AUDIT COMMITTEE

23 MAY 2017, 9.10AM

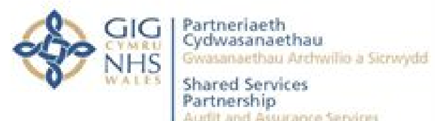
CORPORATE MEETING ROOM
HEADQUARTERS, UHW

CARING FOR PEOPLE
KEEPING PEOPLE WELL

AUDIT COMMITTEE
Tuesday, 23 May 2017 at 9.10am
CORPORATE MEETING ROOM, HQ, UHW
AGENDA

PART 1 - SECTION 1: PRELIMINARIES *(Chair)*		
1.	Welcome and Introductions	*Oral* *Chair*
2.	Apologies for absence	*Oral* *Chair*
SECTION 2: AUDIT		
3.	Internal Audit Position Report including the following finalised audit reports/updates as follows: **Assignment** — **Assurance Rating** 1. Waiting List Initiative — Limited 2. Continuing Healthcare — Limited 3. IT System – Trauma & Orthopaedics (Bluespier) — Reasonable 4. Integrated Medium Term Plan (Workstreams) — Reasonable 5. Theatres Stock Follow-up — Reasonable 6. Mental Health CB – Information Governance — Reasonable 7. Community Resource Team — Substantial 8. Clinical Diagnostics & Therapeutic CB Information Governance — Substantial 9. Specialist Services - Medical Staff Study Leave — Reasonable 10. Medicine Clinical Board Specialing — Reasonable 11. Patient Access — Substantial 12. Health & Care Standards — Reasonable 13. Rookwood Relocation – Capital Scheme — Reasonable	*J Johns*

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]



Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee May 2017

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

Cardiff and Vale University Health Board

Audit Committee May 2017

1. OUTCOMES FROM COMPLETED AUDIT REVIEWS

1.1 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.

1.2 A summary of the key points from the assignments with Reasonable and Substantial assurance are reported in Section two. Reports with Limited Assurance are included as full versions.

AUDIT ASSIGNMENT	ASSURANCE RATING	
CD&T Clinical Board Information Governance	Substantial	
Patient Access	Substantial	
Community Resource Team	Substantial	
IT System (T&O), Bluespier	Reasonable	
Theatres Stores Follow up	Reasonable	
IMTP (Work Streams)	Reasonable	
Mental Health Information Governance	Reasonable	
Medicine Clinical Board Specialling	Reasonable	
Health and Care Standards	Reasonable	
Specialist Clinical Board Medical Staff Study Leave	Reasonable	
Capital Scheme Rookwood	Reasonable	
Continuing Healthcare	Limited	
Waiting List Initiative Payments	Limited	

2. FINAL REPORT SUMMARIES

2.1 CD&T Clinical Board Information Governance

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the management of information governance within the CD&T Clinical Board is **Substantial Assurance**.

There is a structure in place for the management of information governance within CD&T with each directorate managing the process via its Quality and Safety agenda. There are directorate risk registers in place and information asset registers have been developed.

Records are generally held securely and there is a plan in place for moving records from Whitchurch to a new secure site.

The audit did identify a small number of issues, these relate to the structure not being fully developed in Cellular Pathology and the lack of a formal process for ensuring that all records are up to date and archived appropriately.

2.2 Patient Access

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

The review identified that patient booking staff in all the sampled Directorates have had PMS training and are conversant with booking processes and the Referral to Treatment (RTT) and Fixed Appointment Booking (FAB) rules. However, both Acute Child Health and Urology Directorates do not currently hold summary procedures/guidance notes that aid and support any queries or issues with these rules.

It is noted that revised RTT guidance was issued by Welsh Government and distributed to UHB management in early April 2017.

Whilst the majority of appointments sampled across the 3 Directorates were appropriately provided, testing did identify that a very small number of appointments booked in the Acute Child Health and Urology Directorates did not comply with the reasonable offer rules and any reasons for these were not recorded on PMS.

Good practice is noted that all clock adjustments pertaining to DNAs, CNAs and patient refusals were appropriate and in accordance with RTT rules.

2.3 Community Resource Team

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the NW Cardiff Locality Community Resource Team is **Substantial Assurance**.

Overall there are good processes in place to manage the operation of the CRT. Referrals are received from a number of sources including GP's, Hospitals, Residential / Care Homes and the Council Social Services Department. These are assessed each morning by a multi-disciplinary team of social and health care professionals and if accepted are allocated to the appropriate service(s) within the team, e.g. home care, physiotherapy, Occupational Therapy, dietician. Although there are a large number of rejected referrals, these are generally due to the patient already being under the care of the CRT.

Following acceptance by the CRT, a Service Delivery Plan is prepared for each patient, and this includes a planned discharge date (PDD). The target length of stay within the CRT is 6 weeks, but this can, based on clinical assessment, be extended to 12 weeks for patients receiving therapy and where the potential to further improve function is identified. In addition, patients identified as being at risk of falling are put on the Individualised Strength and Balance Programme (ISBP) for up to six months during which time they will remain as a patient of the CRT. There is on-going monitoring of patients however performance reports do not split the patient categories and target LoS, as such there is no tiered monitoring of this.

2.4 IT system T&O - Bluespier

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Bluespier IT system is **Reasonable Assurance**.

Overall the level of assurance given is reasonable. Bluespier is used for managing Trauma patients and organising theatre lists within T&O, and although there is a facility for clinical management, this is not fully used. The system is provided by an external firm and the UHB has a client manager contact, however recent changes within the Directorate have led to weaknesses in governance, with the new staff unaware of the system contract or management arrangements. Accordingly the UHB cannot demonstrate that it is gaining full value from the use of the system or from the support contract.

The system is securely hosted within the UHB SAC and is regularly backed up, although these backups are not tested.

Access to the system is controlled by password via the nadex account for most users, with users having defined roles within the system, this would allow for hierarchal / modular access to data.

2.5 Theatre Stores Follow up

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

Significant work has been put into developing a stock management system for consumables. The system now holds information on about 28,000 consumable items based stock transactions extracted from the Oracle system dating back to April 2014.

The knowledge of the Procurement department in conjunction with that of the Theatre stock staff has been drawn together to design the stock system; however there is additional work to be done to ensure:

- Adoption and use of system with consignment stocks;
- Interface with other systems such as ADC (Automated Data Capture) and Oracle;
- Possible use in the monitoring of stocks KPI which could support future reporting systems etc.

A new barcoding system (ADC) has been put in the main store room in UHL & UHW. The plan is to expand the range to other items held within Theatre stores.

On the basis of this follow up conclusion, the level of assurance that would be given as to the effectiveness of the system of internal control in place to manage the risks associated with Theatre stock is **Reasonable Assurance**. It should be noted that this rating assumes the continued implementation of the new stock system and processes.

2.6 Integrated Medium Term Plan (Work Streams)

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with implementation two work streams Mental Health Services for Older People and Primary Care) contained within of the Integrated Medium Term Plan is **Reasonable Assurance**.

The review found that overall the controls in place to manage the risks associated with this review are of a reasonable standard.

The audit identified a number of areas of good practice, including; clinical Boards operational plans had been developed in junctions with multiple stakeholders. Standard templates had been issued by the UHB that identifies the lead officers, key milestones and delivery measures.

There was also scrutiny of the operational plan at Clinical Board level, which has executive membership. There were differences between the two Clinical Boards, with PCIC have a better documented governance process in place which allows fuller tracking of plans though the process. Mental Health however lacked the full documented process and so cannot fully demonstrate an effective audit trail of scrutiny and challenge.

There have been delays in implementing plans within both clinical boards, largely due to recruitment delays however these are known by management.

2.7 Mental Health Clinical Board Information Governance

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the management of information governance within the Mental Health Clinical Board is **Reasonable** Assurance.

There is the basis of a structure in place for the management of information governance within Mental Health with all directorates linking together to produce an integrated structure, and managing the process via its Quality and Safety agenda. There are directorate risk registers in place and information asset registers (IARs) are being developed.

Records are generally held securely and risks to these have been identified via the register process.

The audit did identify a small number of issues, these relate to the structure not being fully developed, in particular the supporting Information Asset Administrators (IAA) posts are not in place and the IAR is still in development.

2.8 Medicine Clinical Board Specialling

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Medicine Clinical Board Specialling is **Reasonable.**

Both the sampled wards within the Medicine Clinical Board are following appropriate processes for identifying care for vulnerable patients and assessing the need for Specialling. Processes are also in place for monitoring the numbers of patients receiving Specialling and these are reported to the Senior Nurse.

A Specialling User Guide is in place; however this was produced in 2013 and requires updating to reflect the use of the Clinical Workstation and the essential documents that are now being used.

The testing carried out as part of the Audit identified that Specialling Risk Assessment's (SRAs) had been completed for all sampled patients and procedures are in place for monitoring the their on-going requirement for specialling. However there were instances where the procedures weren't followed consistently. Some of the essential documents that are required for specialling were missing or misfiled, regular reviews of the documents found were not always taking place and there was evidence of gaps in the monitoring of the Behaviour charts.

The paper SRAs are not being consistently replicated within Clinical Workstation (CWS). Issues were also identified around the time taken for the completion of the SRA on CWS and the removal of patients that are no longer receiving specialling from the specialling tab.

The level of engagement staff are having with patients to help stimulate them through the day was poor on ward A4. In addition, the current state of the facilities available to patients would not assist staff in improving their well-being. Ward C7 are however currently piloting the use of Mental Health Matters, an organisation that helps to promote mental well-being across Wales. The Ward Manager feels this is invaluable for the recovery of patients and has seen a huge improvement in their happiness as a result.

2.9 Health and Care Standards

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 & Care Standards is **Reasonable Assurance.**

The current review has confirmed that the Health Board continues to make good progress with the embedding of the Standards across the organisation. The introduction of a process for continuous monitoring of performance against the Standards, as opposed to a one-off annual assessment, is recognised as a positive development that should enable

more effective utilisation of the Standards to drive improvements in service delivery.

There is clear evidence that Clinical Boards are actively engaging in the process and that the revised assessment methodologies are being embedded across their respective clinical specialities. Testing of 2 sampled Standards confirmed that progress is being made towards the effective utilisation of the process for continuous monitoring.

Our previous Health & Care Standards review, completed in September 2016, confirmed that the Health Board has carried out an appropriate self-assessment against the Standards during 2016/17, although these actually covered services provided during 2015/16.

2.10 Specialist Services Clinical Board Medical Staff Study Leave

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Medical Staff Study Leave is **Reasonable Assurance**.

Study Leave is covered by the All Wales Study Leave Policy which was last updated in January 2015, and the Cardiff & Vale Study Leave Procedure. However this is dated June 2006 and is in need of review by the Health Board to reflect significant changes including the introduction of the Intrepid system which is now used to submit, approve and process study leave applications and expenses claims.

Although there is process for study leave in place, testing of a sample of episodes of study leave identified issues with late submission of claims and with incomplete approval of costs incurred.

Requirements for study leave should initially be identified and quantified as part of the annual appraisal process, and this feeds into a Personal Development Plan. Across Wales the Medical Appraisal & Revalidation System (MARS) is the only route to an annual appraisal, and this is done through the MARS website. The completion of annual reviews via MARS is monitored by Clinical Directors, but not the contents of the review.

Consultants can take up to 30 days study leave over a 3 year period, plus an additional 2 days per year which is specific to Wales. Trainee doctors can take up to 30 days study leave per year. Most study leave counts towards CPD which all Consultants are required to undertake as part of the re-validation cycle. This must be completed every 5 years to retain their medical qualification.

Analysis of study leave taken to date for a sample of Consultants and trainee doctors indicated that the take up of study leave was relatively low at the time of our audit. Testing also identified several instances of study leave being taken but costs not being claimed. This could have an adverse effect on the levels of care that the UHB provides, and

Consultants that do not undertake sufficient CPD to complete their annual re-validation can be dismissed. This is partially mitigated by completion of other forms of educational activity and monitored by the annual appraisal process.

2.11 Capital Scheme Rookwood

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

General compliance was noted with the established control frameworks in each of the objective areas sampled, particularly in relation to project governance. Of the six areas covered four areas, Approvals, Business Case Development, Contract Awards/ Contract Documentation and Change Management, were allocated reasonable assurance and two, project governance and Client Brief & Design Development were allocated reasonable.

Cardiff and Vale University Health Board

Audit Committee May 2017

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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.

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

Waiting List Initiative Payments (WLI)

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference: CUHB17.11
Report status: Final
Fieldwork commencement: November 2016
Fieldwork completion: February 2017
Draft report issued: February 2017
Management response received: May2017
Final report issued: May 2017
Auditors: Kimberley Rowe

Executive sign off: Chief Operating Officer
Distribution:
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.

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1. Introduction and Background

In accordance with the 2016/2017 internal audit plan, a review of the implementation of Waiting List Initiative Payments (WLI) was undertaken.

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

Waiting List Initiative (WLIs) are additional clinics and lists undertaken outside of core contracted hours to alleviate or reduce patient waiting times. WLI work does not form part of the consultant job plan or the contract for staff on Agenda for Change terms and conditions. No notice period is required for the suspension or cessation of WLIs.

The UHB spends a considerable amount on WLI sessions with a total spend to Sep16 of £965k. This is split between clinical boards as follows:
Surgical Services –£406k
CD&T -£245k
Specialist Services- -£140k
Medicine -£134k
Children and Women -£24k
Dental -£10k
Primary Care -£7k

There is further expenditure on waiting list activity with an Ophthalmology contract with a cost of £201k in the same period.

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of arrangements for the management of WLIs in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of systems objectives are managed appropriately.

The scope of the review was to ensure that Waiting List Initiative Payments (WLIs) are appropriately managed, authorised and justified and that payments are in line with guidance.

The review focused on two Clinical Boards, Specialist Services and Surgical Services, based on the highest level of spend on WLIs (N/B, separate review of Clinical Diagnostics and Therapeutics has been undertaken).

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

- Guidance is in place for the management and payment of WLI sessions;

- WLI sessions are booked appropriately in advance, authorised and are justified;
- WLI session productivity is consistent with routine work and patients seen in WLI are appropriately selected;
- Payments for WLI sessions are based on appropriately verified sessions and authorised claims;
- Pay rates for WLI sessions are appropriate and comply with A4C and WG guidance.

3. Associated Risks

The potential risk considered in the review is as follows:

i. 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 level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with WLIs is **Limited Assurance**.

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

The review has identified inadequate arrangements for the management of WLIs within UHB with an inconsistent approach across the Clinical Boards and even within the Clinical Boards across different Directorates. This is mainly due to the lack of policy or operational procedures for management and staff to use as guidance.

Whilst good practice has been noted that all Clinical Boards perform periodic demand/capacity projections and approve the number of WLI sessions required, the directorates are lacking records of planned and approved WLI sessions and how these approved sessions are within the remit of those approved at a Clinical Board level.

In general WLI session productivity is consistent with routine work, there were only a few deviations observed and patients are being appropriately selected.

There were a number of weaknesses in the processes for approval of payments for WLI work. There is an absence of reasonableness checking and verification of claims prior to authorisation, and in many cases claims are not authorised to the appropriate level.

There were further issues identified with rates paid for WLI work. Non consultant staff have been paid at rates above that set out within pay circulars with the WLI sessional rate of £579 being for Consultants only, however there are numerous instances where this is being incorrectly applied across the Clinical Boards.

5. Assurance Summary

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

Assurance Summary					
1	*Unnecessary/inappropriate expenditure*		✓		

Design of Systems/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the system control/design for WLIs.

These are identified in the management action plan as (D).

Operation of System/Controls

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

These are identified in the management action plan as (O).

6. Summary of Audit Findings

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

Risk: Unnecessary/inappropriate expenditure

The following areas of good practice were noted:

- The Urology directorate have a written document that depicts the process for claiming for extra duty sessions.
- The Specialist Services Clinical Board performs demand/capacity work on an annual basis and a planned care proposal is agreed by the Chief Operating Officer.
- Within the Surgical Services Clinical Board RTT is reviewed quarterly and the number of WLI sessions required are agreed with finance.
- Within the Trauma & Orthopaedics Directorate (T&O), theatre and clinic lists highlight the planned WLI sessions.
- Productivity of WLI sessions is not monitored in either of the Clinical Boards/all the Directorates; however:
    - the number of patients to be seen during the WLI session is agreed beforehand for Cardiac Surgery;
    - in Urology, twelve patients are planned per session; the guidance from British Association of Urology Surgeons suggests eight, therefore this is above the expected efficiency;
    - in Ophthalmology sessions are booked in accordance with set rules for number of patients; and
    - for T&O, it is clear within the directorate how many patients are to be seen during each type of clinic and theatre list.
- Discussions with each of the Clinical Boards/ all Directorates have specified that longest waiting patients are selected for WLI sessions based on the nature of their procedure and therefore patients are being offered appointments based on 'treat in turn'. Testing has not sought to evidence this.
- Testing of the Specialist Services Clinical Board (Cardiac Surgery Directorate) WLI claims has noted:
    - following an erroneous claim in April 16 (mentioned below), no claims have overlapped with contracted work as per the

consultant job plan (N/B One job plan outstanding at reporting date and therefore not reviewed);
    - No WLI sessions tested were found to overlap inappropriately with on-call rotas.
    - Claims for WLI sessions were submitted within a timely manner (90 days after occurrence)
    - All claims tested were appropriately authorised
    - The claims agreed to PMS or TheatreMan and therefore confirmed occurrence (despite not being checked prior to payment by the Directorate).

- Testing of the Surgical Services Clinical Board (Urology, Ophthalmology & ENT and T&O Directorates) WLI claims has noted:
    - In Urology claims are submitted using the UHB standard template, in Ophthalmology and T&O a standard template developed by the Directorates is used;
    - In Urology the claim forms are verified to TheatreMan and PMS before being authorised, this was corroborated during sample testing as all occurrence was satisfactory and all claims had theatre lists attached and evidence of the forms being reviewed (eg. rates corrected). In T&O the claims are checked to planned sessions prior to approval using the clinic and theatre lists, the form contains a box to check when activity has been confirmed;
    - All claims submitted within Urology and Ophthalmology/ENT were within the required 90 days for expenses.

- In the Specialist Services Clinical Board, the testing confirmed that consultants are being paid the correct rate in line with the WG pay circular

The following significant findings were noted:

- There is no UHB policy for WLI sessions and payments.

- During testing of Specialist Services (Cardiac Surgery), one WLI session claim was identified to be for a private patient theatre list and therefore incorrectly paid by UHB.

- Within Surgical Services, in the Ophthalmology/ENT and T&O Directorates, lower grade staff (eg Fellows) are being paid the Consultant WLI rate. There is no formal agreement or policy allowing this and therefore should be paid in line with their contract, ie. as overtime.

- Within Cardiac Surgery (Specialist Services) there is no log of the booked WLI sessions or verification at Directorate level to ensure they are within the remit of the planned care proposal.

- Within Surgical Services, although the number of WLI sessions are agreed quarterly, there is no reconciliation of whether the planned/booked sessions are within the remit of those authorised, the only indication would be if spend goes over the planned budget.

- The Cardiac Surgery Directorate do not keep a log of claims, this means that duplication of claims is not checked by the directorate prior to submission to the Director of Operations for payment. Claim forms are stored in a file.

- Within Cardiac Surgery (Specialist Services) there is no consistent approach to checking occurrence of work claimed to TheatreMan/PMS or overlap with core job plans (or duplication with extra duty work already paid for). This coupled with a non-standard claim form being used resulted in an erroneous claim being submitted, processed and a large erroneous payment was made.

- Testing of claims within Surgical Services identified issues with: sessions overlapping with job planned time; a lack of verification of sessions; low productivity of some sessions and late submission of claims.

- Within Urology, the authorisation of the claim form by the Service Manager is not consistent with the Urology local procedure which states authorisation by the Directorate Manager. This is also not consistent with the Template Extra Duty Claim form which requires approval by the authorising Clinical Director and Clinical Board Director. Testing confirmed all claims were authorised by the Service Manager, 6/8 of these claims were above the authorised signatory level of £1000 and therefore not appropriately authorised.

- Within Ophthalmology the claims are signed by the Directorate Manager only; the form requires second approval by the Assistant Director of Operations. Two of the 10 available claim forms were authorised by the Directorate Support managers who are not an approved signatory.

- During sample testing of Cardiac Surgery, one WLI claim for a full session (3.5hrs) was found to be a Theatre that lasted 52mins. A half session should have been claimed for this or additional patients booked to ensure full utilisation.

Additionally as part of the review it was also identified that within Ophthalmology additional activity sessions are contracted out to an LLP formed by the UHB consultants in order to support the delivery of waiting list targets. Having identified this matter; it flags up questions over governance and cost effectiveness, and whether alternative solutions would be more appropriate for delivering this work. Internal Audit recommends that a wider audit of contracted out activity is undertaken in the year ahead to ensure that robust process exist for governing such arrangements.

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**	**4**	**11**

Finding 1	Risk
Although there is a "protocol" for management of WLI sessions and payments, this is out of date, and is not stored on the UHB intranet, with staff not aware of its existence. (D)	Unnecessary/Inappropriate Expenditure
Recommendation 1	**Priority level**
A policy should be developed for the management of WLI sessions and payments. Local procedures at a Directorate Level should be produced that define how WLI sessions should be planned in advanced, justified and authorised and also provide guidance to management for the approval of WLI claims prior to payment to ensure sessions are verified and payments are authorised appropriately. This procedure should comply with the UHB policy and the WG annual pay circular.	**High**
Management Response 1	**Responsible Officer/ Deadline**

Whilst there is a UHB wide protocol for the payment of staff undertaking additional sessions, circulated July 2013, it is acknowledged that this needs updating and developed into a UHB wide policy for approval and circulation. The UHB policy will cover planning, justification and authorisation of claims and, therefore, should negate the need for local procedures at a Directorate level.	Assistant Chief Operating Officer in conjunction with Clinical Board Director of Operations and Assistant Director of Finance June 2017
Finding 2	**Risk**
Within Surgical Services, in the Ophthalmology/ENT and T&O Directorates, lower grade staff (eg Fellows) are being paid the Consultant WLI rate. There is no formal agreement or policy allowing this and therefore non consultant staff should be paid in line with their contract, ie. as overtime. (O)	Unnecessary/Inappropriate Expenditure
Recommendation 2	**Priority level**
Payments made to non-consultant staff should be in line with their working contract.	**High**
Management Response 2	**Responsible Officer/ Deadline**
Payments to non-consultant staff will be paid in line with their working contract.	Surgery Clinical Board Deputy Director of Operations

	May 2017
Finding 3	**Risk**
A review of the authorisation processes for WLI identified the following issues: Urology The authorisation of the claim form by the Service Manager is not consistent with the Urology procedure which states authorisation by the Directorate Manager. This is also not consistent with the Template Extra Duty Claim form which requires approval by the authorising Clinical Director and Clinical Board Director. Testing confirmed all claims were authorised by the Service Manager, 6/8 of these claims were above the authorised signatory level of £1000 and therefore not appropriately authorised. Ophthalmology The claims are signed by the Directorate Manager only; the form requires second approval by the Assistant Director of Operations. Two of the 10 available claim forms were authorised by the Directorate Support managers who are not an approved signatory. T&O One claim was paid in Dec 16, however was with the Clinical Director for approval during testing in Jan 17.	Unnecessary/Inappropriate Expenditure

(O)	
Recommendation 3	**Priority level**
The directorates should ensure claims are appropriately authorised.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
All directorates will be reminded of the authorisation hierarchy and the need to ensure claims are appropriately authorised and in line with the revised UHB wide policy (recommendation 1)	Surgery Clinical Board Deputy Director of Operations May 2017
Finding 4	**Risk**
A review of the processes for monitoring WLI sessions identified the following issues: Specialist Services (Cardiac Surgery) - There is no log of the booked WLI sessions or verification at Directorate level to ensure they are within the remit of the planned care proposal. Surgical Services - Although the number of WLI sessions are agreed quarterly there is no reconciliation of whether the planned/booked sessions are within the remit of those authorised, the only indication would be if spend goes over the planned budget	Unnecessary/Inappropriate Expenditure

(D)	
Recommendation 4	**Priority level**
Maintain a list of planned WLI sessions at a Directorate level and record how this aligns within the remint of those agreed planned WLI sessions by the Clinical Board/Finance. This should include date of clinic/list, clinic code where relevant, and planned number of patients.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
Specialist Clinical Board: Each Friday the theatre schedule for the following week is circulated to the Directorate and Clinical Board, clearly identifying where additional sessions are planned due to vacancies or consultant leave. In addition, the Directorate have now established a database of planned additional sessions against which claim forms are cross referenced.	Service Manager - completed
Surgery Clinical Board:	Director of Operations

Each Directorate will maintain appropriate records of planned additional sessions. As part of RTT monitoring agreed additional paid activity will be monitored against agreed spend.	Directorate Managers April – May 2017
Finding 5	**Risk**
The Cardiac Surgery Directorate do not keep a log of claims with claim forms being stored in a file. This means that duplication of claims is not checked by the directorate prior to submission to the Director of Operations for payment. (D)	Unnecessary/Inappropriate Expenditure
Recommendation 5	**Priority level**
A log of claims submitted should be maintained by the Directorate to ensure duplicate submissions are not made	**Medium**
Management Response 5	**Responsible Officer/ Deadline**
The Directorate have now established a database of planned WLI sessions against which claim forms are cross referenced to ensure there is no duplication of claims before they are submitted to the Director of Operations for authorisation.	Service Manager - completed

Finding 6	Risk

A review of the processes for verifying WLI work identified the following issues:
 	
<u>Specialist Services</u>
(Cardiac Surgery) - There is no consistent approach to checking occurrence of work claimed to TheatreMan/PMS or overlap with core job plans (or duplication with extra duty work already paid for). This coupled with a non-standard claim form being used resulted in an erroneous claim being submitted, processed and a large erroneous payment was made. The claim forms contain ticks which would indicate that they have been checked, however, the Service Manager expressed that the sessions are not verified to TheatreMan for occurrence. The absence of checks has contributed to erroneous payments being made.
 	
<u>Surgical Services</u>
Testing results:
• Urology
    ○ One claimed session overlapped with the consultants job plan
    ○ One sample was found to have the consultant on call during the same time as the WLI session.
• Ophthalmology
    ○ claims are not checked to TheatreMan or PMS prior to authorisation
	Unnecessary/Inappropriate Expenditure

for payment (1 claimed session could not be agreed to PMS). ◦ All claims were checked to Job Plans, two claimed sessions overlapped with SPA time ◦ One sample was found to have the consultant on call during the same time as the WLI session. • T&O ◦ no job plans have been provided for audit so unable to confirm any duplication with contracted work (O)	
Recommendation 6	**Priority level**
Each claim form should be checked to ensure there is no overlap with contracted hours as per the job plan and on-call rotas (where relevant). The sessions should be verified to TheatreMan or PMS to ensure occurrence. Evidence of these checks should be made on the claim form and log. Where overlap with contracted time is deemed appropriate, the nature of the displaced SPA activated and when this will be rescheduled should be agreed and recorded within the WLI claim form.	**Medium**
Management Response 6	**Responsible Officer/ Deadline**

Specialist Clinical Board: The Directorate has now established a database of planned WLI sessions against which claim forms are cross referenced. The Service Manager will check all claims against patient activity recorded on TheatreMan/PMS and consultant job plans before they are submitted to the Director of Operations for authorisation.	Service Manager - completed
Surgery Clinical Board: The process for authorising and verifying claims will be revised so that it is in accordance with the revised UHB wide WLI policy	Deputy Director of Operations and Directorate Managers

Finding 7	**Risk**
During testing of WLI claims across the five directorates covered, one WLI session claim (within cardiac surgery) was identified to be for a private patient theatre list and therefore not payable by UHB. (O)	Unnecessary/Inappropriate Expenditure
Recommendation 7	**Priority level**

Appropriate checks should be implemented to ensure that WLI claims are only submitted and processed for genuine WLI sessions.	**Medium**
Management Response 7	**Responsible Officer/ Deadline**
The Directorate has established a database of planned WLI sessions against which claim forms can be cross referenced. The Service Manager is checking all claims against patient activity recorded on TheatreMan/PMS and consultant job plans before they are submitted to the Director of Operations for authorisation. With regard to the identified claim for a WLI session which was a private patient list, there is a meeting arranged for April with the Clinical Director and Clinical Board Director and steps will be taken to recover the monies.	Service Manager – completed Director of Operations/Clinical Director/Clinical Board Director – 1 month
Finding 8	**Risk**
A review of WLI productivity identified the following issues: Specialist Services (Cardiac Surgery) - During sample testing, one WLI claim for a full session (3.5hrs) was found to be a Theatre that lasted 52mins. A half session should have been claimed for this or additional patients booked to ensure full utilisation.	Unnecessary/Inappropriate Expenditure

Surgical Services Ophthalmology: During testing, one sample has only 6 patients booked when should have 10 according to booking rules. T&O: During testing: 1 claimed session (theatre) was found to have lasted 1hr23mins, and only 7 injections performed (expected 8-10). 1 claimed session (clinic) was only booked for 1hr 40mins. In general no area had a process in place to ensure WLI productivity. (O)	
Recommendation 8	**Priority level**
Ensure that theatre lists are adequate to fully utilise a WLI session or ensure claims are only submitted for part session where appropriate.	**Low**
Management Response 8	**Responsible Officer/ Deadline**
Specialist Clinical Board: The Directorate has established a database of planned WLI sessions against which claim forms can be cross referenced. The Service Manager will check all claims against patient activity recorded on TheatreMan/PMS and consultant job plans to ensure the correct sessions have been claimed before submission to	Service Manager - completed

the Director of Operations for authorisation.	
Surgery Clinical Board: Additional RTT activity has been agreed for 17/18, which sets out the expected number of patients per additional session. This will form part of the weekly monitoring process of RTT activity.	Director of Operations Assistant Director of Finance April- May 2017
Finding 9	**Risk**
The rate for WLI sessions changed from £573 to £579 in April 2016, the directorates were not informed of the pay circular so continued paying at the old rate until they noticed. In Urology 1 of the sample contained the incorrect rate, in Ophthalmology 2 of the samples contained the incorrect rate, and in T&O all claims sampled used the incorrect rate. (O)	Unnecessary/Inappropriate Expenditure
Recommendation 9	**Priority level**
Clinical Boards should ensure WG Pay circular is communicated to the relevant personnel.	**Low**

Management Response 9	Responsible Officer/ Deadline
Communication to directorates has been strengthened and a process in place to ensure information is circulated not only via email but verbally discussed as key Clinical Board meetings.	Director of Operations April 2017
Finding 10	**Risk**
Ophthalmology - two claims were missing and unable to support payments. (O)	Unnecessary/Inappropriate Expenditure
Recommendation 10	**Priority level**
Ensure claim forms are retained to support authorised payments.	**Low**
Management Response 10	**Responsible Officer/ Deadline**
Directorates will be reminded of the importance of audit trails and the need to retain all relevant documentation relating to additional paid sessions. Directorate Managers to review processes to ensure robust audit trails are in place	Deputy Director of Operations Directorate Manager May 2017
Finding 11	**Risk**
In T&O two of the claims were received after the 90 day window from work occurring.(O)	Unnecessary/Inappropriate Expenditure

Recommendation 11	Priority level
The directorate should ensure all claims are received in a timely manner, and those that are not should be justified appropriately.	**Low**
Management Response 11	**Responsible Officer/ Deadline**
Directorates will be reminded of the 90 day timeframe for additional claims Directorate Managers to ensure that all staff are aware of the 90 day timeframe for additional claims	Deputy Director of Operations Directorate Managers May 2017

Waiting List Initiatives (WLIs)

Cardiff & Vale University Health Board

2

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.

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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.

3

Continuing Health Care (CHC)

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Executive sign off: Steve Curry, Chief Operating Officer
Distribution: Sue Morgan, Director of Operations
Kay Jeynes, PCIC Director of Nursing
Paula Davies, Lead Directorate Nurse
Committee: Audit Committee

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

Please note:

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

In accordance with the 2016/2017 internal audit plan, a review of the management of Continuing Health care within the UHB was undertaken.

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

Continuing NHS healthcare (also known as CHC) is the name given to a package of services which is arranged and funded solely by the NHS for those people who have been assessed as having a primary health need.

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of arrangements for the management of CHC in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The scope of the review was to ensure that there are appropriate systems and processes are in place for the assessment of CHC patients along with the commissioning and approval of placements and the on-going monitoring of these.

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

- There is a formally documented procedure in place for assessment, decision making and commissioning processes for CHC.
- There are adequate processes in place to ensure timely appropriate commissioning of placements.
- All CHC placements are appropriately approved within the relevant timescales and are based on an appropriate assessment process.
- Contracts are in place for the provision of care, which include KPIs.
- There are appropriate processes in place for contract management.
- The quality of care provision is monitored.
- Periodic reports on CHC and the associated costs are produced and submitted to appropriate groups for review and action.

3. Associated Risks

The potential risks considered in the review are as follows:

I. Impact of placement delays on patient care.
II. Poor patient care provision.
III. Financial loss due to inadequate management of CHC process/ performance management of providers.

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 CHC is **Limited Assurance**.

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

Overall the level of assurance given is limited. There is guidance in place at an All Wales, UHB and Clinical Board level for the assessment, quality assurance and approval of Primary Care CHC. It is noted that there is no National Framework in place for Children CHC; however Welsh Government guidance is available. Testing showed that the processes were working appropriately with patients being appropriately assessed utilising the Decision Support Tool (DST) and then subject to quality assurance.

Databases are in place to fully record all approved CHC patients and appropriate reports are produced to ensure that costs are monitored.

However issues were identified with the on-going monitoring process with a lack of evidence of regular annual reviews of clients and care providers. In addition there were cases where funding commenced prior to approval by CHC Panel and further the timeliness of the process was not always compliant with guidance.

It should be noted that despite the absence of a framework for Children CHC, the files tested were found to contain the majority of expected information and additional assurance is gained by the annual review of service providers performed by Community Child Health Hub.

There are further contractual risks as the Heads of Service Agreement is out of date, although it is also noted that there is on-going work to produce a renewed overall Service Agreement for all placements there is no timescale for the completion.

5. Assurance Summary

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

Assurance Summary					
1	*Impact of placement delays on patient care.*		✓		
2	*Poor patient care provision.*		✓		
3	*Financial loss due to inadequate management of CHC process/ performance management of providers.*			✓	

Design of Systems/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the system control/design for CHC.

These are identified in the management action plan as (D).

Operation of System/Controls

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

These are identified in the management action plan as (O).

6. Summary of Audit Findings

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

RISK: Impact of placement delays on patient care.

The following areas of good practice were noted:

- The UHB has developed a standard operating protocol (due for review in October 2019) to reflect the requirements of the National Framework implemented in Wales for Adult General and Learning Disability patients.

- The CHC children team in practice use the WG guidance for Children and Young Peoples Continuing Care and the adult process referenced above is used for any appeals.
- The UHB have a process in place to quality assure Multi-disciplinary team (MDT) recommendations following the DST, prior to approval by a CHC Panel.
- Across all localities, all new packages of Adult General and Learning Disability care had a copy of the DST on file that showed evidence of MDT hearing. All Children cases had an adequate assessment as per the WG guidance.
- The Adult General Quality Assurance summaries provide good detail, requesting more evidence from MDT where required or approval for CHC panel.
- All Learning Disability CHC Quality Assurance notes are documented on the individual client files.
- Quality Assurance for Children takes place every two weeks and is attended by appropriate members of staff, all individual files contained evidence of QA with extensive scrutiny of the assessment and approval prior to CHC panel.
- Majority of Adult General care packages and all Children files evidenced an initial care plan with only a few exceptions.
- All Children case files contained an initial three month review of eligibility and care plans, with the exception of one file that was due for review in January 2016 (however, this file evidenced on-going contact with the client and correspondence with the family).

The following significant findings were noted:

- There is no national framework in place for Children and Young Peoples CHC and there is no local policy or procedure in place to adopt the WG Guidance.
- Across the localities, 4/19 Adult General and Learning Disability cases were significantly over the Framework's 8 week timeframe from trigger to agreeing a care package (13-27weeks DST to CHC Panel).
- Adult General QA notes are held in a lever arch file in chronological order, however there is no list of QA dates and the clients reviewed on these dates. Names are not on the QA notes, just initials for the clients making it difficult to search. 7/20 QA notes could not be found.
- Many of the Adult General and Learning Disability case files were missing initial three month review of eligibility and care plans.

RISK: Poor Patient Care Provision

The following areas of good practice were noted:

- An annual review of service providers for Children CHC was undertaken last summer; this included a comprehensive review of the care environment and individual case files.
- The majority of Children files contained on-going annual reviews.

The following significant findings were noted:

- The Head of Service Agreement is out of date and there is no timescale for the completion therefore there is no overall contract in place for the provision of care.
- Performance KPIs for adult general focus on number of clients and costs, there are no KPIs that cover aspects such as timing delays and quality of patient care.
- Children residential placements are jointly commissioned with the LA, contracts are commissioned and held by LA and are not specific to health. Therefore there are no service user agreements that are specific to commissioning health aspects. Due to this there are no KPIs for monitoring within Children CHC, internally performance and timescales are monitored but they are not always compliant due to resourcing.
- Completion of annual reviews of Adult General and Learning Disability CHC clients is behind target. From testing completed, 12/22 files were missing annual reviews. This is not mitigated by regular review of service providers as reliance is placed on the Care and Social Services Inspectorate reviews and these are not checked regularly unless informed by Local Authority that there is an issue.

RISK: Financial loss due to inadequate management of CHC process/ performance management of providers.

The following areas of good practice were noted:

- CHC Panel Papers were available for all of the Adult General and Learning Disability clients tested confirming appropriate approval of funding.
- The majority of Children care packages were approved at CHC panel prior to funding, with the exception of 1 case. However, this was scrutinised by the QA panel prior to funding and commenced in order to avoid delaying care as the CHC panel only occurs monthly.
- Majority of Adult General and Learning Disability care packages evidenced an individual service user agreement outlining the care package agreed with the placement, only 2 packages of care did not

have a relevant individual service user agreement due to t/f from MH and from fully funded under LA.

- Spend is monitored at a clinical board level (PCIC Service Delivery Group) and a quarterly report is submitted to the UHB PPP Committee as required by the National Framework. A monthly report is also submitted to Welsh Government.

The following significant findings were noted:

- 12/20 CHC Panels were not held prior to the commencement date of funding for Adult General and Learning Disability care packages.

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**	**3**	**3**	**8**

Finding 1	Risk
Testing of the commissioning and placement process indicated that for 12/20 clients the submission to the weekly CHC Panels was after the commencement date of funding for Adult General and Learning Disability care packages. In addition 1/5 children care packages commenced funding prior to CHC Panel. Audit notes that these placements related to clients who were transitioning from Children or FNC to CHC, or where the care needs had changed and did not relate to new placements. As such the CHC Funding Panel has no choice but to accept backdated CHC funding where eligibility is found upon review of a client in a home/community. The process as it stands cannot operate effectively in these cases, as placement necessarily comes before funding approval. (O)	Financial loss due to inadequate management of CHC process/ performance management of providers.
Recommendation 1	**Priority level**
The UHB should accept the residual risk relating to these changes in care requirements.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
A recent Ombudsman ruling in 2015 has expressly advised the UHB when considering eligibility that the nurse assessor needs to look back at possible	Director of Nursing, PCIC

triggers before the date the individual has been referred for an assessment, this does then lead to cases where eligibility precedes panel authorisation. This is something we will need to continue to undertake in line with the ruling and NHS Continuing Healthcare policy.	

Finding 2	**Risk**
The Head of Service Agreement is out of date and there is no timescale for its completion therefore there is no formal, in date framework contract in place for the provision of care. (D)	Poor patient care provision.
Recommendation 2	**Priority level**
A timescale should be set to ensure the Head of Service Agreement is agreed promptly.	**High**
Management Response 2	**Responsible Officer/ Deadline**
The Heads of Service agreement is being reviewed following the Operation Jasmin work (Flynn Report). The review is being led by the joint Cardiff and Vale Local Authorities, timescales are currently unclear, the PCIC Director of Nursing will write to the LA leads and ask for an agreed timescale for conclusion of the work.	Director of Nursing, PCIC

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Finding 3	**Risk**
Completion of annual reviews of Adult General and Learning Disability CHC clients is behind target. From testing completed, 12/22 files were missing annual reviews. Only 1 Children CHC file was missing an annual review. This is not mitigated by regular review of service providers as reliance is placed on the Care and Social Services Inspectorate reviews and these are not checked regularly unless informed by Local Authority that there is an issue. Audit notes that for most of these there has been periodic contact with the clients. (O)	Poor patient care provision
Recommendation 3	**Priority level**
PCIC should ensure an annual review is carried out on existing CHC placements as per the framework and evidence of this review should be maintained on the patients file.	**High**
Management Response 3	**Responsible Officer/ Deadline**
A schedule is in place to meet statutory requirements for review which is monitored at PCIC SDG (Performance monitoring meeting) also at Welsh government Complex Care board. There is recognition both locally and nationally that staffing establishments within the nurse assessor teams	Director of Nursing, PCIC

expected to undertake this work are limited and further put under pressure when safeguarding issues arise in Nursing homes which need immediate and often long term support. This risk is on the PCIC Risk register and additional resources have been highlighted for potential investment in the PCIC IMPT, the business case was not requested from the Executive team on this POD as a priority for funding.	

Finding 4	**Risk**
There is no National Framework in place for Children and Young Peoples CHC and there is no local policy or procedure in place to adopt the WG guidance. (D)	Impact of placement delays on patient care.
Recommendation 4	**Priority level**
The Children CHC team should develop a local procedure that sets out how they adopt the WG guidance.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
The Community Child Health Directorate will develop a local Operational Policy based on WG CC Guidance for Children. The policy will include: • The CVUHB Appeals Process as WG Children's Guidance is not specific; and • Recommendation of key performance indicators for children's CHC.	Paula Davies, Lead Nurse, CCH October 2017

Finding 5	Risk
Performance KPIs for adult general focus on number of clients and costs, there are no KPIs that cover aspects such as timing delays and quality of patient care. Children residential placements are jointly commissioned with the LA, contracts are commissioned and held by LA and are not specific to health. Therefore there are no service user agreements that are specific to commissioning health aspects. Due to this there are no KPIs for monitoring within Children CHC, internally performance and timescales are monitored but they are not always compliant due to resourcing. (D)	Poor patient care provision
Recommendation 5	**Priority level**
Individual Service User Agreements should be produced to cover health aspects of child residential placements and KPIs developed/expanded to monitor performance internally.	**Medium**
Management Response 5	**Responsible Officer/ Deadline**
The Community Child Health Directorate will agree a process for KPI's to be measured and reported on in line with other Directorate Performance Management.	Paula Davies, Lead Nurse, CCH October 2017

Finding 6	**Risk**
Across the localities, 4/19 Adult General and Learning Disability cases were significantly over the Framework's 8 week timeframe from trigger to agreeing care package (13-27weeks DST to CHC Panel). (O)	Impact of placement delays on patient care.
Recommendation 6	**Priority level**
All new placements should have a placement agreement in place and be processed within the timescales required by guidance. Compliance with this target should be reported within the Performance Report.	**Low**
Management Response 6	**Responsible Officer/ Deadline**
This is in place	Director of Nursing, PCIC

Finding 7	**Risk**
Adult General Quality Assurance notes are held in a lever arch file in chronological order, however there is no list of QA dates and the clients reviewed on these dates. Names are not on the QA notes, just initials for the clients making it difficult to search. 7/20 QA notes could not be found. (O)	Impact of placement delays on patient care.
Recommendation 7	**Priority level**
A list of QA dates should be maintained with corresponding patients reviewed on these dates. Locality teams should ensure that QA summaries produced are kept to evidence decisions made.	**Low**
Management Response 7	**Responsible Officer/ Deadline**
QA is held every Tuesday each week for 52 weeks (Whitchurch Locality Meeting room, 9-10.30), the date of the QA is entered on the top of the sheet. The QA sheet is not held with the individuals records as records transfer to the nurse assessor team on transfer of the patient. The nurse assessor team now have electronic records, it is hoped all records from January 2017 will be held in one place.	Director of Nursing, PCIC

Finding 8	Risk
Many of the Adult General and Learning Disability case files were missing an initial 3 month review of eligibility and care plans: •6/20 cases were missing initial reviews; •1 case has not had a review since t/f from MH; •1 review outstanding at reporting. (O)	Impact of placement delays on patient care.
Recommendation 8	**Priority level**
PCIC should ensure an initial 3 month review is carried out on new CHC placements as per the framework and evidence of this review should be maintained on the patients file.	**Low**
Management Response 8	**Responsible Officer/ Deadline**
Agreed – this will be undertaken if the staffing resource is available.	Director of Nursing, PCIC

Continuing Healthcare (CHC)

Cardiff & Vale University Health Board

3

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.

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Prioritisation of Recommendations

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

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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*

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4

Surgery Clinical Board
Bluespier IT System

FINAL INTERNAL AUDIT REPORT
2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Executive sign off: Director of Therapies
Distribution:

Committee: Audit Committee

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1. Introduction and Background

In accordance with the 2016/2017 internal audit plan, a review of the Bluespier IT System used within Trauma & Orthopaedics (T&O) in Surgery Clinical Board was undertaken. The assignment originates from the internal audit plan and the subsequent report will be submitted to the Audit Committee.

The relevant lead Executive Director for the assignment is the Director of Therapies

2. Scope and Objectives

The objective of the audit is to evaluate and determine the adequacy of the systems and controls in place for the management of the Bluespier IT System, 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 is to provide assurance that data held within BLuespier is accurate, secure from unauthorised access and loss and that the system is used fully.

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

- Appropriate control is maintained over the database.
- All input is authorised, complete, accurate, timely and input once only;
- Proper control is exercised over access to application systems;
- Controls ensure the accuracy, completeness, confidentiality and timeliness of output, reports and interfaces;
- A complete audit trail is maintained which allows an item to be traced from input through to its final resting place;
- Appropriate business continuity arrangements are in place which include backing up copies of data and programs, storing and retaining them securely, and recovering applications in the event of failure.

Due to staff turnover within the directorate and supplier the knowledge of the system and governance arrangements had decreased. As such no testing of database access could be carried out as no data or access could be obtained. In addition no verification or testing of the logging process could be undertaken at the time of the audit.

3. Associated Risks

The potential risks considered in the review are as follows:

i. Inappropriate access to system / data.
ii. Inaccurate data held in system.
iii. Loss of processing / data.
iv. The UHB is not maximising the benefits from the system.

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 Bluespier system is **Reasonable Assurance**.

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

Overall the level of assurance given is reasonable. Bluespier is used for managing Trauma patients and organising theatre lists within T&O, and although there is a facility for clinical management, this is not fully used. The system is provided by an external firm and the UHB has a client manager contact, however recent changes within the Directorate have led to weaknesses in governance, with the new staff unaware of the system contract or management arrangements. Accordingly the UHB cannot demonstrate that it is gaining full value from the use of the system or from the support contract.

The system is securely hosted within the UHB SAC and is regularly backed up, although these backups are not tested.

Access to the system is controlled by password via the nadex account for most users, with users having defined roles within the system, this would allow for hierarchal / modular access to data.

5. Assurance Summary

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

	Assurance Summary				
1	*Inappropriate access to system / data.*			✓	
2	*Inaccurate data held in system.*			✓	
3	*Loss of processing / data.*		✓		
4	*The UHB is not maximising the benefits from the system.*		✓		

Design of Systems/Controls

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

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 the Bluespier system.

These are identified in the management action plan as (O).

6. Summary of Audit Findings

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

Risk: Inappropriate access to system / data.

The following areas of good practice were noted:

- The system uses the nadex account for login.

The following significant finding was noted:

- Testing identified a number of weaknesses over user access, with no minimum password length, no complexity requirement and no

forced change of password. In addition generic accounts are in use and there is no formal process to identify leavers.

RISK: Inaccurate data held in system.

The following areas of good practice were noted:

- User guides are available for the system.
- Patient demographic information is imported from PMS.

There were no significant findings highlighted under this risk owing to the lack of data within the system and the inability to extract information for the audit.

RISK: Loss of processing / data.

The following area of good practice was noted:

- The held on servers within the SAC and is backed up.

The following significant findings were noted:

- Although backups are taken and reports provided to the admin team from IT, these have not been tested by a restore. In addition due to the change of staff in the office the new system admin is not fully aware of the files to be backed up, or have copies of previous backup reports for comparison.
- There is no business continuity procedure in place for the Bluespier system.

RISK: The UHB is not maximising the benefits from the system.

The following significant findings were noted:

- The system is not fully used. The system allows for the collection of operation notes and clinical information (as per the business case). This information can then be extracted as operation notes or in the form on business information reports that can be generated. However this information isn't always entered and the UHB cannot therefore get full information out.

- Due to change of staff at both the UHB and the supplier the governance over the management of the system has decreased. The new Assistant Directorate Manager has the responsibility for managing the system and the contract. However due to a lack of documentation in the directorate he was unaware of how the system

is managed, did not have a copy of the support contract and did not know who of the company representative or local administrator was. From reviewing the support contract there are a number of areas where the UHB is not demonstrating appropriate governance or value:

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**	**5**	**1**	**6**

4

Finding 1	Risk
The system is not fully used. The system allows for the collection of operation notes and clinical information (as per the business case). This information can then be extracted as operation notes or in the form on business information reports that can be generated. However this information isn't always entered and the UHB cannot therefore get full information out. (O)	The UHB is not maximising the benefits from the system.
Recommendation 1	**Priority level**
The system should be fully used with all users entering clinical information.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
Introductory meeting took place in March with the new account manager for the company. Discussions now underway regarding expanding use of the system further, to allow the department to get the most from the system.	Deputy Directorate Manager – action underway.
Finding 2	**Risk**
Due to change of staff at both the UHB and the supplier the governance over the management of the system has decreased.	The UHB is not maximising the benefits from the system.

The new Assistant Directorate Manager has the responsibility for managing the system and the contract. However due to a lack of documentation in the directorate he was unaware of how the system is managed, did not have a copy of the support contract and did not know who of the company representative or local administrator was. From reviewing the support contract there are a number of areas where the UHB is not demonstrating appropriate governance or value: - There is no record kept of service or change requests raised by the UHB; - There is no monitoring of contract performance against the defined KPIS; - There have been no service reports provided. (O)	
Recommendation 2	**Priority level**
Management of the contract and the system should be improved with records kept of SRs and performance monitored against the levels set out in the contract. The governance documentation should be kept in the directorate record structure to ensure new staff can continue the function.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
A new system has been put in place to ensure any current and new records are	Complete.

filed in the Directorate Management office at the UHW.	

Finding 3	**Risk**
Testing identified a number of weaknesses over user access: - There is no minimum password length, no complexity requirement and no forced change of password. - Generic accounts are in use, with 2 having access to create / amend data and 1 being a super user - 4 users do not have a nadex user name and therefore do not use active directory for login. - There is no formal process to identify leavers. As a result 1 super user has moved to a new department and is still active and 1 user has moved to another organisation and is still active. (O)	Inappropriate access to system / data.
Recommendation 3	**Priority level**

Minimum password controls should be enacted in line with the IT Security Policy. The use of generic accounts should cease. A process for identifying when staff leave the UHB and for deactivating the user accounts should be established.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
Directorate to address this in line with recommendations above.	End of May 2017 Assistant Directorate Manager

Finding 4	**Risk**
Although backups are taken and reports provided to the admin team from IT, these have not been tested by a restore. In addition due to the change of staff in the office the new system admin is not fully aware of the files to be backed up, or have copies of previous backup reports for comparison. (O)	Loss of processing / data.
Recommendation 4	**Priority level**

4

The backups should be periodically tested by restore. The log files should be checked to ensure all expected items are included and that the file sizes are consistent.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
Directorate to discuss with supplier and healthboard I.T. department.	End of May '17 Assistant Directorate Manager

Finding 5	**Risk**
There is no business continuity procedure in place for the Bluespier system. (O)	Loss of processing / data.
Recommendation 5	**Priority level**
A formal continuity procedure should be developed	**Medium**
Management Response 5	**Responsible Officer/ Deadline**

4

To be reviewed as part of the All Wales strategy around national system implementation.	Directorate Manager – currently underway.
Finding 6	**Risk**
There is no departmental user group at which UHB staff can discuss the use of the system and potential improvements. In addition the super users are unaware of any national user groups. (O)	The UHB is not maximising the benefits from the system.
Recommendation 6	**Priority level**
A departmental user group should be established. A UHB representative should seek to attend any national user group.	**Low**
Management Response 6	**Responsible Officer/ Deadline**
To be reviewed and recommendations taken on board.	End May 2017 Assistant Directorate Manager

Surgery CB – Bluespier IT System

Cardiff & Vale University Health Board

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.

5

Integrated Medium Term Plan

INTERNAL AUDIT REPORT
2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Auditors: Murray Gard – Principal Auditor
Martyn Lewis – Audit Manager

Executive sign off: Abigail Harris – Executive Director of Planning

Distribution: Sue Morgan – Director of Operations (Primary, Community & Integrated Care Clinical board

Ian Wile – Director of Operations (Mental Health Clinical Board)

Committee: Audit Committee

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

Please note:

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

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

1. Introduction and Background

In accordance with the 2016/2017 internal audit plan, a review of the implementation of two work streams contained within the Integrated Medium Term Plan (IMTP) within the UHB has been completed.

The relevant lead Executive for the assignment is the Executive Director of Planning and the subsequent report will be submitted to the Audit Committee.

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of arrangements for the management of the IMTP in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of systems objectives are managed appropriately.

The scope of the review was to ensure that the IMTP work streams are being delivered as planned and these are monitored appropriately.

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

- IMTP work streams are accepted and devolved to appropriate management level;
- Plans are implemented appropriately, with remedial actions being identified to resolve any shortcomings;
- Progress against the plans are monitored and reported appropriately.

In order to undertake the audit the work focussed on 2 work streams within the IMTP, these being Mental Health Services for Older People and Primary Care.

3. Associated Risks

The potential risks considered in the review are as follows:

I. The UHB fails to meet its targets.

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 implementation of the Integrated Medium Term Plan 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 review found that overall the controls in place to manage the risks associated with this review are of a reasonable standard.

The audit identified a number of areas of good practice, including; clinical Boards operational plans had been developed in junctions with multiple stakeholders. Standard templates had been issued by the UHB that identifies the lead officers, key milestones and delivery measures. There was also scrutiny of the operational plan at Clinical Board level, which has executive membership. There were differences between the two Clinical Boards, with PCIC have a better documented governance process in place which allows fuller tracking of plans though the process. Mental Health however lacked the full documented process and so cannot fully demonstrate an effective audit trail of scrutiny and challenge.

There have been delays in implementing plans within both clinical boards, largely due to recruitment delays however these are known by management.

5. Assurance Summary

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

Assurance Summary					
1	The UHB Fails to Meet Its Targets.			✓	

Design of Systems/Controls

The findings from the review highlighted one issue classified as weaknesses in the system control/design for the implementation of the Integrated Medium Term Plan.

These are identified in the management action plan as (D).

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 the implementation of the Integrated Medium Term Plan

These are identified in the management action plan as (O).

6. Summary of Audit Findings

Details of the key overall findings from the review that require corporate actions can be found in the Management Action Plan under Appendix A.

The main areas of good practice and significant findings noted under each objective heading are as follows:

Objective: The UHB Fails to Meet Its Targets.

The following areas of good practice were noted:

Primary, Community & Integrated Care Clinical board (PCIC)

- In developing the PCIC Clinical Board operational plan for 2016/17 a wide range of staff from within the Clinical Board came together at two IMTP development sessions to consider the PCIC Clinical Board and the Business Units.

- Clinical Board meetings occur frequently (with executive membership), in respect of PCIC performance, delivery and planning (including the IMTP).

5

- The Service Delivery Group (SDG) which feeds into the Clinical Board is the main forum where scrutiny and review to a level of depth and detail, not possible at the Clinical Board takes place.
- Standard templates had been utilised within the 2016/17 operational plan that stipulates the lead officer, key milestones and delivery measures.
- Cluster developments are currently a contractual requirement of practices and are governed via the Quality of Outcomes Framework (QOF). The Cluster Network Development (CND) domains outline what is expected of practices and GPs.
- All 9 Clusters and clinically led throughout the UHB and had appointed Community Directors (CDs), with one of these CDs as lead locality director.
- Clusters had a 3 year Development Plan (2014-17) where actions are agreed to be implemented.

<u>Mental Health Clinical Board</u>

- Mental Health's Clinical Board's Operational Plan was devised with consultation from directorates in September/October 2015, which set the objectives for 2016/17.
- Mental Health's IMTP submission was noted through the clinical board in December 2016 as being *"commended by the executive Board and Welsh Government"*.
- Clinical Board meetings occur frequently (with executive membership), in respect of performance, delivery and planning (including the IMTP).
- The Senior Management Team within mental health meets on a regular basis and the IMTP is a standard agenda item.
- Standard templates had been utilised within the 2016/17 operational plan, however, the details were populated in an inconsistent manner.
- The Clinical Board has issued a project management toolkit including project initiation document templates.

The following significant findings were noted:

- There was no business plan in place, within any in the 9 clusters that sets what the future vision is for the clusters within their communities.
- There were no formal terms of reference (TOR) identified for these cluster meetings that would outline the governance arrangements including; approval structure, roles & responsibilities of individuals etc.
- There had been delays in achieving the key milestone and delivery measures within the PCIC clusters, mainly due to the current working arrangements and recruitment difficulties.
- Governance arrangement within mental health need to be strengthened so that an effective audit trail of scrutiny and challenge can be maintained.
- Standard templates had been utilised on an inconsistent basis within Mental Health e.g. no lead officer assigned.
- There had been delays in achieving the key milestone and delivery measures within Mental Health. Similar to PCIC, the main reasons are the working arrangements (noting Mental Health relocation) and recruitment issues.

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**	**5**	**2**	**8**

Finding 1 PCIC - Business Plan (O)	**Risk**
The Welsh Government guidance is not specific in their requirements for developing and managing Primary Care Clusters. Each individual cluster has their own action plan for implementation (2014-2017); Clusters had begun to engage (via workshops) as to what their future priorities are to be. The Community Directors Forum (January 2017) noted the need to develop a template business plan that would support robust development planning. However, at the time of audit fieldwork it was not yet clear what the future vision of the clusters would be.	The UHB fails to meet its targets.
Recommendation 1	**Priority level**
A business plans will be established for each cluster that sets the future vision and developments of individual clusters.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
It is not envisaged that each cluster will adopt the same approach to cluster development i.e. some may be more ambitious than others, however, each cluster will develop a vision proportionate to their ambitions and these will be documented in a business plan document.	Locality Managers. Business Plans with cluster development timeframes and expectations documented by

5

NB: The cluster plan will specify the clusters clinical and service planning priorities, the business plan will document the clusters development plan.	January 2018.

Finding 2 PCIC - Cluster Workings (O)	**Risk**
The approval structure within the clusters was evolving and needs to be sustainable for their future needs, in order to drive change and make decisions effectively. The main operational governance forum is centred on cluster meetings, where GP practices are all represented. These meetings can however be challenging, as there could be circa 20 individuals attending each meeting, which only occurs once every 6 weeks. So gaining a consensus and an appropriate way forward can prove challenging given the time constraints. There were no formal terms of reference identified for these cluster meetings that would outline the governance arrangements, including; approval structure, roles & responsibilities of individuals etc.	The UHB fails to meet its targets.
Recommendation 2	**Priority level**
Cluster governance needs to be reviewed, to ensure future sustainability.	**Medium**

5

Management Response 2	Responsible Officer/ Deadline
Cluster governance arrangements to be reviewed and documented ToR and reporting lines to be confirmed and documented to include cluster meetings, locality CD meetings, CD forum.	Asst. Head of Ops, July 2017.

5

Finding 3 PCIC - Achieving Targets (O)	Risk
There had been delays in achieving the key milestone and delivery measures Within the clusters PODS. Significant factors that had affected the pace of change within the clusters, is the governance arrangements (mentioned previously) and the recruitment of appropriate staff to fill the necessary positions e.g. 1. Inability to recruit a lead community director within 1 cluster (until January 2017); 2. No Diabetic nurse recruited; 3. No PICT doctor recruited. Delivery measures had also been very ambitious and being able to evidence achievement of the same proved challenging (at locality level due to availability of baseline data).	The UHB fails to meet its targets.

Recommendation 3	Priority level
Key milestones/delivery measure, should be achievable, with appropriate mechanisms will be in place at a locality level, to monitor the outcomes.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
Clusters and the localities have learnt that recruitment to cluster based posts can take upwards of 6 months from the start of the process to getting staff in post. This will be reflected in cluster planning going forward, although frustrating in terms of pace, this will provide a realistic planning expectation. PODs including the cluster development POD will be reviewed at locality level (key milestones/delivery measures) during 2017/18 to ensure ongoing monitoring of outcomes and lessons learnt.	Locality Managers, April – March 2017/18 (quarterly via SDG meetings).

5

Finding 4 PCIC - Cluster Maturity (O)	Risk
Clusters are currently developing at different paces in their maturity levels. Effective project management support, coupled with the current clinical leadership would help drive the clusters forward. However, only one cluster has identified the need for project management expertise.	The UHB fails to meet its targets.

Recommendation 4	Priority level
Considerations should be given to providing targeted project management support for the development and sustainability of the clusters.	**Low**
Management Response 4	**Responsible Officer/ Deadline**
Feedback and lessons learnt will be taken from the cluster (South West Cardiff) seeking to appoint project co-ordinator support. Discussions will take place at CD Forum so that all other clusters can learn from the impact/benefit this additional resource has in driving cluster development and priority projects forward.	Locality Managers/Cluster CDs, July – December 2017
The OD and Workforce planning resource will continue to prioritise cluster development and the OD programme in particular will provide some project management support to aid cluster development.	OD Lead/Workforce Planning Manager, April 2017 – Sept 2018
Localities will continue to provide support to clusters, although it is acknowledged they do not have the capacity to provide project management support to the level required.	Locality Managers, underway

Finding 5 PCIC – Corporate Governance (O)	Risk
Governance arrangements within PCIC were evident during the review, specially the Clinical Board meetings and Service Delivery Group (SDG). However enhancements to governance arrangements can be enacted via; 1. A review of the TOR of the Clinical Board and SDG to ensure roles and responsibilities are appropriately documented and a definition of a quorum is incorporated. 2. Attendance at Clinical Board to be improved - During financial year 2016/17 there has been 5 meetings of the board with the lead executive for the IMTP (Director of Planning) was not in attendance at the last 2 meeting (as per February 2017).	The UHB fails to meet its targets.
Recommendation 5	**Priority level**
Governance arrangements to be reviewed and updated appropriately.	**Low**
Management Response 5	**Responsible Officer/ Deadline**
The SDG and CB terms of reference will be reviewed and updated to include a definition of quorum. A governance review is planned as part of a future Clinical Board Development session during 2017/18 which will help address this.	Asst. Head of Ops, July 2017

5

The attendance at Clinical Board by the Direcot or Planning will be discussed with the Director of Planning, and discussions can take place at the planned governance review (mentioned above).	Asst. Head of Ops, July 2017

Finding 6 Mental Health - Governance Structure (D)	Risk
Governance arrangements within Mental Health were evolving at the time of audit fieldwork, with the Clinical Board and Senior Management Team Meetings being the main forums for scrutiny. Enhancements to governance arrangements can be enacted via; 1. Attendance at Clinical Board - During financial year 2016/17 there has been 5 meetings of the board with the lead executive not in attendance at 2 of these (as per January 2017). 2. The Senior Management Team meets on a monthly basis, where the implementation of the IMTP is discussed. However, there were no minutes of these meetings, so being able to verify the level of discussion was not possible. 3. Monthly performance meetings within individual directorates had been re-established in 2016 (July onwards). This is the main forum for	The UHB fails to meet its targets.

<table>
<tr><td>discussing the implementation of in individual PODS that make up the operational plan. It was noted that these meetings had been infrequent due to operational pressures i.e. moving services to alternative location.

4. No documented structure was in place that shows the flow of information and interactions between individual groups and committees.</td><td></td></tr>
<tr><td>Recommendation 6</td><td>Priority level</td></tr>
<tr><td>Governance arrangements need to be strengthened, to ensure a robust audit trail is in place for monitoring the Operational Plan.</td><td>High</td></tr>
<tr><td>Management Response 6</td><td>Responsible Officer/ Deadline</td></tr>
<tr><td>Monthly Performance meetings re-established from January 2017 for the four main service delivery areas. These will be separate and specific for Adult Services, MHSOP, Psychology and Psychological Therapy services and Patient Flow (including Out of area CHC costs

An IMTP tracker document has now been completed for the main work streams in mental health which identifies quarterly progress agreed within the Clinical Board, as well as identifying lead officers and the completion of individual PODs where there is not a fuller case for change document completed.</td><td>Ian Wile – Director of Operations

Ian Wile – Director of Operations
Sarah Lloyd – Directorate Manager Adult Services
Jo Wilson – Directorate Manager MHSOP Services</td></tr>
</table>

Progress against the IMTP tracker will be reported to the Mental Health Clinical Boards formal bi monthly meeting and at the MHCB executive performance meeting	Martin Ford – Directorate Manager – Psychology and Psychological Therapy Services

Finding 7 Mental Health - Standard Templates (O)	**Risk**
The Health Board utilises standard templates for the implementation of the operational plan (POD system); this POD system sets the delivery objectives, lead officer and key milestones for implementation. However, this was being utilised on an inconsistent basis within Mental Health. There are multiple examples of where there is no lead officer assigned; 1. Iorwerth Jones relocation. 2. CMHT Co-location and integration, including Single point of entry. There was also multiple instances identified, where no key milestones had been set; 1. Community Service Review 2. Development of National Psychosis Service at Llanfair Unit.	The UHB fails to meet its targets.
Recommendation 7	**Priority level**

5

For future iterations of the operational plan, the standard templates will be completed to show the defined leads and key milestones for implementation.	**Medium**
Management Response 7	**Responsible Officer/ Deadline**
The IMTP tracker identified in Finding 6 will require the identification of a lead officer where that isn't apparent as part of a broader 'case for change' or more formal document required to implement that change – such as for the Iorwerth Jones changes identified in the findings. The IMTP tracker identified in Finding 6 will contain the identification of quarterly key milestones and annual following that.	Ian Wile – Director of Operations Sarah Lloyd – Directorate Manager Adult Services Jo Wilson – Directorate Manager MHSOP Services Martin Ford – Directorate Manager – Psychology and Psychological Therapy Services

Finding 8 Mental Health - Achieving Targets (D)	**Risk**
There had been delays in achieving the key milestone and delivery measures within both the Community Services Review and the Developing Services for First Episode Psychosis Review. Significant factors that had affected the pace of change within the above, is identifying the service change criteria including key in year milestones (mentioned previously) and the recruitment of appropriate staff to fill the	The UHB fails to meet its targets.

necessary positions e.g. • Inability to recruit an appropriate psychologist and specialty Nurse.	
Recommendation 8	**Priority level**
Delivery measure should be achievable, with appropriate mechanisms in place at an operational, to monitor and report on outcomes.	**Medium**
Management Response 8	**Responsible Officer/ Deadline**
The IMTP tracker identified in the previous sections will contain actions and measures which will evolve through negotiations with the directorates to ensure they are realistic and achievable. Monthly performance meetings will be the mechanism to review the achievement of these outcomes.	Ian Wile – Director of Operations Sarah Lloyd – Directorate Manager Adult Services Jo Wilson – Directorate Manager MHSOP Services Martin Ford – Directorate Manager – Psychology and Psychological Therapy Services

5

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.

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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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Theatres Stock Follow-Up

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff and Vale University Health Board

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NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Review reference:	CUHB1617.51
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Auditor/s:	Olubanke Ajayi Olaoye
Executive sign off :	Steve Curry, Chief Operating Officer
Distribution:	Sian Crowley, Directorate Manager Steve Hill, Senior Assistant Finance Director
Committee:	Audit Committee

ACKNOWLEDGEMENT

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

Please note:

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

The follow up review of Theatre Stock has been completed in line with the 2016/17 Internal Audit Plan. The review seeks to provide the Health Board with assurance that agreed actions from the previous review of Theatre Stock have been implemented appropriately.

The initial internal audit report was finalised in February 2016 and highlighted a total of eleven issues which resulted in an overall assurance rating of Limited Assurance.

The risks considered in the previous review were as follows:

- Stock is lost / damaged / stolen.
- Too much stock is held resulting in unnecessary cost or wastage.
- Insufficient stock causes delays to patient treatment.
- Management is not aware of stock position.

Follow up work has been undertaken to determine whether progress / full implementation had been made relating to the following recommendations of the agreed issues / management responses:

- An appropriate stock management system should be developed / purchased. *(Finding 1, High Priority)*
- All stocks should have a minimum and maximum level set. *(Finding 2, High Priority)*
- A robust policy should be published which should include the update of the current information and inclusion of relevant sections as control processes for outgoing stock and monitoring and reporting system. *(Finding 3, High Priority)*
- Consignment agreements and additions should be signed by the delegated representative of both the UHB and supplier and retained. *(Finding 4, High Priority)*
- Stock items should be securely stored in appropriate locations with access controlled. *(Finding 6, Medium Priority)*
- A review of the storage available should be undertaken which should consider the provision of additional space (safe storage) and ensure that stock is held in the most suitable location. *(Finding 7, Medium Priority)*
- A stock control system should be developed that identifies when stock levels are at a reorder level and allows ordering to be collated to maximise the use of resources. *(Finding 8, Medium Priority)*
- All disposals / returns should be appropriately authorised. *(Finding 9, Medium Priority)*

- In the absence of a stock management system a simple / alternative means of identification of almost expired stock such as use me first / small colour stickers should be adopted across stores. *(Finding 10, Medium Priority)*
- Management reporting process should be included in the stock management policy and enacted. There should be periodic reporting of stock management issues to an agreed forum / committee. *(Finding 11, Medium Priority)*

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2. CONCLUSION AND FINDINGS

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

Priority Rating	No of Management Responses to be implemented	Fully Actioned	Partially Actioned	Not Actioned
HIGH	4	2	2	-
MEDIUM	6	4	1	1
LOW	0	-	-	-
TOTAL	**10**	**6**	**3**	**1**

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

Significant work has been put into developing a stock management system for consumables. The system now holds information on about 28,000 consumable items based stock transactions extracted from the Oracle system dating back to April 2014.

The knowledge of the Procurement department in conjunction with that of the Theatre stock staff has been drawn together to design the stock system; however there is additional work to be done to ensure:

- Adoption and use of system with consignment stocks;
- Interface with other systems such as ADC (Automated Data Capture) and Oracle;
- Possible use in the monitoring of stocks KPI which could support future reporting systems etc.

A new barcoding system (ADC) has been put in the main store room in UHL & UHW. The plan is to expand the range to other items held within Theatre stores.

On the basis of this follow up conclusion, the level of assurance that would be given as to the effectiveness of the system of internal control in place to manage the risks associated with Theatre stock is **Reasonable Assurance**. It should be noted that this rating assumes the continued implementation of the new stock system and processes.

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

- A Theatre stock procedure was produced in draft in June 2016. This included the audit recommended items. This is due to be subject to further revision to include the required additional changes following the introduction of the new system. Subsequent to this it will be formally approved by the clinical board.
- Most of the consignment agreements have been signed off and updated with only 2/13 selected agreements tested yet to be updated. On enquiry, this has been due to unresolved disputes between both parties.
- All locations are locked out of hours, other than the Main Theatre suite at UHW, which is only accessible via a TDSI access. The General Stores have keypad locks, which should be locked at all times. Officers in charge have also been advised of the importance of ensuring this protocol is adhered to at all times.
- Stock locations were generally clean and organised although some additional work needs to be done on the labelling of stocks on both sites.

  The following was also observed in UHL:

  - Stocks packed to be returned were placed just outside the Orthopaedic store room.
  - A few empty boxes were at various locations within the CAVOC store room. Audit was informed that store Officers have limited control of this as there is constant entry of Theatre staff to pick up stocks because of its proximity to the Theatres. However, store staff ensures stocks are topped up to the required levels every morning.
- There is a Theatre stock returns process and store losses protocol guideline and procedures. All losses are reported on a monthly basis to Finance.
- The use of "use me first stickers" has now been implemented as required across both sites.

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The management actions which are still in the process of being implemented can be summarised as follows:

- A stock management system has been developed by procurement for own stock (consumables) with the intent to expand its ability/ function in the future. This system is still subject to additional development. The system for consigned stock is yet to be developed.
- Work has been undertaken on resetting key stock levels needs to be done in the setting of levels in store areas. Owing to the large number of stock lines this is a resource intensive piece of work and the levels are to be further reset following the year end stock count. The audit did note that at present the use of a standardised approach across stores in each site is not implemented.

  It was observed via samples selected that a variety of order levels were used in the stores:

  - Minimum/ reorder level
  - Maximum Level
  - Or a minimum & maximum level

  There are desk top exercises/ cycle counts performed in an ad hoc manner in store areas to ensure store stock levels are adjusted as required.
- The ADC system has been trialled for ordering and is still being rolled out with the intention of covering all possible consumable store areas.

The main issue highlighted as not actioned through the follow up review can be summarised as follows:

- The dash board required for monitoring KPI's has been developed and will be implemented from April 2017. It is intended that once the stock management system has been made finalised, it would have the ability to handle this function and management information reporting will be developed.

2016/17 Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

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Mental Health Clinical Board Information Governance

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff & Vale University Health Board

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Appendix A Management Action Plan
Appendix B Assurance Opinion and Action Plan Risk Rating

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Auditors: Martyn Lewis

Executive sign off: Steve Curry, Chief Operating Officer

Distribution: Ian Wile, Director of Operations
Martin Ford, Directorate Manager
Joanne Wilson, Directorate Manager
Sarah Lloyd, Directorate Manager

Committee: Audit Committee

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1. Introduction and Background

In accordance with the 2016/2017 internal audit plan, a review of the management of information governance within the Mental Health Clinical Board has been undertaken.

Information governance, or IG, is to do with the way organisations 'process' or handle information. It covers personal information, i.e. that relating to patients/service users and employees, and corporate information, e.g. financial and accounting records. It is the set of multi-disciplinary structures, policies, procedures, processes and controls implemented to ensure that employees deal consistently with the many different rules about how information is handled and, supports an organisation's immediate and future regulatory, legal, risk, environmental and operational requirements.

The UHB was subject to a review by the Information Commissioners Office in 2016 which resulted in an agreed action plan for the UHB to improve its IG position, and this review intends to build on that work to ensure processes are being embedded within the Mental Health Clinical Board.

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

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2. Scope and Objectives

The objective of the review was to assess the adequacy of arrangements for the management information governance in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of system objectives were managed appropriately.

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

- There is an appropriate IG lead within the Clinical Board, supported by leads within Directorates;
- An appropriate process exists for the identification and management of IG risks;
- The Clinical Board is aware of its information assets;
- Records are stored appropriately and securely.
- Electronic records are appropriately protected by secure passwords and encryption (including when using memory sticks).

3. Associated Risks

The potential risks considered in the review are as follows:

I. Non-compliance with legislation.

II. Inappropriate access to information / Loss of information.

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 management of information governance within the Mental Health Clinical Board 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.

There is the basis of a structure in place for the management of information governance within Mental Health with all directorates linking together to produce an integrated structure, and managing the process via its Quality and Safety agenda. There are directorate risk registers in place and information asset registers (IARs) are being developed.

Records are generally held securely and risks to these have been identified via the register process.

The audit did identify a small number of issues, these relate to the structure not being fully developed, in particular the supporting Information Asset Administrators (IAA) posts are not in place and the IAR is still in development.

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5. Assurance Summary

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

	Assurance Summary				
1	Non-compliance with legislation.			✓	
2	Inappropriate access to information / Loss of information				✓

Design of Systems/Controls

The findings from the review have highlighted **no** issues that are classified as weaknesses in the system control/design for the management of information governance within the Mental Health Clinical Board.

Operation of System/Controls

The findings from the review have highlighted **three** issues that are classified as weakness in the operation of the designed system/control for the management of information governance within the Mental Health Clinical Board.

These are identified in the management action plan as (O).

6. Summary of Audit Findings

Details of the key overall findings from the review that require actions can be found in the Management Action Plan under Appendix A.

The main areas of good practice and significant findings noted under each objective heading are as follows:

Risk: Non-compliance with legislation.

The following areas of good practice were noted:

- Information Asset Owners (IAOs) are aware of the ICO report.
- Information Governance is managed within the quality agenda.
- The intent in MH is to take a combined / coordinated approach for information governance as the risks / issues will be common between the 3 directorates and the supporting roles (IAAs) can work across to cover leave.
- IAOs have received training.

- Information governance risks are managed within the risk management structure.
- There is a clear escalation process for risks.
- Information Asset Registers are being developed.
- Information assets have been risk assessed.

The following significant findings were noted:

- The structure for information governance within Mental Health is not fully developed. At present there is no support underneath the IAOs, although this is being put into place.
- Mental Health are currently developing an Information Asset Register that covers all the Directorates, however this is incomplete with not all departments having returned information and asset owners not fully defined.

Risk: Inappropriate access to information / Loss of information.

The following areas of good practice were noted:

- Records storage areas are identified on the IAR.
- Storage areas have been assessed.
- Electronic records are appropriately protected.

There were no significant findings identified under this risk area.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	**1**	**1**	**1**	**3**

Finding 1	Risk
The structure for information governance within Mental Health is not fully developed. At present there is no support underneath the IAOs, although this is being put into place. (O)	Non-compliance with legislation.
Recommendation 1	**Priority level**
Mental Health should continue to develop the Information Governance structure.	**High**
Management Response 1	**Responsible Officer/ Deadline**
➢ The MHCB will continue to take advice from the IG governance lead, Paul Rothwell. Mr Rothwell is attending the MHCB meet in May 2017. ➢ The 3 directorates now have IAOs who have undertaken the appropriate training. ➢ The 3 directorates have now identified an IAA, one has completed the training, one is attending before the end of May and another is being arranged. ➢ Information Governance is now a routine agenda item on the Health and Safety committee for the Clinical Board.	Ian Wile – Director of Operations Martin Ford – Directorate Manager – Psychology and Psychological Therapy Sarah Lloyd – Directorate Manager – Adult Services Jo Wilson – Directorate Manager – Older Peoples Services May 2017

Finding 2	Risk
Mental Health are currently developing an Information Asset Register that covers all the Directorates, however this is incomplete with not all departments having returned information and asset owners not fully defined. (O)	Non-compliance with legislation.
Recommendation 2	**Priority level**
The register should be completed with all departments submitting information and all assets having defined owners / administrators.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
➢ An individual has been released to be a shared resource to the Directorates to develop an asset register for the clinical board – this post holder will also be completing themed IG risk assessments across the directorates ➢ This work will be undertaken by the end of June 2017	Ian Wile – Director of Operations Directorate Managers June 2017

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Finding 3	Risk
Although the safe storage of records was assessed as part of the IAR development process, there is a lack of awareness that storage should be periodically reviewed to ensure it is still appropriate. (O)	Inappropriate access to information / Loss of information.
Recommendation 3	**Priority level**
Record storage areas should be subject to periodic review to ensure they are still appropriate. As part of this process consideration should be given to ensuring that all records are still in date and accurate.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
➢ Although Mental Health has a single patient electronic system (PARIS), there remains live paper records in all of the community mental health team bases which either pre date PARIS or are supplementary records. Records are stored within the team bases and each team has a different arrangement for this, some with single records rooms and others with more dispersed systems. ➢ An initial review of these storage areas will be undertaken for their suitability through the next work place inspection for that area with a	Ian Wile – Director of Operations Directorate Managers All community team leaders March 2018

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standard that the storage area is locked room. These assessments will be undertaken by March 18 and thereafter annually via the WPI process to review ongoing records safety.	

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.

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Prioritisation of Recommendations

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

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

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

Cardiff Community Resource Team

FINAL INTERNAL AUDIT REPORT 2016/17

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Distribution:	Sue Morgan, Director of Operations
	Lynne Topham, Locality Manager North / West Cardiff
Committee:	Audit Committee

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1. Introduction and Background

In accordance with the 2016/2017 internal audit plan, a review of Community Resource Teams was undertaken. The assignment originates from the Cardiff & Vale internal audit plan and the subsequent report will be submitted to the Audit Committee.

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

The Cardiff Community Resource Team is a joint service provided in collaboration with Cardiff Council. The team is made up of both NHS and Cardiff Council staff but there are two separate and distinct management structures, and all staff report to and are managed by their respective organisations managers / team leaders.

The main purpose of Community Resource Teams is to help free up hospital beds by providing high levels of care that prevent patients from being admitted to hospital (Community Support) and facilitates the discharge from hospital of patients that have been passed medically fit to leave (Discharge Support).

2. Scope and Objectives

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

The purpose of the review was to provide assurance that demand and referrals to the CRTs were managed and that patients were properly treated and discharged.

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

- A process is in place for managing referrals and demand;
- CRTs provide appropriate care and discharge to a home setting within an appropriate timeframe;
- A process is in place for monitoring the impact of admission avoidance / timely discharge from hospital on bed availability in hospital and length of stay.

The review focused on 2 CRTs representing one from each local authority area. Detailed testing included, but was not necessarily limited to:

- Review processes and procedures in place for referral management;
- Ensure criteria for CRT referrals is clear and guidance available;
- Assess the level of non-accepted referrals and establish any underlying reasons;
- Review processes and procedures in place for managing patients towards discharge;
- Test sample of patients to ensure care plan / appropriate discharge date is in place and achieved; and
- Ensure performance of CRTs is monitored and reported appropriately, including the impact on bed availability and length of stay.

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3. Associated Risks

The potential risk considered in the review is as follows:

I. The UHB does not gain the maximum benefit from the CRTs due to patients not moving through the system appropriately.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the NW Cardiff Locality Community Resource Team is **Substantial Assurance**.

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

Overall there are good processes in place to manage the operation of the CRT. Referrals are received from a number of sources including GP's, Hospitals, Residential / Care Homes and the Council Social Services Department. These are assessed each morning by a multi-disciplinary team of social and health care professionals and if accepted are allocated to the appropriate service(s) within the team, e.g. home care, physiotherapy, Occupational Therapy, dietician. Although there are a large number of rejected referrals, these are generally due to the patient already being under the care of the CRT.

Following acceptance by the CRT, a Service Delivery Plan is prepared for each patient, and this includes a planned discharge date (PDD). The target length of stay within the CRT is 6 weeks, but this can, based on clinical assessment, be extended to 12 weeks for patients receiving therapy and where the potential to further improve function is identified. In addition, patients identified as being at risk of falling are put on the Individualised Strength and Balance Programme (ISBP) for up to six months during which time they will remain as a patient of the CRT. There is on-going monitoring of patients however performance reports do not split the patient categories and target LoS, as such there is no tiered monitoring of this.

5. Assurance Summary

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

Assurance Summary		None	Limited	Reasonable	Substantial
1	*The UHB does not gain the maximum benefit from the CRTs due to patients not moving through the system appropriately*				✓

Design of Systems/Controls

The findings from the review have highlighted three issues that are classified as a weakness in the system control / design. These are identified in the management action plan as (D).

Operation of System/Controls

The findings from the review have also highlighted two issues that are classified as weaknesses in the operation of the designed system / control. These are identified in the management action plan as (O).

6. Summary of Audit Findings

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

Risk: The UHB does not gain the maximum benefit from the CRTs due to patients not moving through the system appropriately.

The following areas of good practice were noted:

- The qualifying criteria for referrals to the Community Resource Team had been documented;
- Referrals must be submitted via PARIS or by completing a standard referral form;
- Referrals were reviewed on a daily basis by a multi-disciplinary team made up of health and social care professionals;
- The PARIS system was used to record each patients referral details, medical history and treatment provided by the CRT;
- All patients accepted by the CRT had a Care Plan and Predicted Discharge Date;
- Planned hospital discharges were monitored via the 'One List' on PARIS;
- There were 27 Full Team 'Hot Slots' of day care packages available each week to facilitate discharges from hospital;
- Management information was available from PARIS via a suite of standard reports;
- CRT Performance was monitored and regularly reported to the PCIC Health Board and Cardiff Council at joint performance meetings;

The following significant finding was noted:

- At the time of our audit performance reports provided to PCIC did not include performance against Length of Stay targets for both short and long term patients.

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7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	**0**	**1**	**4**	**5**

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Finding 1 - PARIS Standard Reports	Risk
Patients accepted into the CRT are categorised as with care (therapy and care) or without care (therapy only). The target maximum length of stay (LoS) for 'with care' patients is 6 weeks. For therapy only referrals the target length of stay is also 6 weeks, however, based on assessed clinical need, there may be times where an extended programme of intervention (up to a maximum of 12 weeks) is required. Patients identified as being at risk of falls are also put on the Individual Strength & Balance Programme (ISBP) which has a target maximum stay of 26 weeks. At the time of our audit performance reports provided to PCIC did not include LoS data for all categories of patient, although we were informed that reports were being developed. (D)	The UHB does not gain the maximum benefit from the CRTs due to patients not moving through the system appropriately.
Recommendation 1	**Priority level**
Performance reports provided to PCIC should be developed to include the average LoS for each category of patient identified above on a month by month basis.	**Medium**

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Management Response 1	Responsible Officer/ Deadline
It has been agreed that the regular CRT performance meetings will include a focus on average LOS for all patient categories.	Lynne Topham/May 2017

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Finding 2 - PARIS Standard Reports	Risk
At the time of our audit there were 73 standard reports available to users via the reporting function of PARIS. It was noted during testing that the standard report 'Referrals open six weeks and over' included numerous referrals that had actually been rejected and was therefore misleading and inaccurate. We were informed that some of the standard reports on the system were obsolete having been created for previous versions of the system. (O)	The UHB does not gain the maximum benefit from the CRTs due to patients not moving through the system appropriately.
Recommendation 2	**Priority level**
The integrity of all available standard PARIS reports should be reviewed together with the need for each report on the list. Any reports that do not produce accurate results or are deemed no longer necessary should be removed from the list of available reports.	**Low**
Management Response 2	**Responsible Officer/ Deadline**
A review of current range of performance reports will be undertaken	Lynne Topham/May 2017

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Finding 3 - Updating of Paris	**Risk**
A sample of 40 CRT patient records on PARIS was reviewed as part of the audit. This identified that the patient details were not always fully completed on PARIS. Errors and omissions identified included: • Details of the LA Homecare package not recorded; • Hospital discharge date / details not recorded; • CRT discharge reasons not recorded; and • Incorrect CRT acceptance date. (O)	The UHB does not gain the maximum benefit from the CRTs due to patients not moving through the system appropriately.
Recommendation 3	**Priority level**
Staff should be reminded of the importance of ensuring PARIS is updated with full and accurate patient details.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
All staff have been reminded through PARIS User Group Meetings of the need to ensure completeness of data entry	Lynne Topham/Phill Edwards/May 2017

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Finding 4 - Inappropriate Referrals	Risk
A sample of 20 rejected referrals was reviewed to ascertain the reasons why they had been rejected. All 20 referrals had been classified as an 'Inappropriate Referral' on PARIS. However a detailed review identified that one referral had been rejected because the patient did not live within the CRT area, five were referred on to the Community Physio Team and 14 were already under the care of the CRT and had been re-referred for a different service. (D)	The UHB does not gain the maximum benefit from the CRTs due to patients not moving through the system appropriately.
Recommendation 4	**Priority level**
To facilitate more accurate reporting, a new classification should be set up on PARIS for referrals that are already known to the CRT, and for referrals that are referred on to another service.	**Low**
Management Response 4	**Responsible Officer/ Deadline**
The CRT will be using Welsh Administration Portal as from 8 May, this will enabling re-direction of referrals to other services. A request to add to the current list of reasons for declining referrals will be made to PARIS development Team.	Lynne Topham/May 2017

Finding 5 - Uploading of correspondence to PARIS	Risk
Review of a sample of 40 accepted referrals did not identify any instances of correspondence such as referral letters from GP's and residential care / nursing homes being uploaded into PARIS. Uploading correspondence to patient records may reduce the need to populate some fields in PARIS and would help ensure accurate patient details are recorded. (D)	The UHB does not gain the maximum benefit from the CRTs due to patients not moving through the system appropriately.
Recommendation 5	**Priority level**
Referral letters and other relevant correspondence should be uploaded to patient records in PARIS.	**Low**
Management Response 5	**Responsible Officer/ Deadline**
Referrals are routinely uploaded onto PARIS. The CRT is also now using Welsh Administration System which will also make the uploading and transcribing of information less time consuming and ensure accuracy of information.	Lynne Topham/May 2017

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NW Cardiff Locality Community Resource Team

Cardiff & Vale University Health Board

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.

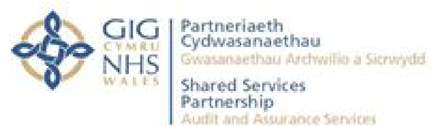
No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual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



CD&T Clinical Board
Information Governance

FINAL INTERNAL AUDIT REPORT
2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix A Management Action Plan
Appendix B Assurance Opinion and Action Plan Risk Rating

Review reference: CUHB17.42
Report status: Final
Fieldwork commencement: March 2017
Fieldwork completion: March 2017
Draft report issued: 12th April 2017
Management response received: 8th May 2017
Final report issued: 11th May 2017
Auditors: Martyn Lewis

Executive sign off: Steve Curry, Chief Operating Officer

Distribution: Matt Temby, Director of Operations
Sion O'Keefe, Directorate Manager

Committee: Audit Committee

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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

In accordance with the 2016/2017 internal audit plan, a review of the management of information governance within the CD&T Clinical Board has been undertaken**.**

Information governance, or IG, is to do with the way organisations 'process' or handle information. It covers personal information, i.e. that relating to patients/service users and employees, and corporate information, e.g. financial and accounting records. It is the set of multi-disciplinary structures, policies, procedures, processes and controls implemented to ensure that employees deal consistently with the many different rules about how information is handled and, supports an organisation's immediate and future regulatory, legal, risk, environmental and operational requirements.

The UHB was subject to a review by the Information Commissioners Office in 2016 which resulted in an agreed action plan for the UHB to improve its IG position, and this review intends to build on that work to ensure processes are being embedded within the CD&T Clinical Board.

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

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2. Scope and Objectives

The objective of the review was to assess the adequacy of arrangements for the management information governance in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of system objectives were managed appropriately. The review covered two directorates within the clinical board, these being Medical Records & Outpatients and Cellular Pathology.

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

- There is an appropriate IG lead within the Clinical Board, supported by leads within Directorates;
- An appropriate process exists for the identification and management of IG risks;
- The Clinical Board is aware of its information assets;
- Records are stored appropriately and securely.

3. Associated Risks

The potential risks considered in the review are as follows:

I. Non-compliance with legislation.

II. Inappropriate access to information / Loss of information.

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 management of information governance within the CD&T Clinical Board is **Substantial Assurance**.

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

There is a structure in place for the management of information governance within CD&T with each directorate managing the process via its Quality and Safety agenda. There are directorate risk registers in place and information asset registers have been developed.

Records are generally held securely and there is a plan in place for moving records from Whitchurch to a new secure site.

The audit did identify a small number of issues, these relate to the structure not being fully developed in Cellular Pathology and the lack of a formal process for ensuring that all records are up to date and archived appropriately.

5. Assurance Summary

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

	Assurance Summary				
1	Non-compliance with legislation.			✓	
2	Inappropriate access to information / Loss of information				✓

Design of Systems/Controls

The findings from the review have highlighted **no** issues that are classified as weaknesses in the system control/design for the management of information governance within the CD&T Clinical Board.

Operation of System/Controls

The findings from the review have highlighted **three** issues that are classified as weakness in the operation of the designed system/control for the management of information governance within the CD&T Clinical Board.

These are identified in the management action plan as (O).

6. Summary of Audit Findings

Details of the key overall findings from the review that require actions can be found in the Management Action Plan under Appendix A.

The main areas of good practice and significant findings noted under each objective heading are as follows:

Risk: Non-compliance with legislation.

The following areas of good practice were noted:

- Information Asset Owners (IAOs) are aware of the ICO report.
- Information Governance is managed within the quality agenda.
- Information Governance / records issues are considered within the Medical Records Management Group.
- Job descriptions for key roles were received and actioned within the Directorates.

- SOPs in place for records management which include information governance within Medical Records and Outpatients Directorate.
- There is a structure in place for Information Governance within Medical Records and Outpatients Directorate.
- Information governance risks are managed within the risk management structure.
- There is a clear escalation process for risks.
- Directorates have Information Assess Registers in place which are developed via a formal process.

The following significant findings were noted:

- The structure for managing information governance within Cellular Pathology / Mortuary Services is not fully developed.
- Although records are stored securely, the processes in place for ensuring that files are up to date and archived / destroyed appropriately are not fully established.

Risk: Inappropriate access to information / Loss of information.

The following areas of good practice were noted:

- Records storage areas are identified on the Information Asset Registers.
- Records storage areas have been assessed.
- There is a tracking process in place for medical records.
- There is a process in place for moving records from Whitchurch to a new secure site.

There were no findings identified under this risk area.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding 1	Risk
The structure for managing information governance within Cellular Pathology / Mortuary Services is not fully developed. The IAO hasn't received formal training or guidance and has not seen the role description. In addition the supporting structure for Information Asset Administrators (IAAs) is not in place. (O)	Non-compliance with legislation.
Recommendation 1	**Priority level**
The structure should be further developed.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
The Clinical Board will prioritise IG training for the Cellular Pathology / Mortuary Services IAO and where possible IAAs, either through the existing corporate programme if timely, or through internal UHB mechanisms if not. The service will develop a clear IG structure, which aligns to the Clinical Board IG structure. The service will be supported in doing this and will pointed to exemplars within the Clinical Board and UHB.	Sion O'Keefe – August 2017

Finding 2	Risk
Although records are stored securely, the processes in place for ensuring that files are up to date and archived / destroyed appropriately are not fully established. (O)	Non-compliance with legislation.
Recommendation 2	**Priority level**
IAOs should be asked to establish a process for ensuring that records in their area are up to date and accurate and old records are securely destroyed.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
The Clinical Board has sought clarification with regards retention and destruction schedules, especially in light of the Jay enquiry. It has been active in raising the matter through the Medical Records Operational Group (MROG) and onwardly at the Medical Records Management Group (MRMG). It has provided support to the production of related papers taken to the Information Governance Sub-Committee. Irrespective of the timing of the above clarification, the Clinical Board aims to ensure its Directorates and Services have retention and destruction programmes embedded within their annual records management plans and audit schedules. The Clinical Board will ensure assurance that these plans are in	Sion O'Keefe, December 2017

place and in action through local and UHB governance routes, such as the CD&T QSE group, MROG and MRMG.	

Finding 3	**Risk**
There is a lack of clarity over dealing with corporate systems on information asset registers. Directorates are responsible for the entering of information / accuracy, however corporate department are responsible for security. (O)	Non-compliance with legislation.
Recommendation 3	**Priority level**
Clarification should be sought on how corporate systems will be included on asset registers.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
The Clinical Board has requested clarification on several occasions. It has been raised at corporate IG training sessions over the past year and repeatedly at the Medical Records Operational Group (MROG), which the Clinical Board has representation at and chairs. The UHB's Head of Information Governance is a member of the group and has taken the matter forward. The Clinical Board is informed discussions with corporate teams continue. Clarification is expected shortly, however, in the	Head of Information Governance, July 2017

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meantime Directorates have been advised to only address matters of data input & accuracy and associated training. The Clinical Board will specifically raise the matter at the next MROG should it not arise through the course of the meeting and enquire as to options for escalation should points of clarity appear unresolved.	

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

9

Prioritisation of Recommendations

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

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

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

Specialist Services Clinical Board
Medical Staff Study Leave

FINAL INTERNAL AUDIT REPORT
2016/17

Cardiff & Vale University Health Board

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Audit and Assurance Service

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7. Summary of Recommendations 7

Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference: CUHB17.28
Report status: Final
Fieldwork commencement: 2nd February 2017
Fieldwork completion: 4th April 2017
Clearance Meeting: 28th April 2017
Draft report issued: 28th April 2017
Management response received: 9th May 2017
Final report issued: 16th May 2017

Auditors: Kimberley Rowe

Executive sign off: Steve Curry, Chief Operating Officer

Distribution: Jessica Castle, Director of Operations
Peter O’Callaghan, Clinical Director
Hilary Sharp, Senior Medical Workforce Manager

Committee: Audit Committee

10

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1. Introduction and Background

A review of Medical Staff Study Leave within the Specialist Services Clinical Board was undertaken in accordance with the 2016/17 annual internal audit plan.

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

2. Scope and Objectives

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

The purpose of the review was to provide assurance that study leave taken by Medical Staff complied with BMA guidance, was of value to the doctor and the UHB and was accounted for appropriately.

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

- An appropriate Policy or Procedure is in place for the assessment and approval of study leave that complies with BMA guidance;
- Study leave is appropriately approved and is relevant;
- All Medical Staff should undertake study / professional leave within the BMA guidelines;
- The costs associated with the study leave are identified and accounted for appropriately.

3. Associated Risks

The potential risks considered in the review were as follows:

I. Unnecessary / inappropriate expenditure
II. Medical staff do not stay up to date within their field / lower quality care provision

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 Medical Staff Study Leave is **Reasonable Assurance**.

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

Study Leave is covered by the All Wales Study Leave Policy which was last updated in January 2015, and the Cardiff & Vale Study Leave Procedure. However this is dated June 2006 and is in need of review by the Health Board to reflect significant changes including the introduction of the Intrepid system which is now used to submit, approve and process study leave applications and expenses claims.

Although there is process for study leave in place, testing of a sample of episodes of study leave identified issues with late submission of claims and with incomplete approval of costs incurred.

Requirements for study leave should initially be identified and quantified as part of the annual appraisal process, and this feeds into a Personal Development Plan. Across Wales the Medical Appraisal & Revalidation System (MARS) is the only route to an annual appraisal, and this is done through the MARS website. The completion of annual reviews via MARS is monitored by Clinical Directors, but not the contents of the review.

Consultants can take up to 30 days study leave over a 3 year period, plus an additional 2 days per year which is specific to Wales. Trainee doctors can take up to 30 days study leave per year. Most study leave counts towards CPD which all Consultants are required to undertake as part of the re-validation cycle. This must be completed every 5 years to retain their medical qualification.

Analysis of study leave taken to date for a sample of Consultants and trainee doctors indicated that the take up of study leave was relatively low at the time of our audit. Testing also identified several instances of study leave being taken but costs not being claimed. This could have an adverse effect on the levels of care that the UHB provides, and Consultants that do not undertake sufficient CPD to complete their annual re-validation can be dismissed. This is partially mitigated by completion of other forms of educational activity and monitored by the annual appraisal process.

5. Assurance Summary

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

Assurance Summary					
1	*Unnecessary / inappropriate expenditure*			✓	
2	*Medical staff do not stay up to date within their field / lower quality care provision*			✓	

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control / design for the management of policies.

These are identified in the management action plan as (D).

Operation of System/Controls

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

These are identified in the management action plan as (O).

6. Summary of Audit Findings

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

Risk: Unnecessary / inappropriate expenditure.

The following areas of good practice were noted:

- There was an All Wales Study Leave Policy covering Doctors and Dentists in Training dated January 2015;
- The UHB had a documented Study Leave Procedure that covered all Medical and Dental staff;
- The Policy and Procedures detailed the application and approval process and specified the costs that may be re-claimed;
- The costs associated with each period of study leave requested must be estimated and approved in advance;
- All reclaimed study leave costs were recorded on the Intrepid system, Main Accounting system (Oracle) and Payroll system.

The following significant findings were noted:

- The Cardiff and Vale UHB Study Leave procedure was out of date;
- Applications for study leave were not always approved in advance;
- Estimated costs for study leave did not always correspond to the actual costs paid.
- Expense claims were not always being submitted within 3 months of the study leave taking place;
- Where foreign expenses are claimed, there is difficulty totalling receipts to agree to claimed costs due to lack of documentation, clarity and audit trail of exchange rates and foreign languages.

Risk: Medical staff do not stay up to date within their field / lower quality care provision.

The following areas of good practice were noted:

- A formal application must be submitted to request study leave;
- All Applications were assessed and only study leave that benefited both the UHB and the individual and met the criteria set out in the study leave policy were approved;
- Applications for study leave must be approved before any claims for reimbursement can be paid;
- The allowed study leave is defined within the policy.

The following significant findings were noted:

- The take up of study leave for the sample of Consultants and trainees tested was generally low;
- Study leave was being taken but costs were not always being reclaimed suggesting study leave was either not always being used or expenses unclaimed.

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

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Finding 1 - Study Leave Procedure	**Risk**
The Study Leave Procedure for Medical and Dental Staff was issued on the 8th June 2006 and was due for review in June 2008. However the Procedure has not been subject to review and consequently is now out of date. For example the procedure makes no reference to the Intrepid system which is now used to submit and approve applications for study leave and to record all reclaimed expenses. (O)	Unnecessary / inappropriate expenditure
Recommendation 1	**Priority level**
The Study Leave Procedure should be reviewed by the Health Board and if necessary updated.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
Review of the Health Board's 'Study Leave Procedure for Medical & Dental Staff' will be discussed as part of a meeting to be held with the BMA on 5th June 2017. Following this the procedure will be updated as required.	Hilary Sharp, Senior Medical Workforce Manager Peter Durning, Clinical Director June 2017

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Finding 2 - Approval of Study Leave	Risk
In accordance with the C & V Study Leave Procedure, study leave must be approved at least 6 weeks in advance, and retrospective approval of claims will not normally be given. Testing of 11 Consultant claims submitted in 2016 showed that 3 had not been completed by the applicant within 6 weeks of the beginning requested study leave, and consequently 4/11 of the applications had not been approved within 6 weeks. Testing of 5 Junior Doctor claims submitted in 2016 showed that 3 had not been completed by the applicant within 6 weeks of the beginning requested study leave, and consequently 3/5 of the applications had not been approved within 6 weeks. Furthermore 1 of the claims had been retrospectively approved after the study leave had been completed. (O)	Unnecessary / inappropriate expenditure

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Recommendation 2	**Priority level**
Management should reissue guidance and reinforce the requirement that all study leave be approved appropriately, with no retrospective approval to be given.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Recommendation agreed. The updated Study Leave Procedure referred to in finding 1 will be circulated to all medical staff within the Directorate as soon as it is issued.	Peter O'Callaghan, Clinical Director / when updated Study Leave procedure is issued
In the meantime, the Clinical Director will issue a memo to all medical staff reminding them of the existing procedure and the requirement to apply for study leave at least 6 weeks in advance.	Peter O'Callaghan, Clinical Director / May 2017

Finding 3 - Study Leave Costs	Risk
All costs associated with study leave should be included in the application and approved in advance, and sums re-claimed should not be higher than those approved in the application. A review of a sample of 12 Consultants claims paid during 2016 showed that 1 claim included sums that were higher than the approved amounts. (O)	Unnecessary / inappropriate expenditure
Recommendation 3	**Priority level**
Management responsible for approving applications for study leave should ensure that applications include estimates of all reclaimable costs, and that these costs are as accurate as possible.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
The Clinical Director will remind all medical staff to include accurate assessments of costs as part of their study leave application.	Peter O'Callaghan, Clinical Director / May 2017

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Finding 4 - Submission of Claims	**Risk**
Claims for the reimbursement of study leave costs should be submitted within 3 months of the study leave being taken in accordance with the study leave policy. From a sample of 9 paid claims tested it was identified that 2 claims had not been submitted within 3 months of the study leave being taken. (O)	Unnecessary / inappropriate expenditure
Recommendation 4	**Priority level**
Management should reissue guidance and reinforce the requirement that all expenses be claimed within the appropriate timescale and that any subsequent claims will not be paid.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
Recommendation agreed. The updated Study Leave Procedure referred to in finding 1 will be circulated to all medical staff within the Directorate as soon as it is issued.	Peter O'Callaghan, Clinical Director / when updated Study Leave procedure is issued
In the meantime, the Clinical Director will issue a memo to all medical staff reminding them of the existing procedure and the requirement to submit claims within 3 months of the study leave being taken.	Peter O'Callaghan, Clinical Director / May 2017

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Finding 5 – Breakdown of Receipts and Costs	Risk
Receipts were provided for all claims tested. There was difficulty in totalling up the receipts to match those claimed, this is for a number of reasons: • Some of the receipts are in foreign currencies and there is no detail of the exchange into sterling and therefore this had to be approximated and a reasonable test applied for the audit. • Some of the receipts are also supplied in a foreign language; it should be made clear by the claimant what the receipts are for. (D)	Unnecessary / inappropriate expenditure
Recommendation 5	**Priority level**
The claimant and study leave administrators should keep clear documentation that records how the expense receipts equate to the claimed costs, this should include where necessary: • foreign exchanges applied. • foreign transactions and explanation for receipts.	**Low**

Management Response 5	**Responsible Officer/ Deadline**
Recommendation agreed. All medical staff will be reminded that when submitting receipts in a foreign language the exchange rate and explanation of the receipt should be included.	Peter O'Callaghan, Clinical Director / May 2017

Finding 6 - Take up of Study Leave	**Risk**
The take up of study leave was generally low for the sample of 15 Consultants and 10 junior doctors reviewed. At the time of our audit 10/15 Consultants and all junior doctors had taken 11 days or less respectively in their current study periods. This could adversely affect the revalidation process. The audit notes that this is partially mitigated by completion of other forms of educational activity and monitored by the annual appraisal process. (O)	Medical staff do not stay up to date within their field leading to lower quality care provision.
Recommendation 6	**Priority level**
Consultants and junior doctors should be encouraged to utilise their full study leave entitlements. The take up of study leave should be monitored and where take up is low this should highlighted to the Clinical Director.	**Low**

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Management Response 6	Responsible Officer/ Deadline
Recommendation partially approved. Whilst the Study Leave Procedure sets out the maximum allocation for study leave, the procedure also states that these are recommended standards and are not individual entitlements. There are multiple educational and learning opportunities day to day through M&M meetings, clinical audit sessions, MDT discussions of clinically interesting or unusual cases, Grand Round, bedside teaching, shadowing more senior staff, observing proctors which do not require formal study leave. All consultants have a session of CPD in their job plans (3.75 hours per week), which supports the revalidation process. The annual appraisal process is designed to ensure that consultants are on track to revalidate. It should be acknowledged that whilst consultants may not apply to use their full entitlement, there are positive benefits for the clinical service and patients as a consequence. Directorate to discuss with Intrepid team the development of a quarterly report on study leave taken by medical staff.	Nick Gidman, Directorate Manager / May 2017

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Finding 7 - Use of Study Leave	Risk
It was identified during testing that 3/15 Consultants had applications for study leave more than 3 months old but had not claimed any expenses. In each case the study leave had been taken. Similarly from a sample of 10 junior doctors tested it was identified that 3 had submitted applications with estimated costs and had taken the leave but had not claimed any costs. This lack of claims leads to a lack of clarity over the uptake of study leave. (O)	Medical staff do not stay up to date within their field leading to lower quality care provision.
Recommendation 7	**Priority level**
The use of study leave should be monitored to ensure that claims are made for all study leave within the appropriate timescale. Where claims have not been made these should be chased up, with confirmation of attendance sought. If the Consultant plans to claim expenses through endowments or R&D funds then this should be stated at the study application stage so estimated costs are not accrued.	**Medium**

10

Management Response 7	Responsible Officer/ Deadline
Recommendation agreed. The updated Study Leave Procedure referred to in finding 1 will be circulated to all medical staff within the Directorate as soon as it is issued. In the meantime, the Clinical Director will issue a memo to all medical staff reminding them of the existing procedure and the requirement to submit claims within 3 months of the study leave being taken.	Peter O'Callaghan, Clinical Director / May 2017

Specialist Services CB - Medical Staff Study Leave

Cardiff & Vale University Health Board

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

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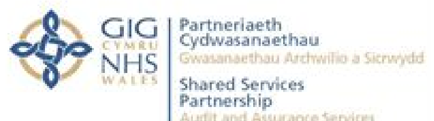
In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

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.



Medicine Clinical Board Specialling

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

DRAFT

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Committee: Audit Committee

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

Please note:

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

In accordance with the 2016/2017 internal audit plan, a review of Medicine Clinical Board Specialling was undertaken within UHW. The assignment originates from the internal audit plan and the subsequent report will be submitted to the Audit Committee.

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

2. Scope and Objectives

The objective of the audit was to assess the adequacy of arrangements for specialling in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of system objectives are managed appropriately

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

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

- Patients requiring Specialling are identified at an early stage.
- Risk assessments are carried out appropriately and care plan / pathway defined.
- Care plan is met and is subject to on-going monitoring.

A sample of 2 wards within the Medicine Clinical Board was chosen for review; A4 and C7 at UHW. At the time of the audit the total number of patients receiving specialling within Integrated Medicine was 13. This figure changes daily due to the reassessment of patients; however at the time the audit took place there was 4 patients on A4 and 1 on C7.

3. Associated Risks

The potential risks considered in the review are as follows:

I. Patient harm due to insufficient nursing provision.

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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 Medicine Clinical Board Specialling is **Reasonable.**

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.

Both the sampled wards within the Medicine Clinical Board are following appropriate processes for identifying care for vulnerable patients and assessing the need for Specialling. Processes are also in place for monitoring the numbers of patients receiving Specialling and these are reported to the Senior Nurse.

A Specialling User Guide is in place; however this was produced in 2013 and requires updating to reflect the use of the Clinical Workstation and the essential documents that are now being used.

The testing carried out as part of the Audit identified that Specialling Risk Assessment's (SRAs) had been completed for all sampled patients and procedures are in place for monitoring the their on-going requirement for specialling. However there were instances where the procedures weren't followed consistently. Some of the essential documents that are required for specialling were missing or misfiled, regular reviews of the documents found were not always taking place and there was evidence of gaps in the monitoring of the Behaviour charts.

The paper SRAs are not being consistently replicated within Clinical Workstation (CWS). Issues were also identified around the time taken for the completion of the SRA on CWS and the removal of patients that are no longer receiving specialling from the specialling tab.

The level of engagement staff are having with patients to help stimulate them through the day was poor on ward A4. In addition, the current state of the facilities available to patients would not assist staff in improving

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their well-being. Ward C7 are however currently piloting the use of Mental Health Matters, an organisation that helps to promote mental well-being across Wales. The Ward Manager feels this is invaluable for the recovery of patients and has seen a huge improvement in their happiness as a result.

5. Assurance Summary

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

Assurance Summary					
1	*Patient harm due to insufficient nursing provision*			✓	

Design of Systems/Controls

The findings from the review have highlighted one issue that are classified as weaknesses in the system control/design for the management of Specialling.

These are identified in the management action plan as (D).

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 the management of specialling.

These are identified in the management action plan as (O).

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6. Summary of Audit Findings

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

Risk: Patient harm due to insufficient nursing provision.

The following areas of good practice were noted:

- Discussions held with the Ward Managers from C7 and A4 established that they are following appropriate processes for identifying care for vulnerable patients and assessing the need for Specialling.
- Towards the end of each shift, nurse handovers are held and patients that are receiving close observations, risk of falls and those that wander are discussed.
- The Senior Nurse for Integrated Medicine is informed daily of the number of patients receiving specialling.
- A SRA had been completed for all patients in the sample.

- All patients on A4 who were receiving specialling had a completed SRA on the CWS that reflected the paper copy.
- All patients had a falls risk assessment completed as part of their Core Patient Risk Assessment booklet.
- A continuous recording of dates could be found on the Behaviour Monitoring Chart (BMC) for the patient on C7. Ward C7 also uses Real Time Nursing Notes.
- Testing showed that the BMCs on A4 had been completed every day.
- Both wards are using 'Reach out to me' or 'Getting to know You' leaflets as a way to understand the patient more.
- Ward C7 are piloting the use of Mental Health Matters; an organisation that helps to promote mental well-being across Wales. They attend on a daily basis and provide a wide range of activities for patients. The Ward Manager believes this is invaluable and can see patients benefiting as a result.

The following significant findings were noted:

- The Specialling User Guide is no longer current and requires updating to reflect changes in the process and documents used.
- Essential documents required for specialling were not present in some instances or were misfiled.
- SRAs were not always completed in full and one ward was using an old version of the form.
- At the beginning of the audit the CWS did not reflect the level of risk by using the specialling symbol, as there was not one available at the time. Towards the end of the audit a specialling symbol was available but staff members were not made aware of it.
- Specific specialling Care Plans were not generated for any of the patients in the sample following completion of the BMCs.
- Both systems used for providing data on the number of patients receiving specialling on the wards were incorrect.

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**	**6**	**1**	**8**

Finding 1 – Specialling User Guide	Risk
There is a Specialling user guide in place which was developed by the Vulnerable Adult Risk Management Group in March 2013. A discussion with Ward Managers and from the testing that was carried out indicates that the guide is no longer current and needs updating. Some of the documents described in the guide are no longer used and have been replaced by more current documents plus there is no reference to the Clinical Workstation in the guide	Patient harm due to insufficient nursing provision
Recommendation 1	**Priority level**
Management must ensure that the User Guide has been updated and reflects the practices that are in place today.	**High**
Management Response 1	**Responsible Officer/ Deadline**
Specialling task & finish group has been set up and will review Specialling user Guide and amend to reflect current practice in conjunction with Vulnerable Adult Risk management group.	Deputy Director of Nursing MCB & Vulnerable adult Nurse Consultant. July 2017

Finding 2 - Required documents for Specialling.	Risk
The bedside notes for the sampled patients were reviewed to establish if the following documents were present; • Care Plans - An up to date care plan specific for specialling was not held on any of the patient's bedside notes. • HCSW or RMN packs - These were not found on any of the patient notes and they were not identified on the SRA's as being issued. • Medical Reviews - Both Ward Managers confirmed that all patients have medical reviews carried out during Medical Ward Rounds. 1 of the 5 SRAs did not show that a recent medical review has taken place. We were unable to verify completion of a review for another patient as page one of the SRA was missing from the patient notes. • DoLS Proforma – DoLS requests had been completed for all 4 patients on ward A4 on 6th March but responses had not been received at the time of review (. It is noted that the requests were completed weeks after the SRAs was undertaken. The patient on C7 had a DoLs authorisation file which expired on 20th March. • Falls Risk Assessment - All patients had a falls risk assessment completed as part of their Core Patient RA booklet. However none of the falls risk assessments had been reviewed weekly. (O)	Patient harm due to insufficient nursing provision.

Recommendation 2	Priority level
Management must ensure that the required documents for specialling are appropriately completed and present on the patient bedside notes. Management must ensure that a HCSW or RMN packs are issued once specialling has been agreed.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Ward Managers to monitor standard of documentation and ensure appropriate individual risk assessments are completed and reassessed dependant on individual patient need. Senior Nurse to undertake spot check audit of nursing documentation & risk assessments.	Lead / Senior Nurses / ward Managers Immediate review and audit of documentation Audit will be ongoing
Senior Nurse to review Dol's authorisation and numbers and action taken to ensure robust process is in place	June 2017
HCSW/ RMN packs to be reviewed in line with revised Specialling user guide	August 2017

Finding 3 - Specialling Risk Assessment.	Risk
The Specialling Risk Assessment (SRA) is made up of 3 pages. The first page is completed by the ward nurse who is requesting the specialling and states the reasons why. The second page is for when a patient is re assessed each shift during handover and de-escalation of specialling is considered. The final page is a risk assessment aid and continued assessment record. Testing showed that although there was a SRA present on all patients' notes: • C7 was using an old version of the form and the front sheet was missing from 1 of the SRAs on A4. • Only 1 out of the 5 SRAs was completed fully. • Whilst all 5 SRAs had been signed by the completing nurse, only 2 had been authorised by the Senior Nurse. (O)	Patient harm due to insufficient nursing provision.
Recommendation 3	**Priority level**
Management must ensure that the Wards are using the most up to date version of the SRA. Management must ensure that the SRA is fully and accurately completed in all cases and authorised by the Senior Nurse.	**Medium**

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Management Response 3	Responsible Officer/ Deadline
SRA documentation will be reviewed and updated to reflect current practice. Revised SRA documentation will be distributed to all wards and all other versions removed.	Lead/ Senior Nurses August 2017

Finding 4 - Clinical Workstation	Risk
Ward staff are required to complete a SRA on the Clinical Workstation (CWS) that replicates the paper SRA which is held on the patient's notes. At the time of the audit on ward A4 SRAs had been completed on CWS for all 4 patients. However it was identified that no symbol was available on the CWS to identify those patients receiving Specialling. An SRA had not been completed on the CWS for the patient on ward C7. The Ward Manager completed one at the time of review to show how it is done and during this a symbol for specialling was discovered. The symbol is an 'eye' which is not very clear. Both Ward Managers feel that the completion of the SRA on CWS is time consuming and a duplication of work. The SRA does not appear unless you enter the Specialling tab and until very recently there was no symbol in place for specialling. Both Ward Managers felt that the symbol that has been chosen for Specialling was not obvious and was difficult to see when highlighted against the patient's name. The Ward Managers also expressed the difficulty in	Patient harm due to insufficient nursing provision.

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removing patients that are no longer receiving specialling from the specialling tab in the CWS. (D)	
Recommendation 4	**Priority level**
Management must ensure that ward staff complete the SRA on the CWS and use the appropriate symbol. Management must ensure that the CWS is used effectively and that ward staff are informed of any changes that have taken place within the system. Management must establish why staff members are experiencing difficulties when removing patients from the Specialling tab within the CWS.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
Ward Managers to monitor completion of SRA and symbols on CWS, difficulties with CWS to be promptly escalated to CWS working group. CWS will be monitored for compliance by senior / lead nurse.	Lead Nurse / Senior Nurses July 2017

Finding 5 - Level of specialling and how often it is reviewed.	Risk
The second page of the SRA is for the re assessment of the patient's needs and consideration of whether specialling can be de-escalated or removed. The SRA implies that this should take place during each handover. The Ward Managers also informed us during the initial meetings that review of the level of specialling should take place during handover. Testing showed that in most instances the level of specialling was reviewed once a day for each patient in the sample. Page three of the SRA is the Risk Assessment Decision Aid and Continued Assessment Record. There were gaps in the recording of dates on the Continued Assessment Record for all 5 of the sampled patients. 2 out of the 4 patients on A4 had not been reviewed since 12th March 2017, which was 4 days overdue at the time the testing was carried out. (O)	Patient harm due to insufficient nursing provision.
Recommendation 5	**Priority level**
Management must ensure that the re assessment of patients receiving specialling is carried out during each handover and documented on the SRA. Management must ensure that if Specialling is required longer than 48 hours then the Continued Assessment Record is consistently updated.	**Medium**

Management Response 5	Responsible Officer/ Deadline
Process for review of patient specialling requirements for reassessment and appropriate escalation or de escalation will be reviewed as part of the specialling user guide review.	Deputy Director of Nursing MCB August 2017

Finding 6 - Care Plans	Risk
The Specialling User Guide states that using the Behaviour Monitoring Chart (BMC) for a minimum of 7 days, will help staff to devise an appropriate person centred care plan. The patient notes in the sample did not have specific Specialling Patient Care Plans in place, so in the absence of these we looked to see if each patient had a Fundamentals of Care plan within their bedside notes. • 2 out of 5 did not have a Fundamentals of Care Plan within the bedside notes or in the Main Patient notes. • 3 out of 5 did have a Fundamentals of Care Plan on file but none had been reviewed regularly. The longest date since review was 25th December 2016 and the most recent was 10th February 2017. (O)	Patient harm due to insufficient nursing provision.

Recommendation 6	Priority level
Management must ensure that all patients should have an up to date care plan on their patient notes, which has incorporated the findings from the BMC.	**Medium**
Management Response 6	**Responsible Officer/ Deadline**
As part of the update and review of the specialling user guide, the process and standards for completion of BMC will be reviewed and the requirement for a care plan will be individualised to patient need which may be in the form of " This is me / read about me" document.	Lead nurses/ Senior nurses. August 2017

Finding 7 - Accurate data	Risk
There are 2 systems in place which should provide accurate and up to date information on the number of patients being specialled within Integrated Medicine. One is a 'Nurse Tracker' which is maintained by the Senior Nurse and held on the S: Drive for Lead Nurses and Finance to access and the second is Clinical Workstation. The Senior Nurse updates the Nurse Tracker daily after Senior Nurse walk round. A copy of the most recent tracker was obtained on 23/03/17, which showed that the majority of patients for UHW were reviewed on the 13/03/17. Therefore the tracker had not been updated for 10 days and the number of patients receiving specialling for C7 and A4 was different to the numbers we	Patient harm due to insufficient nursing provision.

identified during testing. The CWS should also reflect the numbers of patients receiving specialling. As highlighted in finding 4 above, ward nurses are not always completing the SRA on the CWS and are unable to remove patients from the specialling tab. This illustrates that the list is out of date and cannot be relied upon for accurate data. (O)	
Recommendation 7	**Priority level**
Management must ensure that both systems are updated regularly and reflect the actual number of patients receiving specialling.	**Medium**
Management Response 7	**Responsible Officer/ Deadline**
This duplication of effort has been reviewed and a decision has been made to only record specialling activity on the CWS. This process needs to embed within clinical areas.	Lead nurse / Senior Nurse July 2017

Finding 8 - Behaviour Monitoring Charts	**Risk**
Discussions with family members regarding specialling are not routinely entered onto patient's notes. If a patient requires specialling this is discussed with the family who are normally willing for this to take place. Problems can arise when the specialling has been deescalated or removed which can make the family anxious. (O)	Patient harm due to insufficient nursing provision.
Recommendation 8	**Priority level**
Management must ensure that conversations with family members regarding specialling are recorded on the patient notes.	**Low**
Management Response 8	**Responsible Officer/ Deadline**
A patient / relative information leaflet will be developed to explain the reason for increased supervision of patients and family will be encouraged to participate with care. This information will inform and be captured within the Risk assessment / care plan documentation and information leaflets will be provided to patients and their families/ carers.	Lead nurse / Senior Nurse August 2017

Medicine Clinical Board Specialling

Cardiff & Vale University Health Board

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.

PATIENT ACCESS

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff & Vale University Health Board

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NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix A Management Action Plan
Appendix B Assurance Opinion and Action Plan Risk Rating

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Executive sign off: Steve Curry, Chief Operating Officer

Distribution: Paul Rothwell, Senior Manager, Performance and Compliance
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Eira Yassien, Deputy Directorate Manager

Committee: Audit Committee

12

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1. Introduction and Background

The review of Patient Access was completed in line with the 2016/17 Internal Audit Plan.

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

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of arrangements for the management of Patient Access across the University Health Board in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to provide assurance that patients are provided with reasonable offers for appointments and that any subsequent patient clock adjustments are appropriate.

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

- The UHB has procedures in place to provide reasonable offer appointments to patients.
- Processes for producing patient appointments are in compliance with Referral To Treatment and Fixed Appointment Booking rules.
- Appropriate patient clock adjustments are made on the basis of appointment refusals / CNA (Could Not Attend) / DNA (Did Not Attend).

Patients placed on waiting lists between April and September 2016 were sampled across three UHB Directorates during this review, namely;

- Urology Directorate, UHW
- Acute Child Health Directorate, UHW
- University Dental Hospital

3. Associated Risks

The potential risk considered in the review was as follows:

- Inequitable treatment of patients.

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 Patient Access is **Substantial Assurance**.

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

The review identified that patient booking staff in all the sampled Directorates have had PMS training and are conversant with booking processes and the Referral to Treatment (RTT) and Fixed Appointment Booking (FAB) rules. However, both Acute Child Health and Urology Directorates do not currently hold summary procedures/guidance notes that aid and support any queries or issues with these rules.

It is noted that revised RTT guidance was issued by Welsh Government and distributed to UHB management in early April 2017.

Whilst the majority of appointments sampled across the 3 Directorates were appropriately provided, testing did identify that a very small number of appointments booked in the Acute Child Health and Urology Directorates did not comply with the reasonable offer rules and any reasons for these were not recorded on PMS.

Good practice is noted that all clock adjustments pertaining to DNAs, CNAs and patient refusals were appropriate and in accordance with RTT rules.

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5. Assurance Summary

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

Assurance Summary					
1	Inequitable treatment of patients.				✓

Design of Systems/Controls

The findings from the review did not highlight any issues that are classified as weaknesses in the system control/design for the management of Patient Access.

Operation of System/Controls

The findings from the review have highlighted 3 issues that are classified as weakness in the operation of the designed system/control for the management of Patient Access.

These are identified in the management action plan as (O).

6. Summary of Audit Findings

Details of the key overall findings from the review that require corporate actions can be found in the Management Action Plan under Appendix A.

The main areas of good practice and significant findings noted under each risk heading are as follows:

Risk: Inequitable treatment of patients.
The following areas of good practice were noted:

- Booking staff within the 3 sampled Directorates have an awareness of the Welsh Government RTT guidance through completion of PMS training.
- University Dental Hospital patient access management is supported by departmental booking summary guidance for staff.
- All the appointments sampled within the University Dental Hospital were provided in accordance with the reasonable offer rules stated in the Welsh Government RTT guidance.

- All sampled appointments in each of the three Directorates were supported by appropriately recorded clock adjustments relating to CNAs and DNAs in accordance with the RTT rules.

The following significant findings were noted:

- A small number of the sampled patient appointments booked in the Acute Child Health and Urology Directorates did not comply with reasonable offer rules.

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**	**2**	**3**

Finding 1: Acute Child Health and Urology non-compliance with reasonable offer rules.	Risk
Testing identified that 1 of the 20 sampled Acute Child Health Directorate appointments and 2 of the 20 sampled Urology Directorate appointments were not provided in accordance with reasonable offer rules stated in the Welsh Government RTT guidance. It is noted that any potential mitigating reasons for non-compliance were not stated within the patient's correspondence section within PMS. Good practice is noted that all appointments sampled within the University Dental Hospital were provided in accordance with reasonable offer rules. (O)	Inequitable treatment of patients.
Recommendation 1	**Priority level**
All appointments should be_booked in accordance with reasonable offer rules as per Welsh Government RTT guidance. Any mitigating reasons for non-compliance with the rules should be stated within PMS.	**Medium**

Management Response 1	Responsible Officer/ Deadline
Agreed. As stated on page 4, Welsh Government has issued new rules for the management of patients on RTT pathways. These rules are being phased in during quarter 1 of 2017/8. During this period issues/questions on implementation are being collected and responses shared for action as required to support implementation and learning. The UHB is also planning to deliver training to familiarise waiting list management staff. The suggested implementation date is intended to reflect this process.	Relevant Directorate Managers Immediate – consolidate practice re existing rules July 2017 onwards – new rules

Finding 2: Lack of Acute Child Health and Urology local guidance.	Risk
Whilst there is evidence of PMS training and the awareness of existence of Welsh Government RTT guidance within each Directorate, neither the Acute Child Health or Urology Directorate have departmental procedures/summary guidance notes that support and reinforce the patient booking processes specific to those Directorates and the rules relating to reasonable offer and patient clock management. (O)	Inequitable treatment of patients.
Recommendation 2	**Priority level**
Directorates should produce summary guidance that underpins and reinforces the PMS training in order to help mitigate any shortfalls in knowledge.	**Low**

Management Response 2	Responsible Officer/ Deadline
Agreed as centrally driven exercise. The UHB will update its existing Patient Access Policy staff handbook to reflect the new WG rules as per recommendation 1. This handbook will need to be agreed by the successor committee to the Planned Care Board. Summary guidance can then be produced.	Senior Manager (Performance and Compliance) August 2017

Finding 3: UDH incorrect cancellation /	Risk
One patient cancellation was erroneously made by a Central Booking Medical Records Officer who does not deal with University Dental Hospital patients but accessed and made the changes to the wrong patient. It is noted that the Directorate Manager has confirmed that this issue has been corrected. Additionally, 2 of 20 sampled UDH appointments were made which did not strictly comply with current reasonable offer/cancellation rules. These related to appointments being brought forward due to additional clinic capacity in order to alleviate RTT targets. However, this was not clearly documented within the respective patient notes. (O)	Inequitable treatment of patients.

Recommendation 3	Priority level
All appointments staff in the UHB should be reminded to check entries made on PMS so as to prevent erroneous entries that may impact of patient appointments and the RTT clock status and all appointments brought forward due to additional clinic capacity/availability should be recorded on PMS accordingly.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
Agreed – details to be recorded on PMS as per "recommendation" as opposed to being recorded in patient records as per "finding" as latter impractical.	Directorate Manager UDH Immediate

Patient Access

Cardiff & Vale University Health Board

Audit Assurance Ratings

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

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

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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.

Health & Care Standards

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Review reference: CUHB17.56
Report status: Final
Fieldwork commencement: 30th March 2017
Fieldwork completion: 5th May 2017
Draft report issued: 10th May 2017
Final report issued: 16th May 2017

Auditors: Stuart Bodman, Ross Hughes

Executive sign off: Ruth Walker, Director of Nursing

Distribution: Carol Evans, Assistant Director, Patient Safety & Quality

Alex Scott, Patient Safety & Quality Assurance Manager

Committee: Audit Committee

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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 Health & Care Standards was completed in line with the Internal Audit Plan.

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

In accordance with the 2016/2017 internal audit plan a review of the Health and Care Standards process was undertaken to expand upon the previous Internal Audit review in September 2016.

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 UHB has adequate procedures in place to ensure that the standards are effectively utilised to improve clinical quality and patient experience and that appropriate process 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 introduced 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.
- Improvement actions are identified to address any areas of poor performance and plans are produced to ensure implementation;
- The Health Board has processes in place to oversee and monitor performance against the standards.

3. Associated Risks

The 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.

4. Summary of Key Findings

From a review of the processes underpinning the utilisation, embedding and assessment of the Health and Care Standards in 2016/17 the following points can be noted:

- The Health Board has developed a revised self-assessment scoring methodology with prescribed definitions/requirements attributed to each score which are specific to each Standard assessed.
- Following the pilot self-assessments carried out on 5 standards in February 2016, Clinical Boards undertook an effective SBAR based assessment of all the remaining 18 Standards during June 2016.
- Improvement actions were identified as part of the self-assessments completed in June 2016. The Health Board will need to ensure that progress against these actions is appropriately reported within the updated self-assessments scheduled to be completed in June 2017.
- The Health Board is working towards the introduction of a system of continuous monitoring of its performance against the Standards, as opposed to a one-off, year-end self-assessment. This will help to further embed the Standards across the organisation and develop the service provision that underpins each of the Standards.

  As part of the new system the Health & Care Standards will be aligned to existing committees or groups whose agendas will reflect the criteria dictated in the Standards. Monitoring of Clinical Board performance against these Standards will be reported to the committees / groups at appropriate intervals.

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The new system will be implemented for the following 6 Standards during 2017/18:

- 2.3 Falls Prevention
- 2.4 Infection Prevention Control and Decontamination
- 2.5 Nutrition and Hydration
- 2.6 Medicines Management
- 2.7 Safeguarding
- 2.9 Medical Devices, Equipment and Diagnostic Equipment

- Review of evidence for a sample of two of the above Standards (2.4 and 2.6) confirmed that the agendas for the relevant Groups appropriately reflect the criteria of the Standards.
- There is a timetable in place for the completion of the assessment of compliance against the 6 Standards under the new continual monitoring process in June 2017. Self-assessments are also timetabled to be completed against the remaining 18 Standards during June. These assessments will be subject to separate Internal Audit review during 2017/18.
- Details of the proposed approach to the utilisation and assessment of the Standards and monitoring of progress are reported to the Quality, Safety and Experience Committee.

5. Audit Assurance

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 & Care Standards is **Reasonable Assurance.**

RATING	INDICATOR	DEFINITION
Reasonable		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 introduction of a process for continuous monitoring of performance against the Standards, as opposed to a one-off annual

assessment, is recognised as a positive development that should enable more effective utilisation of the Standards to drive improvements in service delivery.

There is clear evidence that Clinical Boards are actively engaging in the process and that the revised assessment methodologies are being embedded across their respective clinical specialities. Testing of 2 sampled Standards confirmed that progress is being made towards the effective utilisation of the process for continuous monitoring.

Our previous Health & Care Standards review, completed in September 2016, confirmed that the Health Board has carried out an appropriate self-assessment against the Standards during 2016/17, although these actually covered services provided during 2015/16.

Audit Assurance Ratings

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Specialist Neuro & Spinal Rehabilitation and Older People's Services

Final Internal Audit Report

Cardiff & Vale University Health Board

2016/17

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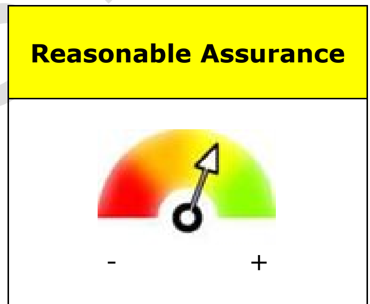
NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance



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Specialist Neuro & Spinal Rehabilitation and Older People's Services

Cardiff & Vale University Health Board

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Appendix A Management Action Plan

Appendix B Business Case Costs

Appendix C Assurance opinion and action plan risk rating

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Review reference:	SSu CV 16-17 02
Report status:	Final
Fieldwork commencement:	January 2018
Fieldwork completion:	March 2017
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Final report issued:	May 2017
Auditor/s:	Eifion Jones Felicity Quance
Executive sign off	Abigail Harris, Executive Director of Planning
Distribution	Geoff Walsh, Director of Capital, Estates and Facilities Jeremy Holifield, Head of Capital Planning
Committee	Audit Committee

ACKNOWLEDGEMENT

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1. Introduction and Background

The project intention is to reprovide Specialist Neuro & Spinal Rehabilitation and Elderly Care Services from Rookwood Rehabilitation Hospital.

The Outline Business Case (November 2012) anticipated that the specialist neurological and spinal rehabilitation services would relocate to a new facility at the University Hospital Llandough and Elderly care services currently based at Rookwood would relocate to St David's Hospital. It was anticipated at that time that the capital cost requirement was £16.3m and was expected to open in summer 2017.

Having received OBC approval in August 2015, work progressed on the development of the Full Business Case with the deadline for submission extended to 31 March 2017 at the time of the audit. The forecast 'not to exceed' FBC cost at the time of review was £29.984m.

Whilst the service aspirations remain unchanged from those outlined at the OBC, due to the time that has elapsed since submission, it has been necessary to revise the proposed build solution.

The UHB advisers have prepared an outline of the significant issues impacting the project (see **Appendix B**), key themes summarised include:

- Inflation from original OBC approval (circa £4.04m);
- Increased requirement for new build areas due to unavailability of free space originally identified at the Llandough site (£577k);
- Increased requirement for space at the CRI site due to unavailability of free space originally identified at the Llandough site (£1.472m);
- Engineering plant now beyond useful life (£1.966m);
- Increased preliminary costs having failed to achieve potential economies of scale from running this and the Adult Mental Health project concurrently (£1.137m); and
- Additional fees (£1.721m).

We have not performed an assessment of the cost assumptions, as these will subject to detailed scrutiny as part of the Welsh Government business approval process – and is therefore excluded from the assurance opinion.

2. Scope and Objectives

The assignment originates from the 2016/17 internal audit plan.

The scope of the audit included:

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- **Governance Arrangements**

  Assurance that adequate governance arrangements existed, including management ownership, defined roles and responsibilities and clearly defined accountability and delegation arrangements.

- **Approvals**

  Assurance that appropriate internal/external approval mechanisms were applied as the project progresses through key junctures.

- **Business Case Development**

  To assess the adequacy of arrangements to develop the component elements of the five-case business case including resource, structures, monitoring and reporting and ensure scrutiny comments were adequately addressed.

- **Contract Awards/Contract Documentation**

  To ensure that appropriate mechanisms had been applied at the appointment of contractors and design team members, ensuring compliance with local and national protocols. Also to obtain assurance that all contract documentation had been appropriately completed to the current state of the development.

- **Client Brief and Design Development**

  A review of the arrangements to define and sign-off the client brief and the engagement processes thereafter to develop the design.

- **Change Management**

  To evaluate the robustness of arrangements to manage the time, cost and quality implications arising from the implantation of client and design team changes.

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3. Associated Risks

The potential risks considered in the review are as follows:

- Inadequate organisational and governance arrangements may be in place;
- Roles and responsibilities may not have been developed and assigned to appropriate individuals;
- Appropriate project management tools may not have been employed effectively at the programme;
- The project may have progressed at risk without appropriate approvals;

- The business case may not have been produced in a timely manner or may have been inadequate to define the case for change;
- The client brief may not have been adequately understood impacting outcomes and objectives; and
- Key objectives may have been at risk through the lack of management of changes.

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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.

It is important to note that the audit has not sought to assess the reasonableness of the submitted business case, capital cost and/or revenue cost assumptions outlined, as these will be subject to formal detailed scrutiny as part of the Welsh Government business case approval processes.

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

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

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

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

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5. Assurance Summary

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

Assurance Summary					
1	Governance arrangements				✓
2	Approvals			✓	
3	Business Case Development			✓	
4	Contract Awards / Contract Documentation			✓	
5	Client Brief and Design Development				✓
6	Change Management			✓	

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

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Design of Systems/Controls

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

Operation of System/Controls

The findings from the review have highlighted **4** issues that are classified as weaknesses in the operation of the designed system/control for managing the requirements of the re-provision of Specialist Neuro and Spinal Rehabilitation and Elderly Care Services from Rookwood Rehabilitation Hospital.

6. Summary of Audit Findings

Governance arrangements

The project structure was formally developed and set out in the Outline Business Case (OBC).

A Project Board and a Project Team were established with appropriate terms of reference with monthly meetings being held.

The Executive Director of Planning fulfilled the role of Project Director as set out in the NHS Capital Investment Manual. However, a Project Director's Acceptance Certificate and consequently acceptance of the Project Director's authority was not confirmed for this project **(recommendation 1).**

Robust decision making processes were established for the project. Assurances and accountability to the Board was demonstrated via the Specialist Services Major Project Board supported by the Specialist Rehabilitation and Clinical Gerontology Project Team.

Project progress against plan was regularly reported in standard Highlight Reports produced by the UHB Project Manager (Head of Capital Planning).

We determine **substantial assurance** in respect of governance arrangements with one low recommendation made.

Approvals

As outlined previously, the Outline Business Case (dated November 2012) was approved by the Welsh Government in August 2015 with associated capital costs £16.3m.

Noting the delay to the OBC approval, whilst the service aspirations remain unchanged, various changes to the build solution contributed to an increased 'not to exceed' FBC cost of £29.984m (key themes are summarised in the *Introduction and Background* section above, and further detailed at **Appendix B**) e.g.

- Changes in PUBSEC index since OBC submission in 2012 to reflect inflation;
- Increased preliminaries costs from failing to achieve economies of scale from having two schemes operating under the same contractor concurrently;
- An alternative building solution having to be provided noting that previously identified vacant space at the Llandough site has now been occupied (the new solution being to provide new build accommodation at Llandough and to refurbishment of additional space at the CRI site).

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As will be detailed in the *Change Management* section below a significant element of the increase in forecast cost from £16.3m to £29.984m was not progressed via the change management process.

However both internal and external reporting relating to the increase has been fully transparent. Ultimately, the Board will be requested to approve the Full Business Case, which will reflect the increase in cost (see **recommendation 2**).

The Outline Business Case also assumed that the project would be revenue neutral. Whilst no additional revenue funding will be requested as part of the Full Business Case from Welsh Government, it is understood that there will be an additional revenue cost to be funded by the UHB; however the amount had yet to be confirmed at the time of the review.

Accordingly, upon the conclusion of the Full Business Case, the source of funding for the same will be confirmed and Board approval sought (see **recommendation 3**).

Separately, planning consent for the works at UHL had been awarded by Vale of Glamorgan Council in January 2017.

The level of assurance determined in this area is therefore **reasonable assurance,** subject to the aforementioned.

In the period subsequent to the audit, the full business case (including capital and revenue assumptions has been concluded and the target is to table the same at the next meeting of the Board.

Note: It is important to note that this assurance assessment does not seek to challenge the increase in cost, which will be subject to formal scrutiny as part of the Welsh Government business case approval process.

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Business Case Development

The 5-case business model had been followed in the development of the OBC and FBC.

The OBC and FBC set out the UHB's plans to facilitate the long term development and delivery of specialist neuro and spinal rehabilitation services for the catchment population of Mid and South Wales at University Hospital Llandough (UHL) and the implementation of an integrated model for elderly care services at St David's Hospital (SDH), Cardiff.

The capital costs increased from £16.344m at OBC, to a 'not to exceed' FBC value of £29.984m (further details are provided at **Appendix B**).

Revenue implications differed significantly between OBC (£17m) and FBC (£9m) respectively. The reduction was attributed to the OBC assessment relating to the whole cost of the division, while the revision, at the FBC,

was redefined to be solely reflecting those elements impacted by the Business Case.

These variances should be explicit within the FBC presented to the Board and an exercise will be undertaken to identify any opportunities/ lessons learnt.

A **reasonable assurance** has been determined in relation to the processes in place to derive the Full Business Case.

As outlined in the previous section, the Full Business Case has now been concluded for Board consideration.

Note: The assurance rating does not consider the content which will be subject to formal scrutiny as part of the Welsh Government business case approval process.

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Contract Awards/Contract Documentation

The procurement strategy was documented in the Outline Business Case and agreed for the Supply Chain Partner (SCP) and advisers. The SCP and advisers were procured under the Designed for Life: Building for Wales 1 Framework (D4L:BfW1) and all contract documentation was appropriately executed in relation to the same.

In due course, pending FBC approval, the SCP will enter contract with the UHB on a target cost based on robust market testing. The existing market testing exercise is to be held for a finite time and some coincided with the proposed 31 March 2017 FBC submission date. It is important that the risk associated with the same is appropriately defined and managed **(recommendation 4)** – given the current provision of £45k may be understated given that a number of sub-package tenders will have expired at the time of submitting the FBC.

We determine **reasonable assurance** in respect of contract awards to date and contact documentation, with one low priority recommendation made.

Client Brief and Design Development

It is important the user requirements are confirmed and frozen at key stages of the project lifecycle.

Due to the time that elapsed from SOC and the change in key users, it was necessary to re-appraise the client brief; although the main

aspirations remain unchanged, it has been necessary to revise the proposed build solution.

Key users were also involved in the design process, demonstrated via clinical sign-off of the design and adjacencies – a key benefit to the investment is maximising clinical adjacencies namely interventional and diagnostic facilities, such as dental and x-ray.

Derogations had been prepared and authorised as acceptable by the Director of Capital, Estates and Facilities and will be included within the Estates Annex of the FBC. Derogations listed were minor in nature; primarily related to appropriateness of fixtures and fittings for patient needs / ability.

A value engineering exercise had taken place to review design and identify further efficiencies in the run up to the agreement of the target 'not to exceed' cost.

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

Change Management

We confirmed that a robust contractual change mechanism was in operation on the project in accordance with the Designed for Life Framework requirements.

This mechanism required the completion and authorisation of a Project Issues Form (PIF), an authorised Project Manager Instruction (PMI) and an approved Compensation Event (CE).

A total of £872k project changes had been approved and related to additional design fees due to the increased scope of work required at the UHL and CRI sites. The changes were documented within the monthly cost reports prepared by the Cost Advisers, presented to the Specialist Rehabilitation and Clinical Gerontology Project Team.

As noted at the *Approvals* section of this report, the significant element of the increase in cost (as outlined in **Appendix B**) has not been progressed through the change management process – as these elements will be considered, along with their associated capital/ revenue implications within the Full Business Case (see **recommendation 2 & 3**).

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Whilst **reasonable assurance** has been determined, formal approval of the significant changes to the project is required, as part of the Full Business Case approval process.

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	2	**4**

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Finding: Project Director's Acceptance Certificate	Risk
Delegated authority from the Chief Executive to the Project Director should be made explicit and should cover financial authority, ability to direct resources and make decisions. Best practice as still set out in the Capital Investment Manual requires the Chief Executive to sign a formal certificate delegating authority to the Project Director and for this to be signed as acceptance by the Project Director. There is no reference in the UHB's Capital Procedures Manual of the requirement for a Project Director's Acceptance Certificate. Consequently, acceptance of the Project Director's authority was not confirmed for this project noting that two individuals held the position from OBC submission to date.	Lack of clarity and acceptance of delegated authority invested in the Project Director.
Recommendation 1	**Priority level**
As has been included in previous reports, the Capital Procedures Manual should be revised to include the requirement for a Project Director's Acceptance Certificate signed by the Chief Executive and Project Director **(O)**.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Director of Capital, Estates and Facilities/ Project Director Post-conclusion of the Full Business Case

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Finding: Approvals	Risk
A significant element of the increase in forecast cost between OBC and FBC from £16.3m to £29.984m was not progressed via the change management process. Whilst this has been openly reported both internally and externally, the Board will be required to approve the Full Business Case, reflective of the increased cost. The Outline Business Case also assumed that the project would be revenue neutral. Whilst no additional revenue funding will be requested as part of the Full Business Case submission to Welsh Government, there is an additional revenue tail which had yet to be finalised at the time of review.	Appropriate approvals for additional revenue have not been secured.
Recommendation 2 & 3	**Priority level**
Appropriate internal approval will be sought for the increase in capital cost and supporting assumptions, prior to submission to Welsh Government **(O)**. The Board will be asked to approve the additional revenue associated with the project, and confirm the source of funding **(O)**.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The Full Business Case has now been concluded and the next meeting of the Board has been targeted for submission of the same.	Director of Capital, Estates and Facilities July 2017

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Finding: Value for Money	Risk
The cost adviser commenced market testing of contractors for individual target cost packages to confirm value for money. Tender returns stated that prices are to be held for a finite time and some coincided with the proposed 31 March 2017 FBC submission date. Time continues to elapse from submission to eventual Welsh Government approval increasing the risk of further cost implications on the project and the defined 'not to exceed' cost. The existing provision of £45k at the risk register may require further consideration noting that a number of packages will have expired at the time of submitting the Full Business Case.	Use of UHB discretionary capital funds to the detriment of other capital projects.
Recommendation 4	**Priority level**
Management will establish the mitigating controls with Welsh Government for cost increases likely to be encountered in the time period following approval of FBC and commencement of site works at UHL and CRI **(O)**.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. Any delay will in approval will be carefully considered and any resulting fluctuations in price will be managed within the existing envelope or additional inflationary adjustments.	Director of Capital, Estates and Facilities July 2017

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Specialist Neuro & Spinal Rehabilitation and Older People's Services

Cardiff & Vale University Health Board

Business Case Movement

	£,000	£,000
Outline Business Case Approval		16,300
Update to reflect changes in PUBSEC Index		4,040
Additional works included at Llandough site		
Increased new build areas - 445 m2	577	
Replacement of windows	158	
Bus turning circle	277	
New engineering plant	1,398	
Temporary services to ITU	169	
Works to plant room	54	
LED lighting	85	
New LTHW pipe lines from Central Boilers	225	
Dedicated lift	360	
Additional preliminaries - extended construction period and loss of overlap with Adult Unit	1,137	
IT - cable upgrade and outlet increase	84	
Ty Hyfred Bungalow	44	4,524
Additional works included at Cardiff Royal Infirmary Site		
Increased floor area (Ground and first floors)	424	
Stair and lift access to first to third floors	462	
Works to second and third floors - fire escape only	45	
New heat source and engineering services from Plant room 12 (Block 14and 14a)	339	
Preliminaries	203	1,473
Other additional costs		
Fees SCP only	751	
Fees - Client only	551	
Surveys	88	
IT & Telephony	249	
Local Authority Charges	101	
Fit out of Post Graduate for Headways	120	
Asbestos removal (Llandough and CRI)	100	
Cycleway/ Footpath	25	
Return Temporary Car Park to Meadowland	111	
Longcross Court Disposal	300	
St. Davids	354	
C1 North & South	(937)	
Equipment	5	
Planning Contingency	435	
VAT	980	3,233
Current Forecast		**29,990**
Not to exceed		**29,984**

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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.

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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

RESTRICTED

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REPORT OF THE LOSSES AND SPECIAL PAYMENTS PANEL	
Name of Meeting : Audit Committee Meeting	23rd May 2017

Executive Lead : Director of Finance
Author : Head of Financial Accounting, Financial Information and Services
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : £ 16.753m (actual figure)
Quality, Safety, Patient Experience impact: The appendix to the report outlines those agreed actions by panel members which will attempt to reduce the numbers of similar instances occurring in the future and hence reduce any impact on quality, safety and patient/carer experience.
Health and Care Standard Number: The contents of the report and the attached appendix cut across multiple health standards.
CRAF Reference Number: Not Applicable
Equality Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- The work, review and recommendations of the Losses and Special Payments Panel;
- Overview of the Audit Committee;
- Compliance with the Scheme of Delegation, Standing Financial Instructions and Standing Orders

The Audit Committee is asked to:

- **APPROVE** the write off of the losses and special payments outlined in the assessment section shown below:
- **NOTE** the minutes of the 17th May 2017 meeting of the Losses and Special Payments Panel.

SITUATION

As defined in the Standing Financial Instructions, the Audit Committee is required to approve the write off of all losses and special payments within the delegated limits determined by the Welsh Government. To assist the Audit Committee with this task, the UHB has established a losses and special payments panel, under the chairmanship of the Director of Finance. This

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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 17th May 2017 to consider the 6 month period October 1st 2016 to March 31st 2017. This report informs the Audit Committee of the items considered at this meeting and the recommendations made for formal Audit Committee approval. The minutes of the last meeting of the Losses and Special Payments Panel are attached as Attachment 1. These minutes give more detail about the issues discussed at the meeting, including those items that have been recommended to the audit committee for approval.

ASSESSMENT

For the period in question the following losses have been identified for write off:

- £92,546 in respect of bad debt write offs for the period 1 October 2016 to 31 March 2017;
- Clinical negligence claims of £15.379m and personal injury claims of £0.469m for the period 1 October 2016 to 31 March 2017;
- £5,650 in respect of theft and damage to UHB property for the period 1 October 2016 to 31 March 2017;
- Small Claims Panel Losses of £9,185 for the period for the period 1 October 2016 to 31 March 2017;
- £7,362 in respect of Ex Gratia Payments made during the period 1 October 2016 to 31 March 2017;
- £428,558 settlement costs re Employment Tribunal cases for the period 1 October 2016 to 31 March 2017.
- £361,858 re obsolete or lost/damaged stock for the period April 1st 2016 to 31 March 2017.

Attachment One

MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS PANEL HELD ON 17th MAY 2017.

PRESENT:

Mr A Gough (Chair)
Mr A Crook
Mr S Monk
Mr R Cockayne
Mrs A Hughes
Mrs S Wicks
Mr R Hurton

APOLOGIES:

Mr C Greenstock
Mrs A Hughes
Mr C Lewis
Mr A Williams

Minutes of Last Meeting

The minutes of the last meeting were reviewed and the group endorsed them as an accurate record.

Agenda Items

1. Clinical Negligence and Personal Injury Losses

Mr Monk presented the financial report on Clinical Negligence and Personal Injury losses for the six months to 31 March 2017.

The income and expenditure effect re the year ended March 31st 2017 was described as shown below: For comparison, the figures for the same period in 2015/2016 were also discussed

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SUMMARY OF LOSSES

	2016/2017 £'000		2015/2016 £'000
Clinical Negligence	68,240	Note 1	-1,728
Personal Injury	253	Note 2	1,325
Total Loss	68,493		-403
Less WRP Receipts	-66,000		2,866
Total Net Cost to the UHB	**2,493**		**2,463**

Note 1

123 new cases	29,816	(104)	5,125
34 possible/remote moved to robable/certain	36,819	(18)	4,405
4 probable/certain moved to possible/remote	-957	(5)	-10,067
Movement in quantums	4,666		1,528
77 Clin Neg cases settled and closed	-1,912	(60)	-2,328
43 Clin Neg cases cancelled/withdrawn	-442	(35)	-691
43 new PTR cases	206	(15)	65
Movement in PTR quantums	27		1
23 PTR cases settled and closed	57	(43)	275
17 PTR cases cancelled and closed	-40	(29)	-41
	68,240		**-1,728**

Note 2

53 new cases	106	(56)	476
3 possible/remote moved to probable/certain	37	(10)	236
2 probable/certain moved to possible/remote	-15	(1)	-11
Movement in quantums	267		536
34 cases settled and closed	-72	(44)	98
15 cases cancelled/withdrawn	-70	(28)	-10
	253		**1,325**

With respect to clinical negligence claims, Mr Monk advised that in respect of the cases costing £29.816m, £25.311m was attributable to 5 high value ones – 2 Neurosurgery, 1 Obstetrics and 2 Paediatric Surgery. The trend for the number of new cases has risen slightly on the previous year

Mr Monk noted that the gross expenditure on personal injury claims totalled £0.253m for the year ending March 31st 2017. This was down significantly on the previous year. He suggested that the resources which the UHB has put into the investigation of PI claims in recent years has served to drive down our Solicitors costs and the Claimant costs. Moreover, the use of our in house Alternative Compensation Scheme has continued to be used and has

provided redress to injured individuals without the need for costly litigation. Improvements in working practice, safety at work and investigative process has resulted in individuals being dissuaded from seeking legal advice to pursue potential claims.

Mr Monk went on to explain that in February 2017, the Lord Chancellor announced a change in the Personal Injury Discount rate from +2.5% to minus 0.75%. The new rate came into effect on 20th March 2017. The discount rate adjusts personal injury compensation pay-outs to take into account how much an individual can expect if they invest a lump sum over their lifetime, designed to ensure that claimants are not under or over compensated. The rate had been set at 2.5% since 2001. This change in the discount rate would effect the more complex higher value claims and result in settlements costing more. Given the proximity of this announcement to the end of the financial year, it was not possible for Legal & Risk services to assess the effect of the change on a case by case basis. Instead they developed a model in conjunction with Welsh Government which has been used to estimate the effect of the change. Applying this model to Cardiff & Vale, Legal & Risk advised The UHB to increase our Clinical Negligence provision by £16.820m and Personal Injury by £0.058m and these amounts have consequently been provided for in the annual accounts. This increase to gross expenditure was in addition to the figures shown on page 4. The increase had not effected the UHB's reported income and expenditure position as the increase was all covered by the Welsh Risk Pool and will not ultimately impact on the risk sharing agreement, since Treasury would be providing additional funding to Wales to cover the cost of the change.

Recommendation

The Panel recommended that the Audit Committee note that following expected reimbursement from the WRP, the net expenditure incurred by the UHB on these Clinical Negligence and Personal Injury claims was £2.493m for the year ending 31st March 2017.

Finalised Clinical Negligence (including Redress) Claims

During the six months ending 31st March 2017, there were 57 claims (where liability had been conceded and settlements paid) which had concluded at a total cost of £15.905m (£15.379m re settlements and £0.526m re defence fees).The UHB was successful in recovering £14.932m from the WRP for these claims, resulting in a net cost to the UHB of £0.973m.

Finalised Personal Injury Claims

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During the period, 16 claims where liability had been conceded and settlements paid have concluded at a total cost of £0.534m (£0.469m re settlements and

£0.065m re defence fees).The UHB was successful in recovering £0.318m from the WRP for these claims, resulting in a net cost to the UHB of £0.216m

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

Recommendation

The Panel recommended that the Audit Committee approve the write off of the settlement costs of claims finalised in the period 1st October 2016 – 31st April 2017. The value of these claims finalised was - Clinical Negligence, 57 cases - £15.379m. Personal Injury, 16 cases - £0.469m.

2. Debt Write Offs

Mrs Gregory presented a report on proposed invoice write offs for the period 1st October 2016 to 31st March 2017. These were as follows:

Category of Debt	Value	No
Accommodation	611	4
Dental	81	6
Medical Records	310	18
Payroll	13,668	43
Overseas Patients	16,475	10
Private Patients	23,786	25
Misc	37,615	30
Total	**92,546**	**136**

Mrs Gregory also presented the group with a table comparing the amount to be written off in 2016-17 to amounts written off in previous years.

	2011/12		2012/13		2013/14		2014/15		2015/16		2016/17	
	Value	No	Value	No	Value	No	Value	No	Value	No	Value	No
Accommodation	266	4	1,821	7	1,598	5	0	0	8	1	1,049	8
Dental	306	21	195	14	629	35	90	7	130	10	81	6
Medical Records	803	39	360	20	2,127	75	1,182	48	360	22	650	35
Payroll	49,196	39	27,250	36	32,629	46	15,229	18	2,004	7	20,025	53
Private Patients	2,755	15	12,243	10	2,675	22	4,573	18	4,578	32	24,325	28
O/Seas Patients	35,058	25	3,363	7	62,700	23	24,761	38	53,011	48	16,475	10
IVF Wales	1,108	4	150	1	825	5	0	0	0	0	31,026	24
Misc	15,809	87	63,101	98	9,860	65	122,466	68	17,787	50	78,685	61
	105,301	**234**	**108,484**	**193**	**113,043**	**276**	**168,301**	**197**	**77,877**	**170**	**172,315**	**225**

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In the last six months of the year, there were 136 debts with a value of £0.093m recommended for write off and Mrs Gregory explained the following:

The 43 overpayment of salary invoices had all been referred to CCI Credit Management but have all resulted in a negative trace. All overpayment of salary invoices are referred to CCI Credit Management for collection and legal action is taken depending on the value of the debt and the financial status of the debtor.
Of the 53 debts referred for write off 32 relate to overpayments made due to late notification of termination/changes to the payroll department.

There were 25 Private Patient invoices with a total value of £23,786.38. These invoices have been put forward for write off by the Private and Overseas Patient Manager as all avenues for collecting the debt have been exhausted. Where possible all debts have been referred to CCI Credit Management.

The following debts were included in the miscellaneous category:

4 invoices totalling £26,381.40 raised to Prospec Laboratories dating back to 2010/11, these invoices were referred to CCI Credit Management but the company collapsed in 2011 and they have been unable to obtain any payment and have therefore closed the case. The delay in submitting this debt for write off has been due to ongoing attempts to try and obtain part payment.

Recommendation

The Panel recommended that the Audit Committee approve the write off of £92,546 in respect of Bad Debts for the period 1st October 2016 to 31st March 2017.

3. Permanent Injury Losses

Mr Monk presented a report on permanent injury costs for the final six months of the financial year 2016-17.

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 26 cases ongoing, which in expenditure terms cost the UHB £0.423m. There were payments made in the same period of £0.098m

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

Recommendation

The Panel recommended that the Audit Committee be asked to note the impact on expenditure of £422.768 (for the period 1st October 2016 to 30th September 2016).

4. Employment Tribunal Costs

Mr Crook presented a paper outlining the claims and costs for the period 1st October 2016 to 31st March 2017.

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

Nine of these cases had previously been reported to the Losses and Special Payments Panel, and the remaining three cases had been submitted to the Employment Tribunal since 1st October 2016.

During the period £428,558 had been paid in settlement costs. £425,808 of this related to one particular case for which the UHB had obtained written approval from WG before making the settlement payment.

Recommendation

The Panel recommended that the Audit Committee approve the write off of £425,808 in respect of Employment Tribunal Settlements for the period 1st October 2016 to 31st March 2017.

5. Ex Gratia Payments and Other Losses

Mr Monk presented a report on costs for the period 1 October 2016 to 31 March 2017.

Mr Monk noted that there were 9 ex-gratia losses totalling £7,362 made in the six months under consideration.

Seven of the cases (costing £5,750) were the result of the independent review/ombudsman process.

The other 2 losses comprised court awarded costs awarded against us for the late release of medical records to a solicitors practice and translator fees incurred in respect of patients who did not attend scheduled appointments.

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Recommendation

The Panel recommended that the Audit Committee approve the write off of the losses incurred in the period 1st October 2016 to 31st March 2017 amounting to £7,362.

6. Security Losses

Mr Cockayne presented the report for the six months to March 31st.

During the period there had been 5 incidents involving theft of UHB property (Cost £230) and 14 incidents of damage to UHB property (Cost £4,420). The vast majority of these incidents had occurred at properties which the UHB had previously vacated. These properties remained the biggest area of risk going forward. Mr Hurton noted that the UHB had recently spent significant amounts on fencing and CCTV at Whitchurch Hospital and Mr Cockayne indicated that a new gate had been put in at Lansdowne with a view to better securing UHB property there.

Recommendation

The Panel recommended that the Audit Committee approve the write off of the losses incurred in the six months to 31st March 2017 amounting to £5,650.

7. Small Claims Panel Losses

Mr Monk presented a report on costs for the period 1 October 2016 to 31 March 2017. During that period 21 claims had been settled at a total cost of £9,185.

The report explained that lack of accurate record keeping is still a problem across most clinical boards which has resulted in 14 claims being paid as the investigation has shown that they are unable to account for the loss. Other claims were paid as items were lost while changing bed sheets and accidental damage had also resulted in supported claims.

The Concerns team had continued to carry out the following with a view to reducing claims and payments:

- Working with Clinical Boards to ensure that each ward has enough Disclaimer Notices to display for patient information.

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- An Information flyer for staff to be produced explaining the importance of completion and regular update of property lists and disclaimers, e-datix incident forms for loss or damage.
- Education sessions to be held within Concerns as part of study days emphasising the importance of property lists, standards of care of important items such as dentures, and the cost to the Health Board in terms of monetary loss and reputation and how this can be prevented.

Recommendation

The Panel recommended that the Audit Committee approves the write off of the £9,185 in respect of compensation payments made which had been authorised by the Small Claims Panel over the last 6 months of 2016-17.

8. Report of the Counter Fraud Manager

A report on fraud investigations undertaken during the last six months of 2016/17 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 Committee. An update on the current position of fraud cases under investigation had last been reported to the Audit Committee on April 24th.

As at 31st March 2017, 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 thirty three (33) cases still under investigation and which have an estimated potential total loss of approximately £140k.

Recommendation

The Panel asked The Audit Committee to note that no further action is required in respect of counter fraud cases.

9. 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.

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

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

There had been 10 payments during the last 6 months of the year totalling £0.237m.

Recommendation

The Panel recommended that the Audit Committee note the £0.237m paid in Voluntary Early Release Payments made during the last 6 months of 2016/17.

10. Stock Write Offs

Mr Monk presented a report on stock identified for write off during the year to March 31st 2017. During this period there were 14 instances of obsolete stock totalling £272,207 and 8 instances of lost or damaged stock totalling £89,650. Mr Hurton noted that the overall loss was up on the £339k written off in 2015/16. Whilst the amount written off represented a relatively small proportion of the UHB's monthly stock holding (£15m), it was still a significant amount and offered room for improvement in 2017/18.

The Panel recommended that the Audit Committee approves the write off of the £361,858 in respect of lost, damaged or obsolete stock during 2016-17.

11. Salary Payments paid to the Wrong Bank Account

Mrs Gregory presented a paper asking the group to endorse the action of the financial services team in preparing a draft formal policy to address the above situation. Mrs Gregory explained that it is possible for this to happen as a result of the actions of the employee themselves or the due to the actions of UHB or NWSSP staff. Where it does occur then the UHB tries to mitigate the chances of a loss by either recalling the BACS payment (if the error is spotted in time) or writing to the Bank involved and asking them to approach their customer with a view to them returning us the money. The Local Counter Fraud Team are subsequently involved if these initial measures are not successful in getting the money returned.

In respect of the employee who has not yet been paid, Mrs Gregory suggested that the policy might be.

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- If the error was the result of either the UHB or NWSSP, the monies would be reissued regardless of whether the original monies were returned. If the money is not subsequently recovered the Health Board's budget is charged twice**.** Consideration would be made on a case by case basis to determine if the employee's department should suffer the cost of this loss or not.

- If the error was the result of the employee, payment could be advanced and recovered over a period of time. If the money is not recovered currently the member of staff would effectively have an advance to cover any potential short term financial issues, but would ultimately take a loss on the pay.

The Panel agreed that Mr Williams and Mrs Gregory would prepare a formal policy on the above basis **(Action Mr Williams/Mrs Gregory).**

In conjunction with this, Mr Crook agreed to look at the wording on staff changes and enrolment forms to see if this could be edited to make clear to all that they could suffer financial loss if they don't enter bank details correctly on these forms. (Action Mr Crook).

12. Any Other Business

Mr Hurton confirmed that the next meeting of the panel would be in November, the timing of which would need to be determined by the date of that months Audit Committee.

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