCP is readily accessible to Finance staff. This is stored within Finance's shared folder.
- There is a Capital Asset Booklet which details the relevant information that key staff responsible for the maintenance of the asset register should be aware of.
- The Capital Asset Booklet is usually reviewed before the annual training session is held for the relevant staff.
- This booklet is made available to all staff on the intranet.

There were no significant findings noted for this objective.

Objective 2: The Health Board has an up to date asset register in place that accurately records all assets

The following areas of good practice were noted for this objective:

- The main asset register is tracked and reconciled on a monthly basis.
- The physical asset verification exercise is undertaken once a year and a guidance booklet provided.
- Emails are sent out to the Clinical Boards, Managers and relevant members of staff where they are informed of the verification process. An updated asset register is usually sent out to the various departments in October.
- Two training sessions were held in October 2018 where key staff responsible for the maintenance of the asset register within the various Directorates were brought up to date on the asset register system and the verification process.

The following significant finding was noted for this objective:

- Review of the physical asset verification exercise undertaken for a sample of 6 departments / Directorates, identified that a number of highlighted changes had not been updated on the main asset register.

Objective 3: New assets and asset disposals are accurately identified and promptly recorded on / removed from the register

The following areas of good practice were noted for this objective:

- Fixed Asset additions are identified (as stated in the Financial Control Procedure) by periodically reviewing:
  - The Capital Programme.
  - Revenue expenditure over £5,000.
  - Charitable funds donations greater than £5,000.
- Additions to the asset register are updated on a quarterly basis.
- 5 additions were randomly selected from the Main Asset Register for testing. All 5 assets had their details accurately and promptly entered into the asset register.
- Disposals are usually done on a monthly basis, however, this is dependent on the volume of assets being disposed of at the time.

There were no significant findings noted for this objective

Objective 4: Assets are appropriately accounted for including valuation, depreciation and indexation.

The following areas of good practice were noted for this objective:

- Review of a sample of 20 assets with varying life spans confirmed that the correct valuation and required depreciation had been accurately calculated and recorded.

There were no significant findings noted for this objective.

Objective 5: Approval hierarchies within the general ledger are appropriate and are in line with the Health Board's Scheme of Delegation.

The following area of good practice was noted for this objective:

- Testing carried out on a sample of staff with an approval amount on the Oracle hierarchy greater than £75K confirmed that they were all currently employed by the Health Board. Their stated limits were all also in compliance with the requirements of the Health Board's Scheme of Delegation.

The following significant finding was noted for this objective:

- The equivalent testing carried out on a sample of staff with an approval limit delow£75K identified to individuals who are no longer employed by the Health Board.

Objective 6: Robust processes are in place for reviewing and maintaining the approval hierarchies

The following areas of good practice were noted for this objective:

- All new users, users that require a change in detail or leavers complete a Budget Holder- Financial Limit Form in order to be allocated a financial limit within the Oracle Purchasing Hierarchy. This is signed off by the Finance leads within each Clinical Board and subsequently submitted to eEnablement.
- The Oracle purchasing hierarchy has undergone ad hoc reviews by the Finance leads at the Clinical Board level.

The following significant findings were noted for this objective:

- There is no overarching guidance available stating the processes to be undertaken for reviewing and updating the Oracle hierarchies to support the CB leads and Corporate Finance.
- eEnablement were unable to provide copies of Budget Holder- Financial Limit forms for the majority of staff sampled from the Oracle Hierarchy list.

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**	**4**	**1**	**5**

Finding 1 - Asset Verification Process (Operating effectiveness)	Risk
The Finance Department carry out an annual asset verification exercise whereby departments are provided with lists of their capital equipment, as detailed on the Asset Register, to be physically checked against actual equipment present. 6 Departments / Directorates were randomly selected to check if changes recorded on their returned and verified lists had been accurately updated on the main Asset Register. The selections were made from those areas that had responded and sent confirmatory emails to update Finance of their physical verification exercise. The following issues were noted: **Cardiac Services** • 1 asset is yet to be reclassified / transferred to the appropriate Directorate. **Clinical Gerontology** • The department identified a number of additional assets on their verified list which are yet to be added to the main Asset Register along with a number of condemned assets that have not yet been removed from the Asset Register. The Finance Department believe that these identified differences may relate to hoists that have potentially been double counted. They are therefore arranging to carry out a visit to the department in order to review and clarify the identified additional / condemned assets but this had not been completed at the time of audit; and	The capital asset register may be inaccurate and assets may be incorrectly recorded or valued

• 6 assets were identified as having been transferred to an Internal Medicine Ward but these have not yet been changed on the Asset Register. **Dental** • 3 assets could not be located by the department but are still recorded on the asset register. The department subsequently confirmed that the assets had been disposed of. The assets in question are shown at nil net book value on the asset register.	
Recommendation 1	**Priority level**
Management should ensure that the main Asset Register is updated to reflect the correct position and steps are undertaken to ensure the required follow up is commenced as soon as possible on all applicable assets.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed and accepted. The follow up visits with clinical gerontology will be completed by the week ending May 24th 2019. The remaining transfers will be actioned by the end of July 2019.	Richard Hurton – 31/7/2019

Finding 2 - Physical Asset Verification Re-Performance Testing (Operating effectiveness)	Risk
A total of 45 assets across 5 Directorates were randomly selected for testing by audit to establish if the physical assets present within the department corresponded to the details recorded in the main Asset Register. The following issues were noted: **Radiology** • 1/10 assets belonged to Endoscopy Department; and • 1/10 assets was not labelled with an asset number. **Obstetrics & Gynaecology** • 1/10 assets was not labelled with an asset number. **Haematology** • 2/5 assets had been disposed, however the department had not completed a disposal form as at time of the physical asset verification. It is noted that a disposal form was subsequently completed and the assets were removed from the asset register prior to the year-end on 31/03/19; and • 1/5 assets was not labelled with an asset number. **Medical Biochemistry & Immunology** • 1/5 assets was not labelled with an asset number **Cardiac Services** • 1/10 assets was broken and not in use. The asset is still currently recorded on the Asset Register but with a nil Net Book Value (NBV); and	The capital asset register may be inaccurate and assets may be incorrectly recorded or valued

• 1/10 assets was not labelled with an asset number. It was further observed that 11/45 of all the assets selected had no serial number within the asset register. This made it difficult to verify assets without an asset number where there was more than one of its kind.	
Recommendation 2	**Priority level**
Management should ensure departments are aware that all assets should have asset numbers, where this is not the case Finance should be informed. Management should advice Departments that where assets are to be disposed or no longer in use a disposal form should be completed and passed to Finance as soon as possible. The asset register should also be updated with asset serial numbers.	**Low**
Management Response	**Responsible Officer/ Deadline**
The Director of Finance will again write to departments during 2019/20 emphasising the need to place the asset identification labels provided onto new capital assets purchased and to ask for replacement labels where necessary. Departments will also be reminded of the need to inform finance of asset disposals on a timely basis and to provide details of missing serial numbers when they respond to the annual asset verification request. This will once again be supported with training sessions for directorate managers.	Richard Hurton – October 31st 2019

Finding 3 Financial limit testing (Operating effectiveness)	Risk
A sample of 30 staff was selected from the Oracle Approval Hierarchies list to check that the financial limit was in line with the requirements of the Health Board's Scheme of Delegation or individual Clinical Board limits. The details for 6 of the sampled staff were non-compliant when checked against the financial limit list provided by the Clinical Boards due to the following issues: • 2 were no longer employed by the Health Board; • 1 had a different financial limit stated; and • 3 were not within the Clinical Board's list provided (2 due to changed roles & 1 was no longer allocated a financial limit).	Unauthorised expenditure may be incurred
Recommendation 3	**Priority level**
Management should inform responsible staff to promptly notify eEnablement of changes to the Purchasing Oracle hierarchy list. The required forms should be completed to process updates.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Recommendation Accepted. The UHB's current procedure will be updated to clarify the responsibility to review approvers at the Clinical Board level and within Corporate Finance.	Paul Emmerson – 31/7/19

Finding 4 Oracle Hierarchy Guidance (Control design)	Risk
Each Clinical Board has a Finance lead who is responsible for maintaining an up to date list of approval hierarchies for that Clinical Board. Audit met with three of the Finance leads establish and evaluate the process in place for the maintenance and periodic review of the Clinical Board's list of Oracle Purchasing hierarchies. Whilst audit was informed about the review processes undertaken by the Finance leads, these were inconsistent and in some of the cases could not be evidenced. There has not been any form of overall review or monitoring of the Health Board's overall Oracle Purchasing hierarchies by Corporate Finance. It was observed via audit's request for a copy of the Oracle approval hierarchy list and from the responses provided by Finance leads that the reports being issued by eEnablement on request are not of a standardised format. There is currently no standard procedural guidance in place stating the processes to be undertaken in relation to review of the Oracle approval hierarchies. Standard guidance would support the Clinical Board leads and Corporate Finance and could include the following: • The responsibility of both the Clinical Boards and Corporate Finance; • The processes and steps to be undertaken to ensure the Oracle Hierarchy is well maintained and up to date;	Unauthorised expenditure may be incurred

• An agreed time frame for the review of the list of Oracle approval hierarchies both at the Clinical Board level and by Corporate Finance; and • Information on eEnablement contacts and the standard reports to be provided.	
Recommendation 4	**Priority level**
Management should ensure that a standard procedural guide is produced to support staff in the maintenance of the Oracle Purchasing hierarchy. The guide should also state an appropriate agreed period for the review of the hierarchy.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Recommendation accepted. The UHB's current procedure will be updated to clarify respective responsibilities at the Clinical Board level and within Corporate Finance. The minimum expectation is that purchasing hierarchies will be reviewed quarterly.	Paul Emmerson – 31/7/19

Finding 5 Test on Financial Limit forms (Operating effectiveness)	Risk
30 staff members were selected from the Oracle approval hierarchy list to check if they were still employed by the Health Board, that the details of their role were correct and a 'Budget Holder – Financial Limit Form' had been completed. The following issues were noted: • 1/30 staff members was no longer employed by the Health Board; • 10/30 had a different position stated in ESR and/ or their email as compared to that within the Oracle list; • 23/30 financial limit forms could not be provided. The NWSSP e Enablement team is responsible for processing requests relating to additions to the Oracle Hierarchy list. These are processed on receipt of the completed form signed off by the relevant Finance lead within each Clinical board. On request of the selected completed forms from the e Enablement team, Audit was informed that members of staff (within the list) had been migrated from the R11 to R12 platform of Oracle in 2014. This was a batch migration which involved financial limits that had been processed at varying dates prior to 2014. All of the staff are carrying the same processing date with eEnablement as 2014. eEnablement stated that the Forms are unavailable after the migration and cannot be found. 17/23 financial limit forms were not provided due to the 2014 migration.	Unauthorised expenditure may be incurred

It is noted that selections were made based on the 'creation date' within the report provided by eEnablement. On further enquiry, it was observed that the creation date was not the date requests were processed by e Enablement. However 6/23 missing forms relate to more recent dates. eEnablement stated that ~~they~~ were not able to locate the forms because of how they were saved electronically. • 1/7 forms sighted had no financial limit stated within.	
Recommendation 5	**Priority level**
Management should ensure that the required forms are completed, signed and forwarded to eEnablement for all additions to the Oracle Hierarchy. Management should also liaise with eEnablement to ensure there is an organised system for storing the Financial limit forms so they can be easily retrieved where an audit trail is required.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Recommendation accepted. The UHB's revised procedure will be updated to clarify respective responsibilities for establishing approvers and maintaining appropriate records for additions to the Oracle Hierarchy.	Paul Emmerson – 31/7/19

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.

 **Moderate assurance** - The Board can take **moderate 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.

 **Unsatisfactory** - The Board has **unsatisfactory** arrangements in place to secure governance, risk management and internal control, within those areas under review, which 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.

Water Safety

Final Internal Audit Report

2018/19

Cardiff and Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance


CONTENTS Page

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Distribution:	Geoff Walsh, Director of Capital, Estates & Facilities Jon McGarrigle, Head of Performance Tony Ward, Head of Discretionary Capital & Compliance
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.

Please note:

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

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

1. Introduction and Background

The Water Safety audit was commissioned in order to evaluate the associated processes and procedures that support its management and control. The audit assessed compliance with the requirements of Welsh Health Technical Memorandum (WHTM) 04-01, Safe Water in Healthcare Premises.

The University Health Board (UHB) identified in 2014 that substantial improvements were required in all statutory compliance areas, including legionella / water safety, due to the ageing nature of the estate (University Hospital Llandough being nearly 90 years old, and University Hospital Wales being nearly 50), and absence of baseline information (including estate schematics) from which to develop a fit-for-purpose compliance programme.

A long-term strategy was agreed by the Board, including substantial financial investment, to systematically address these issues. The agreed programme included the restructuring of the Estates team to provide dedicated compliance officers, undertaking comprehensive surveys of the estate, associated risk assessments, and completion of identified remedial work. The UHB is presently midway through the implementation programme.

The audit assessed the current position in respect of water safety compliance.

The audit forms a part of the approved 2018/19 internal audit plan.

2. Scope and Objectives

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

The audit evaluated the systems and controls in place within the UHB with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas covered were appropriately managed.

Accordingly, the scope and remit of the audit was directed to the following areas:

- **Governance -** The UHB had adequate arrangements in place to support the implementation of the approved code of practice. Also, that an appropriate policy was in place to address water safety issues, there were defined allocation of responsibilities, clear lines of communication and reporting and approval processes.
- **Monitoring and Reporting -** To ensure that the estate was appropriately monitored. To ensure that the UHB had effective monitoring procedures in place e.g. the establishment of appropriate Water Safety Groups (WSGs). Assurance that there was appropriate record retention and dissemination of information through to the Executive team and Board.

- **Procedures -** To ensure that management were implementing applicable procedures – both internal and external requirements.
- **Management -** Assurance that relevant staff had received appropriate training, and appropriate resources were allocated. Assurance that and an appropriate inspection / detection regime was operated.
- **Risk Management -** Assurance that the UHB had performed a suitable and sufficient assessment of risks. Risks were appropriately managed.

3. Associated Risks

The potential risks considered in the review are as follows:

- Patient Safety;
- Prosecution / criminal negligence;
- Adverse publicity;
- Breach of regulations / Approved Code of Practice;
- Fines and defence costs;
- Ineffective / inappropriate governance arrangements;
- Ineffective / ill-informed management; and
- Ineffective risk control.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

- We noted strong controls in the areas of governance, structures and procedures. The Water Policy and the Water Safety Plan (WSP) were well defined, in terms of the requirements of the WHTM 04-01 and the HSE Approved Code of Practice (ACOP) L8.
- There was insufficient evidence of required flushing activities in the sampled wards at University Hospital Wales (UHW) and University Hospital Llandough (UHL), including a number of wards classed as high risk. The Water Safety Group should ensure it receives assurance that improvements are made in respect of the specific ward areas with non-compliance identified during the audit, to ensure this high risk area is better controlled.

- Substantial improvements have been made in recent years in terms of surveying the infrastructure across the UHB, and producing schematics and risk assessments for the estate, as required by the HSE ACOP and WHTM. This work forms a part of a wider, ongoing statutory compliance programme within the UHB.

  However, further work remains to be completed to ensure the identified risks and required remedial actions are appropriately prioritised, with a full action plan in place to manage these risks. In the meantime, we recognise that significant investment has already been made to address the highest risk areas.

  Noting the ongoing nature of this work, but recognising the substantial improvements already achieved, we have chosen to reserve our assurance opinion in respect of "Risk management" at this point in time; recognising that further improvements will be achieved within the next 6-12 months on completion of this work.

In view of the number of positive areas identified, and ongoing improvement in respect of risk management, we have accordingly determined **reasonable assurance** as to the effectiveness of the system of internal control in place for safe water management within the UHB at the time of the current audit.

However, noting the marginal nature of this positive assurance, and that the opinion is reserved in respect of risk management, this is subject to the agreement of further follow up during 2019/20. The follow up will affirm whether the intended action has been taken in a timely manner and whether it has been effective as evidenced at a new sample of wards / sites to those considered at this audit.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Governance				✓
2	Procedures				✓
3	Monitoring & Reporting			✓	
4	Management		✓		
5	Risk Management	Opinion reserved			

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

Design of Systems/Controls

The findings from the review have highlighted **one** issue that was classified as weaknesses in the system control/design for water safety.

Operation of System/Controls

The findings from the review have highlighted **six** issues that were classified as weaknesses in the operation of the designed system/control for water safety.

6. Summary of Audit Findings

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

Governance

To ensure there is an appropriate policy in place to address water safety issues, there is defined allocation of responsibilities, clear lines of communication and reporting and approval processes.

We evidenced a clear reporting line for water safety issues. The Water Safety Group reported into the Health and Safety Committee and Infection Prevention & Control Group (IPCG) with line of sight to the Board.

The internal monitoring and reporting of water safety was the responsibility of Capital, Estates & Facilities. The UHB had additionally appointed an external "authorising engineer" to provide guidance on water management activities.

Appointed Persons (APs) were in place throughout the UHB, with the delegated responsibility for oversight of monitoring and testing compliance for water safety. These individuals were the Estates Managers and were in

place at each hospital site, as required by the HSE Approved Code of Practice (ACoP).

Within the structure, a Legionella Supervisor (a "Competent Person") had additionally been assigned, based at University Hospital Wales (UHW), with responsibility for undertaking the daily monitoring of water safety. He was supported by an internal team of four and the use of external contractors responsible for servicing and checking.

All roles within the process had been formally assigned, with job descriptions and appointment letters all evidenced during the review.

Noting the positive governance arrangements, **substantial assurance** has been determined.

Procedures

To ensure that management had prepared applicable procedures.

The UHB has a well-defined Water Safety Policy in place. The current Policy was last updated and approved in October 2017, by the Health & Safety Committee, with the next review scheduled for 2020.

The Water Safety Plan (WSP) was robustly prepared in accordance with latest guidance. Local site arrangements had also been defined.

The Plan was prepared in December 2016, and it was confirmed this has been updated since. Management confirmed that the Plan was a "live" document and was updated as required, in accordance with best practice.

The Plan was readily available to Estates staff to assist with the day-to-day undertaking of their duties.

Substantial assurance has therefore been determined in respect of documented procedural arrangements. Note that the application of the Plan is discussed and assessed within the **Management** section below.

Monitoring & Reporting

To ensure that the UHB has effective monitoring procedures in place e.g. the establishment of appropriate Water Safety Groups (WSGs). Assurance that there is appropriate record retention and dissemination of information through to the Executive team and Board.

The UHB has established a Water Safety Group (WSG), in line with Welsh Health Technical Memorandum (WHTM) 04-01 (Part B), which is centrally responsible for monitoring the management of water safety within the UHB.

Whilst the WSG was found to be meeting regularly, and achieved quorate attendances for the meetings reviewed, there were some wider issues noted with attendance, particularly involving representatives from Clinical Boards/Wards (**recommendation 1**).

We found that water safety records were retained within the Estates department for the required 5-year period, as a minimum, and all records requested during the audit (i.e. legionella/pseudomonas sampling and temperature checking) were available for review. There were, however,

certain issues with, for example, the availability of water flushing logs, and this is reviewed in the **Management** section below.

There were some issues with performance monitoring and reporting in respect of remedial actions raised following routine water management checks. Whilst management confirmed that the appointed contractor was fully compliant with the planned preventative maintenance (PPM) schedules, the extent to which associated remedial jobs had been completed in a timely manner could not be established. The reporting and assessment of such issues through the structure to the Water Safety Group was not evident (**recommendation 2**).

However, as monitoring and reporting arrangements were generally robust, we have determined **reasonable assurance** in this area.

Management

Assurance that relevant staff have received appropriate training, and appropriate resources are allocated. Assurance that an appropriate inspection / detection regime is operated.

Training

It was confirmed that formal training for the Appointed Persons was in date.

However, wider training for more general Estates staff with a role in water safety (including the "Legionella Supervisor" / Competent Person and his team) required refreshing, having last been delivered in 2015. We were advised Estates staff place reliance on Infection Control to provide appropriate guidance on implementation of procedures; however, the WHTM requires such staff receive specific training (**recommendation 3**).

Monitoring and testing programmes

To ensure that appropriate monitoring and testing arrangements were in place to enable effective water safety management, a sample of planned preventative maintenance (PPM) records held at University Hospital Wales (UHW) and University Hospital Llandough (UHL) were reviewed during the audit.

Issues identified included:

- Remedial jobs, raised in response to routine temperature monitoring, were not being completed in a timely manner (see also **recommendation 2** in relation to the assessment and reporting of this issue); and
- Whilst water samples had not been taken with the required frequency outlined in the Water Safety Plan (with a period of circa 6 weeks missed at UHW), management confirmed that this was a risk-based decision advised by Infection Control, to divert finite resources to higher risk areas at that time. We note, however, that the audit trail of completion of these jobs could be better recorded. (**Recommendation 4**).

Flushing

Flushing of infrequently used outlets is defined within the Water Safety Plan as being the responsibility of the nursing staff on the respective wards at both the above sites, with monitoring, guidance/training and audit checks delivered by Capital, Estates & Facilities.

Management advised that showers were flushed every two days, noting the higher risk nature of these systems. However, required flushing records of remaining outlets at both sites visited were variable, with staff seemingly unaware in certain cases of the requirements for their area (with audit testing witnessed by the Legionella Supervisor). Therefore, assurance that flushing was being undertaken as required could not be verified.

Estates management and the Water Safety Group acknowledged that flushing compliance was an issue in particular wards/ clinical areas, particularly noting weaknesses in accountability arising from the paper-based process applied. An electronic system was being considered at the time the audit, to improve the robustness and accountability of the system.

It was agreed that flushing guidance would be reissued to all wards, with specific assurance obtained by the Water Safety Group that practices improve in the non-compliant ward areas identified during this audit (**recommendation 6**).

See **Appendix C** for detail of audit findings.

In view of the high risks associated with the potential lack of sufficient flushing practices, **limited assurance** has been determined in this area.

Risk Management

Assurance that the UHB has performed a suitable and sufficient assessment of risks, and that risks are appropriately managed.

The HSE Approved Code of Practice and WHTM 04-01 require risk assessments to be undertaken, to inform the Water Safety Group and assist with the identification and prioritisation of mitigating actions.

The implementation of the above was ongoing at the time of this audit as part of the Board supported Statutory Compliance Programme; to address aforementioned issues relating to the age and condition of the estate.

Substantial progress had been made to date in the area of water compliance, including the preparation of schematics (drawings) across the entire estate, and the undertaking of risk assessments of the water infrastructure. The formulation of an associated risk-prioritised action plan was underway at the time of the audit - Management advised that this process, as required by the HSE ACOP and WHTM 04-01, should be completed within 6-12 months (**recommendations 6 & 7**).

In the interim, the UHB has invested significant sums in addressing the highest risk areas. Supplementary controls are also in place in terms of

water sampling, chlorine dioxide systems, point of use filters etc., to monitor and control the water system.

In conclusion, we therefore recognise that substantial improvements have been made, but with further work required to complete this exercise. Accordingly, we have determined that it would not be appropriate to provide an assurance rating at this time, and therefore defer our assessment of the opinion in this area at this time, recognising the existing environment.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	2	5	-	**7**

Monitoring & Reporting

Finding 1: Water Safety Group	Risk
The Welsh Health Technical Memorandum (WHTM) 04.01 *"Safe Water in Healthcare Premises"* (Bart B), states in respect of the Water Safety Group (WSG): *"The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation and review of the WSP* [Water Safety Plan]*. The aim of the WSG is to ensure the safety of all water used by patients/residents, staff and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring it identifies water-related hazards, assesses risks, identifies and monitors control measures and develops incident protocols."* (6.3). The UHB has implemented a Water Safety Group, as required above, which was found to meet with the required frequency. Section 6.6 additionally states that representation is required from: *"…estates (operations and projects), infection control, medical microbiology, nursing, augmented care, housekeeping/support services, an Authorising Engineer/independent adviser, medical technical officers, specialist users of water (such as renal units and departments offering aquatic therapy), and sterile services departments (SSDs)."* The WSG terms of reference has defined a quorate attendance, as follows:	Governance arrangements may not be sufficient to facilitate effective oversight and control of legionella.

"At least five members must be present including one of the Legionella leads, the Group Chair or Vice Chair and a Microbiologist to ensure quorum of the Group meeting." Whilst noting that the WSG meetings reviewed (within the last year) had met the above quorate requirement, it was noted that that not all WSG members were attending the Group regularly. Notable absences included representatives from Clinical Boards. This reduces the opportunity for sharing of information and best practice, with wards potentially otherwise uninformed of their responsibilities. *Note this links with **finding 5** respect of flushing practices operating at the sites reviewed*.	
Recommendation 1	**Priority level**
Attendances of the Water Safety Group should be reviewed, with staff reminded of their responsibilities to attend, to ensure key groups are appropriately represented (O).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Chair of Water Safety Group June 2019

Finding 2: Performance Monitoring & Reporting: Remedial Backlog	Risk
We evidenced a robust system in place, via the utilisation of an external contractor, for carrying out monthly temperature monitoring checks across the UHB. On completion of a temperature check, should an issue of concern be identified, a remedial job would be raised for the matter to be resolved by UHB Estates staff. We queried whether there was a backlog of such remedial jobs. Although management demonstrated an effective system was in place to raise remedial jobs, a report could not be provided from the system, showing the full extent of the backlog to be addressed. As this information was not being reported/ reviewed by management, the UHB may not be sufficiently informed to address issues in a timely manner. (See also **finding 5** in relation to audit testing in these areas).	The Water Safety Group may not receive sufficient information to fully understand the water safety risk. The risk of incomplete remedial jobs may be unacceptable to the WSG. Appropriate resource prioritisation may not take place.
Recommendation 2	**Priority level**
The current position in respect of the backlog of remedial jobs, should be routinely reported to the Water Safety Group (O).	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed.	Director of Capital, Estates & Facilities June 2019

Management

Finding 3: Training	Risk
The WHTM 04.01 (Bart B), states in respect of training arrangements: *"The Water Safety Group (WSG) should implement a programme of staff training to ensure that those appointed to devise strategies, carry out control measures and undertake associated monitoring are appropriately informed, instructed and trained."* (section 6.27); *"The WSG should review the competence of staff on a regular basis, and refresher training should be given; records of training attendance need to be maintained;"* (section 6.28) and *"Individuals to whom tasks have been allocated (supervisors and managers as well as operatives) need to have received adequate training in respect of water hygiene and microbiological control appropriate to the task they are responsible for conducting." (6.29)* The training position for all staff with a role in safe water management was reviewed. It was confirmed that training for the designated Appointed Persons was in date at the time of the audit. However, the Legionella Supervisor (designated as a "Competent Person"), and his team responsible for daily checks, remedial works, re-testing etc. had not received training in relation to water safety, the HSE Approved Code of Practice or WHTM guidance since 2015. This pre-dates the latest updates of these key documents.	Staff may not be appropriately trained to identify potential hazards or issues, or to undertake testing / monitoring in accordance with the Water Safety Plan.

Management advised that all work was undertaken on advice from Infection Control. However, as these staff have a key role in the day-to-day implementation of the Water Safety Plan, appropriate training should be considered important in line with the WHTM requirements above.	
Recommendation 3	**Priority level**
Training should be updated for all key staff with assigned water management responsibilities (O).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Director of Capital, Estates & Facilities July 2019

Finding 4: Water Safety PPMs	Risk
It was confirmed that both the WHTM 04-01 and the UHB's Water Safety Plan require quarterly legionella sampling, and twice yearly pseudomonas sampling. Further, chlorine dioxide should be added to the water, to help remove bacteria at source, in addition to filters placed on pipework. Temperature monitoring was outsourced to an external contractor in November 2018, to ensure this key task could be completed in a timely manner. A six-month rolling programme was agreed by the Water Safety Group. This audit included site visits to University Hospital Wales (UHW) and University Hospital Llandough (UHL), to review the documentation available in respect of routine checks in relation to water management (managed via PPMs; planned preventative maintenance schedules). See **Appendix C** for audit testing details. **Temperature monitoring** A sample of 15 temperature checks was reviewed at each site to ensure compliance with the requirements of the WHTM 04-01 and the WSP. It was confirmed, from the sampled paperwork, that all tests had been carried out as required. Remedial action (resulting from issues raised during routine monitoring) remains the responsibility of the UHB. Where a temperature anomaly is recorded, the UHB's Legionella Supervisor should raise a remedial job on the electronic system. From a sample of 15 reviewed, none had been completed. 3 of these, raised at the start of December 2018, were in the Children's Ward, which is a high risk area.	Required water safety tasks may not be undertaken as set out in the Water Safety Plan, increasing the risk to patient / staff health. Identified risks may not be effectively prioritised and addressed, risking non-compliance with legislative requirements.

We were additionally advised that review and input of testing results into the electronic system, and the raising of remedial jobs, was the responsibility of one individual (as above). Should that individual not be available, results may not be reviewed and jobs may not be raised in a timely manner. As discussed in **finding 2**, the system does not enable easy analysis of this backlog position, and we identified that the reporting of the position did not appear to be sufficient. We therefore could not confirm the extent of the backlog of remedial works at the time of the audit. **Water Sampling & Filters** The audit review of sampling practices at UHW found that not all samples were being undertaken with the required frequency as set out in the Water Safety Plan. For example, the Sampling List for 2018 *("Distribution Bacteriological Sampling (Legionella-Quarterly, Pseudomonas-Six Monthly)")* showed that the 3rd quarter checks in the majority of areas (including the Children's Ward, being a high risk area), had not been undertaken. Management confirmed that, whilst the WSP sets out an appropriate PPM schedule across the estate, on some occasions the current risks dictate that resources need to be diverted to alternative areas, on the advice of Infection Control. On such occasions, recent changes in the chlorine dioxide system at Llandough Hospital requiring monitoring to be focused at this site, at the expense of routine monitoring at UHW (noting the finite resources available). We confirmed that water filters had been changed in line with manufacturer's guidelines.	

However, the reasons for missed PPMs and deviations from the standard WSP requirements has not been recorded at relevant logbooks.	
Recommendation 4	**Priority level**
a) An audit trail should be maintained where routine checks are not completed, in cases where risk-based decisions dictate alternative monitoring/testing schedules will be applied. b) Key person dependency should be reviewed and removed, where possible, to facilitate the timely identification and completion of remedial work (O). *See also **recommendation 2** in relation to assessment and reporting of the backlog of remedial jobs.*	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Director of Capital, Estates & Facilities June 2019

Finding 5: Flushing	Risk
In respect of flushing requirements, WHTM 04.01 (6.42) states: *"HSG274 Part 2 recommends that generally, for infrequently used outlets, flushing is carried out once a week but that in healthcare facilities the risk assessment, as agreed by the WSG, may indicate a higher frequency, and water draw-off should form part of the daily cleaning process. The procedure for such practice should be fully documented and covered by written instructions."* Flushing was confirmed to be the responsibility of wards in each Clinical Board. Procedures stated that flushing should be done three times a week, recorded on a work sheet (provided by Capital, Estates & Facilities) and retained on the wards for viewing. Management confirmed that there is an audit process in place to monitor flushing practices. Flushing is a standing agenda item at the Water Safety Group, and further, training has been delivered to nurse practitioners, with further awareness sessions planned in agreement with the WSG. In order to review current flushing practices, the audit sampled 10 wards at UHW and UHL to review the flushing records in place. Findings were as follows (full testing details are included at **Appendix C)**: • Only two of seven wards visited (Ward West 5 at UHL and Respiratory Ward at UHW) held the required flushing documentation; • High risk wards without any flushing records included Children's Ward, Antenatal and Medical Emergency (UHL), and Neonatal, Children's Ward, Maternity and Paediatric Critical Care (at UHW); and	Required procedures may be undertaken incorrectly / may not be undertaken at all. Risk to patient / staff health. Potential non-compliance with ACOP / WHTM 04-01.

• Whilst some wards advised they did flush, they were not utilising the appropriate documentation (e.g. Endoscopy at UHL were recording in a diary). It is acknowledged that the above lack of completed flushing records may in part be due to the fact that there were no infrequently used outlets on the wards visited. However, staff when questioned were generally unclear as to what constituted "infrequently" used, and typically the required paperwork was not available to provide guidance. We also note an ongoing process to move the flushing records to an electronic system, that is being implemented by Capital, Estates & Facilities. The system should ensure that, for every recorded outlet, the user notes whether it is regularly used, and if so, if it has been flushed. We acknowledge that the implementation of this system should improve compliance with required practices. However, as there was limited confirmation from on-site testing that outlets were being flushed appropriately, this has therefore been rated as a High priority issue.	
Recommendation 5	**Priority level**
a) For those clinical boards identified in this audit as being non-compliant with required flushing practices, the Chair of the WSG should request assurance from the clinical boards that practices have been improved. b) The Chair of the Water Safety Group should ensure that flushing guidance is re-issued to all clinical boards for full circulation to relevant staff (O).	**High**

Management Response	Responsible Officer/ Deadline
Agreed.	Chair of Water Safety Group July 2019

Risk Management

Finding 6: Risk Assessments	Risk
WHTM 04.01 section 2.8 states: *"A risk assessment forms an integral component of the WSP and is a legal requirement to identify potential hazards (which may be microbial, chemical or physical) in the system, risks of infection to patients, staff and visitors, and other indicators of water quality (for example, taste, odour, flavour and appearance if intended for drinking)."* (2.8) And *"Once potential hazards and hazardous events have been identified, the severity of risk needs to be assessed so that priorities for risk management can be established."* (6.24). The undertaking of this process was ongoing at the time of this audit. It forms part of a wider Statutory Compliance Project underway within the UHB; which sees the updating of risk assessments in all areas of statutory compliance (44 areas in total), and the associated development of robust PPM schedules and undertaking of remedial work identified as part of the process. This programme of work was supported by, and approved at, Board level. In respect of the water safety element of this project, an external contractor had recently completed detailed surveys and risk assessments of the UHW and UHL sites. The process of risk-prioritising identified actions was underway at the time of the audit. Management advised that this process should be complete within 6-12 months.	High risk actions may not be effectively prioritised and addressed.

In the meantime, management advised that a high level risk assessment was in place and regularly reported to the WSG, and the UHB has already invested significant sums in addressing the highest risk areas. Supplementary controls are also in place in terms of water sampling, chlorine dioxide systems, point of use filters etc. to monitor and control the water system.	
Recommendations 6 & 7	**Priority level**
6) The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D).	**High**
7) Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Director of Capital, Estates & Facilities Ongoing

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.

Appendix C: Audit test findings

Water Sampling (**recommendation 4**).

Water Sampling for legionella at UHW

(legionella: quarterly (grey); months in which they were completed: coloured) – where months or quarters are blank indicates that quarters or months have been missed. E.g. the majority of 3rd quarter sampling was missed and 4th quarter was not undertaken at all.

WARD	1ST	2ND	3RD	4TH	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
UNIVERSITY HOSPITAL OF WALES																
CWST	1ST	N/A					MAR									
WARD A7 SOUTH																
WARD A7 NORTH																
WARD B7 SOUTH	1ST	2ND	3RD		JAN		MAR			JUNE						
WARD B7 NORTH	1ST	2ND	3RD		JAN		MAR			JUNE						
WARD B5 SOUTH (NEPHROLOGY)	1ST	2ND			JAN					JUNE						
WARD B5 NORTH (NEPHROLOGY)	1ST	2ND			JAN					JUNE						
TERTIARY TOWERS 5FL (RENAL)	1ST	2ND			JAN					JUNE						
WARD B4 HAEMATOLOGY	1ST	2ND	3RD		JAN		MAR			JUNE						
WARD A3 SOUTH (HDU)	1ST	2ND	3RD		JAN		MAR			JUNE						

WARD	1ST	2ND	3RD	4TH	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
WARD A3 NORTH (ITU)	1ST	2ND	3RD		JAN		MAR			JUNE						
WARD B3 SOUTH (ITU)	1ST	2ND			JAN					JUNE						
WARD B3 NORTH (PICU)	1ST	2ND			JAN					JUNE						
WARD C3 SOUTH (CCU)	1ST	2ND	3RD		JAN		MAR			JUNE						
WARD C3 LB6 (CARDIAC ITU)	1ST	2ND	3RD		JAN		MAR			JUNE						
WARD C2 SOUTH (BUTTERCUP)	1ST	2ND			JAN					JUNE						
WARD C2 LINK (DAISY NURSERY)	1ST	2ND			JAN					JUNE						
TEENAGE CANCER TRUST	1ST	2ND			JAN					JUNE						

Water Sampling for legionella at UHL (legionella: quarterly (grey); months in which they were completed: coloured) – where months or quarters are blank indicates that quarters or months have been missed. (Note, whilst December 2018 indicates Q4 checks were completed, we were advised on site that these were January 2019 checks backdated and that Q4 had not been undertaken).

WARD	1ST	2ND	3RD	4TH	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
CWST																
CYSTIC FIBROSIS	1ST	2ND	3RD				MAR					AUG				DEC
WEST 06	1ST	2ND	3RD			FEB						AUG				DEC
CERYS WARD (ITU)	1ST	2ND	3RD			FEB						AUG				DEC
BETHAN WARD	1ST	2ND	3RD			FEB						AUG				DEC
ANWEN WARD	1ST	2ND	3RD			FEB						AUG				DEC
DELYTH WARD	1ST	2ND	3RD			FEB						AUG				DEC
WEST 1	1ST	2ND	3RD			FEB						AUG				DEC
WEST 2 (ADULT ONCOLOGY)	1ST	2ND	3RD			FEB						AUG				DEC
WEST 3	1ST	2ND	3RD			FEB						AUG				DEC
WEST 4	1ST	2ND										AUG				DEC
WEST 5	1ST	2ND										AUG				DEC
WEST 6	1ST	2ND										AUG				DEC
EAST 1 (ENHANCED CARE)	1ST	2ND	3RD			FEB						AUG				DEC
EAST 2	1ST	2ND										AUG				DEC
EAST 3	1ST	2ND										AUG				DEC
EAST 3-5 LINK	1ST	2ND	3RD			FEB						AUG				DEC
EAST 4	1ST	2ND	3RD			FEB						AUG				DEC

WARD	1ST	2ND	3RD	4TH	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
EAST 5	1ST	2ND	3RD			FEB						AUG				DEC
EAST 6	1ST	2ND	3RD			FEB						AUG				DEC
EAST 7	1ST	2ND	3RD			FEB						AUG				DEC
EAST 8	1ST	2ND	3RD			FEB						AUG				DEC
MHSOP	1ST	2ND	3RD			FEB						AUG				DEC
HAEMATOLOGY DAY UNIT	1ST	2ND	3RD			FEB						AUG				DEC
THEATRES	1ST	2ND	3RD			FEB						AUG				DEC
CAVOC	1ST	2ND	3RD			FEB						AUG				DEC
STARLIGHT	1ST	2ND	3RD			FEB						AUG				DEC
ENDOSCOPY	1ST	2ND										AUG				DEC
MAIN KITCHEN	1ST	2ND										AUG				DEC
HAEMATOLOGY DAY UNIT	1ST	2ND	3RD			FEB						AUG				DEC
RADIOLOGY	1ST	2ND										AUG				DEC
PHYSIOTHERAPY	1ST	2ND										AUG				DEC
GWENWYN	1ST	2ND	3RD			FEB						AUG				DEC
CHILDRENS' CENTRE	1ST	2ND	3RD				MAR					AUG				DEC
DIABETES CENTRE	1ST	2ND	3RD				MAR					AUG				DEC
LLANFAIR	1ST	2ND	3RD				MAR					AUG				DEC
BREAST CARE	1ST	2ND										AUG				DEC
BLOODS	1ST	2ND										AUG				DEC

Water Sampling for legionella at the Children's Hospital (legionella: quarterly (grey); months in which they were completed: coloured) – where months or quarters are blank indicates that quarters or months have been missed.

WARD	1ST	2ND	3RD	4TH	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
CWST																
GROUND FLOOR (OUTPATIENT'S)																
UPPER GROUND FLOOR (HAEM)	1ST	2ND			JAN					JUNE						
FIRST FLOOR (ONCOLOGY)	1ST	2ND			JAN					JUNE						
SECOND FLOOR (THEATRE SUITE)																
THIRD FLOOR (PAEDIATRICS ICU)	1ST	2ND			JAN											

Water Sampling for pseudomonas at UHW (pseudomonas 6 monthly (grey); months in which they were completed: coloured) – where months or quarters are blank indicates that quarters or months have been missed.

WARD	1ST		2ND		JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
CWST																
WARD A7 SOUTH																
WARD A7 NORTH																
WARD B7 SOUTH																
WARD B7 NORTH																
WARD B5 SOUTH (NEPHROLOGY)																
WARD B5 NORTH (NEPHROLOGY)																
TERTIARY TOWERS 5FL (RENAL)																
WARD B4 HAEMATOLOGY																
WARD A3 SOUTH (HDU)																
WARD A3 NORTH (ITU)																
WARD B3 SOUTH (ITU)																
WARD B3 NORTH (PICU)																
WARD C3 SOUTH (CCU)																
WARD C3 LB6 (CARDIAC ITU)																
WARD C2 SOUTH (BUTTERCUP)	1ST		2ND				MAR							OCT		
WARD C2 LINK (DAISY NURSERY)	1ST		2ND				MAR							OCT		
TEENAGE CANCER TRUST																

Water Sampling for pseudomonas at UHL (pseudomonas 6 monthly (grey); months in which they were completed: coloured) – where months or quarters are blank indicates that quarters or months have been missed.

WARD	1ST		2ND		JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
CWST																
CYSTIC FIBROSIS																
WEST 06																
CERYS WARD (ITU)																

Water Sampling for pseudomonas at the Children's Hospital (pseudomonas 6 monthly (grey); months in which they were completed: coloured) – where months or quarters are blank indicates that quarters or months have been missed.

WARD	1ST		2ND		JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
CWST																
GROUND FLOOR (OUTPATIENT'S)	1ST													OCT		
UPPER GROUND FLOOR (HAEM)	1ST		2ND				MAR							OCT		
FIRST FLOOR (ONCOLOGY)	1ST		2ND				MAR							OCT		
SECOND FLOOR (THEATRE SUITE)	1ST													OCT		
THIRD FLOOR (PAEDIATRICS ICU)	1ST		2ND				MAR							OCT		

Flushing at UHW (see **recommendation 5**)

Ward	Were recent Flushing records held?[1]	Evidence that Flushing has been undertaken appropriately
Neo Natal	N	N
Maternity	N	N
Children's Ward	N	N
Paediatric Care	N	N
Critical Care	N	N
Respiratory	Y	Y
Transplant Unit	Y	Y

[1]*(at time of Audit visit, January 2019)*

Flushing at UHL (see **recommendation 5**)

Ward	Were recent Flushing records held?[1]	Evidence that Flushing has been undertaken appropriately
Cavoc	N	N
MRI	N	N
Ward West 5	Y	Y
Breast Centre	N	N
Anwen Ward	N	N
Pharmacy	N	N
Endoscopy	Y[2]	Y
Medical emergency assessment unit	N	N
Ante-natal clinic	N	N
Children's ward	N	N

[2]Whilst flushing records were available, demonstrating that flushing has been undertaken, the correct flushing forms had not been utilised.

Cardiff and Vale University Health Board

Specialist Services 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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	Ian Virgil, Assistant Head of Internal Audit
Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Jessica Castle, Director of Operations
	Catherine Wood, Directorate Manager
	Ann-Marie Morgan, Directorate Manager
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 Specialist Services 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 Specialist Services 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 Haematology and Critical Care 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 **Reasonable assurance**.

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

The current review has identified that processes are in place for managing Medical Finance Governance within each of the two sampled Directorates.

The consultants in post are appropriately working their core contracted Direct Clinical Care (DCC) sessions and consultant time is being effectively planned around the requirements of the services.

Issues were however identified around the current level of consultant staff within the Critical Care Directorate and the potential adverse impact this may have on the future delivery of the service.

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 haven't highlighted any issues that are classified as weakness in the system control/design for Specialist Services CB – Medical Finance Governance.

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 Specialist Services 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:

- There are different procedures currently in place within each of the Directorates sampled. However they are both adequate and appropriate for the respective services being delivered;
- Relevant documentation is in place within the 2 Directorates covering the processes for managing medical staff time; and
- The Haematology Directorate Manager and Service Manager have both attended job planning training and maintain adequate documentation and guidance documentation within the office for the job planning process, along with a timetable to ensure job plans are updated on an annual basis.

There were no significant findings noted:

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:

- Consultants are carrying out their contracted hours as per their documented job plans;
- Outpatient clinics are being delivered with the expected activity levels; and
- There is a complicated process to develop the rota for Critical Care, however, it is deemed necessary to ensure the consistency of care provided by the consultants and is fit for purpose for the service delivery.

The following additional issue was noted:

- Whilst outside the direct scope of the current review, the audit notes that job plans for 2 of the selected Critical Care consultants were unavailable, therefore the samples were replaced to ensure testing of 8 consultants.

There were no significant findings noted:

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 key driver for Haematology activity is the relevant cancer targets. The consultant job plans and schedules are developed to allow for effective delivery and outcome measures are submitted to ensure that the actual delivery is meeting the needs of the service.

The following significant finding was noted.

- There is a significant shortfall of Consultant establishment within the Critical Care Rota which is likely to deteriorate further in the future. Recent recruitment drives have been unsuccessful due to the nature of the current rota and service model.

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

Additional sessions are only currently worked by consultants within the Critical Care Directorate. These could not however be tested as part of the current audit due to the unavailability of Internal Audit resources.

This represents a limitation on the scope of the current audit and assurance has not therefore been provided in relation to this objective.

This element of testing and associated assurance could be covered in a future audit if required.

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

Additional sessions are only currently worked by consultants within the Critical Care Directorate. These could not however be tested as part of the current audit due to the unavailability of Internal Audit resources.

This represents a limitation on the scope of the current audit and assurance has not therefore been provided in relation to this objective.

This element of testing and associated assurance could be covered in a future audit if required.

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:

- No Locum shifts are used to cover Consultants within Haematology.
- Locum shifts are offered within Critical Care, however, not through Medacs. Locum shifts are offered as paid sessions at Category 5 rates in accordance with Medical and Dental Terms and Conditions of service. The construction of the rota is based on DCCs worked over a twenty week cycle. Consultants therefore can also pick up a locum shift (i.e. vacant DCC on the rota) and instead of receiving payment they receive a credit against the number of DCC sessions they are job planned to work within that 20 week cycle. There are honorary contracts with English Health Boards for other locum sessions that are also paid at Category 5 rates.

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**	**0**	**1**	**2**

Finding 1 – Critical Care Consultant establishment and Rota (Operating effectiveness)	Risk
It has been identified that there is a significant shortfall of Consultant establishment within the Critical Care Rota. With the current service there is a requirement for approximately 20 WTE Consultants, however, the directorate only has 16 WTE, this is not inclusive of additional beds acquired by the unit. This staffing situation is set to decline with planned maternity leave and requests to decrease number of DCC sessions. Recruitment drives have been unsuccessful due to the service model including a 24/7 residence position, which is uncommon in comparison to other tertiary care models.	Inappropriate / ineffective medical staff activity.
Recommendation	**Priority level**
Management should carry out a comprehensive review of the current and future consultant staffing levels to ensure that the Critical Care service can be sustainably delivered in the future. This should include review of the current service model.	**High**
Management Response	**Responsible Officer/ Deadline**
The shortfall in Consultant sessions within Critical Care is well recognised throughout the organisation. A recent review by the Faculty of Intensive Care Medicine (FICM), part of the Royal College of Anaesthetists, has also highlighted the shortfall in Consultants as a significant governance risk.	Dr Matt Wise, Clinical Director / commenced April 2019 – completion by April 2020

The Directorate team are currently actively attempting to recruit Consultants with an advertisement closing at the end of May. Notwithstanding a piece of work commenced in April led by the Lead Clinician for Critical Care to explore alternative models of medical service delivery, including implementing a treat and transfer model at UHL and a non-resident Consultant out of hours rota at UHW. It is anticipated that in order to enable a revised clinical model at Consultant level significant changes will need to be made to the Junior Doctor tier to safely enable this. The Directorate Management Team are currently repurposing Junior Clinical Fellow posts into Senior post-CCST Fellow posts to enhance airway cover overnight, and thus decreasing reliance upon Consultant presence. In totality this is a complex piece of work requiring significant change to individual job plans and recruitment to specialist clinical fellow posts that will take some time to achieve, albeit significant progress has already been made to date.	

Finding 2 – Approval of Critical Care Rota (Operating effectiveness)	Risk
The Critical Care Directorate has a robust process in place for developing and managing a rolling 20 week rota for its Consultant staff. The process is undertaken by a lead clinician. The audit notes that whilst the rota is communicated to all the consultants, including the Clinical Director, there is currently no process in place to evidence formal approval of each 20 week rota.	Delays in patient treatment / non-achievement of objectives or targets.
Recommendation	**Priority level**
Each 20 week Consultant rota should be subject to formal approval by the Clinical Director and evidence of this approval should be retained on file.	**Low**
Management Response	**Responsible Officer/ Deadline**
A process to sign off the rota by the Clinical Director will be developed by the Directorate Management Team, and a record of which will be retained on file along with existing job planning information.	Daniel Farr / end of August 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.