AUDIT COMMITTEE

26 SEPTEMBER 2017, 9.00AM

CORPORATE MEETING ROOM
HEADQUARTERS, UHW

AUDIT COMMITTEE
Tuesday, 26 September 2017 at 9.00am

CORPORATE MEETING ROOM, HQ, UHW
AGENDA

PART 1 - SECTION 1: PRELIMINARIES *(Chair)*		
1.	Welcome and Introductions	*Oral*
2.	Apologies for Absence	*Oral*
3.	Declarations of Interest	*Oral*
4.	Minutes of the Committee meetings: • 24 April 2017 • 23 May 2017 • 1 June 2017	*Chair*
5.	Action Log following April and May 2017 Meetings	*Chair*
6.	Any Other Urgent Business: To agree any additional items of urgent business that may need to be considered during the meeting.	*Oral*
SECTION 2: PATIENT SAFETY		
7.	Patient Safety	*Oral* *C Evans*
SECTION 3: AUDIT AND COUNTER FRAUD		
8.	Internal Audit Position Report and updates **Please see part 2 agenda item 22 for full copies of audit reports*	*J Johns*
9.	To receive Wales Audit Office Committee Update	*WAO*
10.	Wales Audit Office – Action Plan of Contractual Relationship with RKC Associates Limited and its Owner	*P Welsh*
11.	Action Plan – Deloittes Financial Governance Review of Cardiff and Vale UHB	*R Chadwick*
12.	To Receive Tracking Report on Audit Recommendations	*P Welsh*

13.	To Receive the Post Payment Verification Report	*S Lavendar*
SECTION 4: POLICIES AND COMPLIANCE REPORTS		
14.	No items to report	*R Chadwick*
SECTION 5: CORPORATE GOVERNANCE		
15.	Director of Corporate Governance Report	*P Welsh*
16.	Monitoring of Declarations of Interest and Gifts, Hospitality and Sponsorship	*P Welsh*
17.	To receive the Regulatory and Review Bodies Tracking Report	*P Welsh*
18.	To receive the Corporate Risk Register	*P Welsh*
SECTION 6: ANNUAL FINANCIAL AND GOVERNANCE STATEMENTS		
19.	Topical Legal and Regulatory Items	*Oral* *P Welsh*
SECTION 7: ITEMS FOR DECISION		
20.	No items to report	
PART 2 - ITEMS FOR INFORMATION		
21.	Internal Audit reports for information: **Assignment** — **Assurance Rating** 1. Records Management Follow-up — Reasonable 2. Statutory Compliance — Reasonable 3. Medicine Clinical Board Sickness and Rotas — Reasonable 4. Specialist Clinical Board — n/a 5. Annual Quality Statement — Substantial 6. Charitable Funds — Substantial 7. Environmental Sustainability Reporting — Reasonable 8. Mental Health Clinical Board — Reasonable 9. Quality & Safety Governance Follow-up — n/a	*J Johns*
22.	Consultation on Fees 2018/19	*WAO*
REVIEW AND FINAL CLOSURE		
23.	Items to be referred to Board / Committee	*Oral* *Chair*
24.	To note the date, time and venue of the next meeting of the Committee: • **Tuesday, 5 December 2017, 9.00am** Corporate Meeting Room, Headquarters, University Hospital of Wales	

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

UNCONFIRMED MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON 24 APRIL 2017 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

4.1

Present:

Ivar Grey	Independent Member – Finance, Chair
John Antoniazzi	Independent Member - Capital
Stuart Egan	Independent Member – Trades Unions

In Attendance:

Robert Chadwick	Director of Finance
James Johns	Head of Internal Audit
Peter Welsh	Director of Corporate Governance
Mark Jones	Wales Audit Office
Craig Greenstock	Counter Fraud Manager
Simon Cookson	Director of Audit and Assurance, NWSSP
Sian Rowlands	Corporate Governance Manager
Ian Virgill	Deputy Head of Internal Audit
Carol Evans	Assistant Director of Patient Safety and Quality

Observers:

Kathryn Caldwell	Deloittes

Apologies:

Nigel Gibbs	Trade Union Representative
Anne Beegan	Wales Audit Office
Scott Lavendar	Post Payment Verification

Secretariat: Glynis Mulford

AC: 17/001 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting. Kathryn Caldwell, of Deloittes was introduced and explained to Members that they would be conducting a review of financial governance. Also new to the meeting was Ian Virgill, Deputy Head of Internal Audit.

AC: 17/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 17/003 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

AC: 17/004 UNCONFIRMED MINUTES OF THE MEETING HELD ON 28 FEBRUARY 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 28 February 2017.

AC: 17/005 ACTION LOG FROM MEETING OF 28 FEBRUARY 2017

The Committee **RECEIVED** the Action Log from the meeting of 28 February 2017 and **NOTED** the following:

16/093 – Internal Audit Position Report and Tracking Report: It was stated that the tracking report will be reintroduced for the September meeting.

16/093 - ***Medicines cost reduction:*** Mrs Carol Evans stated that she had exchanged emails and explained every effort was being made to understand the reasons for return and waste and address issues that arose but that pharmacy did not intend to log these in detail as considered too resource intensive.

ACTION: C Evans Will continue to have conversation in relation to high value drugs

16/094 – WAO Consultant Contract: Ms Anne Beegan will complete action this week.

16/079 – WAO Tracking Report: Action complete.

15/008 – Business Continuity Plan: Complete. This item will go forward to 2017/18 workplan.

AC: 17/006 PATIENT SAFETY

Depravation of Liberty and Safeguards (DoLS): Members were informed that a comprehensive report was taken to each Mental Health Capacity Legislation Committee who was actively managing the risk. There was still a backlog due to capacity issues and the concerns feature on the Corporate Risk Assurance Framework (CRAF) this was around the Mental Capacity Act and the ability to implement the legislation.

AC: 17/007 INTERNAL AUDIT POSITION REPORT AND TRACKING REPORT

Mr James John, Head of Internal Audit, highlighted the individual position and progress on each report, stating out of the eight reports two received Substantial Assurance and six Reasonable Assurance.

The overall progress of plan was explained, informing reports had been finalized and those remaining had been progressed to draft stage. Appendix B set out the detail of individual audits and their respective rating and how these fit in with the audit assurance domains around how the plan was structured. Also to note, subject to completion of remaining audit, it was envisaged that the Internal Audit Report and Opinion will be given a Reasonable Assurance rating for the year.

To date 17 reports had not been received although two reports had been finalized since the paper was put together. There was very little work left on the remaining items. The timeline was discussed and emphasized that the 2017/18 programme should be more realistic about when reports will be received so the work is spread over the year.

A short audit committee meeting will be held before the May Workshop to receive some of the outstanding reports.

ACTION: P Welsh and J John to meet and discuss outstanding audits

Members were informed that they will be looking at tightening processes and the progress against plan will go forward to Management Executive team meeting for discussion.

The following reports were highlighted:

Radiology Treat in Turn – Substantial Assurance: It was stated that good systems were in place to ensure patients were treated in turn. There were some minor recommendations.

Core Financial Systems – Substantial Assurance*:* The controls in place were of a high standard and good practice in place. Minor issues had been identified around reconciliation and monitoring of hierarchy structure.

Dental Clinical Board Medicines management – Reasonable Assurance: Operational processes were in place but more documentation was needed around this with a more formal structure to ensure how they oversee and coordinate their approach to Medicines Management.

Clinical Audit follow-up – Reasonable Assurance*:* The previous rating was Limited Assurance but a more detailed review was undertaken and good progress was made to take forward a number of actions although further work was needed to embed processes across the organization. It was recognized that processes had greatly improved. In response to a question about the length of the timeline it was stated this was needed to give to introduce, embed and improve procedures. It was highlighted that the reports on Clinical Audit been presented at QSE Committee.

Leavers Management Process – Reasonable Assurance: The previous rating was Limited Assurance. Follow-up work identified that actions had been taken forward with recommendations actioned and systems put in place. Further work was needed to improve level of compliance with new guidance.

Llanishen Stores follow-up – Reasonable Assurance*:* The previous rating was Limited Assurance. The stores are run on a joint basis with the Local Authority. A project manager was now in place to take forward the recommendations and they were currently looking at implementing a new IT system. In response to a question about other joint stores it was confirmed that the West Point stores rating had been reasonable compared to Llanishen Stores.

ACTION: J John to ask if they are putting an IT system in West Point

Medical locums follow up – Reasonable Assurance*:* The Medical Workforce Department alongside Medacs had made marked improvement with the number of procedures they had put in place. Further work was needed around policy and updating of Service Level Agreements (SLA). This will continue to be followed up as routine.

ACTION: To bring back Committee and show detailed management action and follow-up date.

Mental Health Clinical Board Out of Area – Reasonable Assurance*:* Guidance was in place at an all Wales, UHB and Clinical Board level. Initially they were not fully compliant with standards but had now shown improvements. Evidence also showed a better flow of processes and testing showed that these processes were working appropriately.

It was raised that there still seemed to be number of exceptions around Care Plans. In response it was stated that while there were some anomalies, on balance systems were at a sufficient robust stage to give the above rating.

There was further discussion on Care Plans and patient reviews and whether this had an effect on patient safety. It was asked that reassurance be sought from MHCL Committee.

ACTION: C Evans to make enquiries with Director of Nursing PCIC and if needed to pass information on to I Grey who will talk to MHCL Committee Chair around these concerns

Queries were raised in relation to Public Health Wales receiving a rating 'not applicable'. It was explained that the purpose was to look at two systems and compare information in both systems. A rating was not needed. It was further queried whether this report was to come before the Committee.

The Committee:
CONSIDERED and **NOTED** the Progress Report

AC: 17/008 INTERNAL AUDIT ANNUAL PLAN AND CHARTER

Mr James John, Head of Internal Audit gave a detailed explanation of the report, stating that he set out how to develop the Audit Plan which was to be in compliance with Public Sector Audit Standards. The coverage for the plan was described and how this was structured and kept under review.

Also considered were issues to come up in year with key follow-up for Limited Assurance reviews and ongoing routine processes. As part of the planning process some control weaknesses had been identified and some of the assignments had been considered with Counterfraud that had been raised through their work.

There had been consideration and discussions around the number of audit assignments and improving the flow through the year, as a consequence there would be a smaller number of audits in the programme for 2017/18. As part of detailed discussions with the Executive and Management detailing the scope of work, they had looked at timings and how this will fit in with the organization. The plan includes 80 days to cover contingencies. It was highlighted that the plan has been through Management Executive team for discussion.

The Internal Audit Charter sets out how the work will be delivered and Internal Audit responsibilities to the organization as well as the mechanisms and processes in place for delivery.

The relationship between External and Internal auditors was explained stating there were regular meetings with an exchange of information and risk assessments. It was explained that the Wales Audit Office conducted an annual assessment of Internal Audit as well as an External Quality Assessment. Mr Simon Cookson informed the Committee that he would be commissioning an external organization to carry out an assessment of internal audit.

The Committee:

- **APPROVED** the Internal Audit Plan and Charter

AC: 17/009 WALES AUDIT OFFICE – AUDIT COMMITTEE UPDATE

Mr Mark Jones, Wales Audit Office, presented the Financial Audit Update explaining that little had changed since the last meeting and that the year end audit was in progress. The Audit Deliverables document sets out the obligations of the officers in Health Boards and Wales Audit Office with key

dates. The draft accounts for audit are due on 29 April 2017. Regular meetings will be arranged over the coming weeks to meet various deadlines in order for the signed accounts go to Welsh Government on 2 June. Certification of these accounts will be due on 7 June.

The Annual Report had come forward by two months to 31 July 2017 and WAO were due to receive the final draft of the Annual Report by the end of June. It was stated that a UHB Steering Group had been set up and was on target to meet the deadlines.

There was reference in the report to pooled budgets which was a new audit requirement from 2017. These are audited on Welsh Government guidance on the back of legislation and Certification Instructions will now come into place.

Other items under Performance Audit were explained as ongoing and would be going to future Committees.

The Committee:

- **NOTED** the WAO Audit Committee Update

AC: 17/010 WALES AUDIT OFFICE – REVIEW OF RADIOLOGY SERVICES

The Review of Radiology Services was not discussed but will go forward to be monitored and reviewed by the People, Performance and Planning Committee with the Management Response. The reported would be monitored by the Audit Committee through the Tracking Report.

AC: 17/011 TRACKING REPORT ON AUDIT RECOMMENDATIONS

Mr Peter Welsh, Director of Corporate Governance stated that there was a need for work to be done to improve the Tracking Report. This had been raised at the all Wales Secretaries Group and had devised an all Wales approach and improvements had been made for the September Committee.

It was raised that under the heading 'Status' to remove wording '*ongoing*' where a fuller explanation should be received. It was highlighted that an amendment should be made on the *'Combined follow-up review of progress made against recommendations relating to disaster, recover, data back up arrangements, Caldicott and data quality (Local Work 2013)'*. The Executive lead should be the Medical Director.

The Committee:

- **NOTED** the Wales Audit Office Tracking Report

AC: 17/012 MANAGEMENT RESPONSE TO THE WALES AUDIT OFFICE ANNUAL REPORT AND STRUCTURED ASSESSMENT

Mr Peter Welsh, Director of Corporate Governance informed the Committee that the paper had been through the Management Executive team. An extra column had been added in relation to which would be the Responsible Committee. This will be monitored through the Tracking Report to Audit Committee across all the recommendations. In relation to Recommendation 13, an amendment to be made as the Responsible Officer should read, Director of Corporate Governance.

The Committee:
NOTED and RECEIVED the Management Response to the WAO Annual Report and Structured Assessment

AC: 17/013 POST PAYMENT VERIFICATION

The Chair informed Members that Scott Lavender could not attend but as the report was well understood it would be received. There was an Annual Workplan covering ophthalmology, pharmacy and GPs. Good follow-up procedures had been established involving the UHB staff and where appropriate counter fraud. In relation to errors it was explained that there had been significant improvement in this area.

The Committee:
RECEIVED and **NOTED** the Annual Workplan

AC: 17/014 REPORT ON HOSPITALITY REGISTER & REGISTER OF DECLARATIONS OF INTEREST

For information Mr Peter Welsh, Director of Corporate Governance presented both Registers. This had also been raised with Clinical Boards through a piece of work conducted earlier in the year. A questionnaire had been sent out to Clinical Boards and improvements made. They will keep their own Registers and this element will be inducted into their annual Personal Reviews. It was highlighted that Consultants were being asked to confirm their declarations annually as part of their annual appraisals.

The Chair noted that one Director had disclosed the Cardiff and Vale Charity and asked that the disclosure on the register be consistent. Another amendment was identified as Mr Ivar Grey ceased being a Non-Executive Director of Finance Wales PLC on 30 September 2017.

The Committee:

- **NOTED** Declarations of interest from April 2016 to September 2016

- **AGREED** to receive an update on progress for March 2017 to September 2017 (at the September meeting)

AC: 17/015 CORPORATE RISK AND ASSURANCE FRAMEWORK

Mr Peter Welsh, Director of Corporate Governance stated there were still two significant risks monitored by the Committee. For each higher risks there were backing sheets showing some of the mitigation being taken.

It was explained that at the next Board Development meeting will focus on risk and be facilitated by an outside expert. Members of all clinical boards had been invited to attend. It was highlighted that a report will be going to the Board meeting in May and a progress report will be brought to Audit meeting in September.

The Committee

- **REVIEWED** the risks assigned to the Audit Committee

AC: 17/016 REGULATORY BODIES & REVIEW TRACKING REPORT

The Committee **NOTED** the Regulatory Bodies and Review Tracking Report which showed the level of scrutiny and was **RECEIVED** for information. It was stated that work was still needed to be done and the register was updated on information received to date.

AC: 17/017 AUDIT ENQUIRIES TO THOSE CHARGED WITH GOVERNANCE

Mr Christopher Lewis, Deputy Finance Director presented the report and informed the Committee that the Wales Audit Office had written to the Health Board to gain a response on a number of risks, fraud and governance issues. These responses were required from Management and those charged with Governance. A draft response had been presented to the Audit Committee to review and a copy sent to the Chair and Chief Executive. Any comments would need to be received by end of month.

The members of the Committee confirmed that they were not aware any additional matters requiring disclosure.

The Committee

- **REVIEWED** the draft response to the Wales Audit Office enquiries
- **APPROVED** its submission to the Wales Audit office, subject to any agreed changes required arising from information received the Chair or Deputy Chair

AC: 17/018 INTEMS FOR INFORMATION

The Committee **NOTED** items for information.

AC: 17/019 REVIEW OF MEETING

- For Mrs C Evans to liaise with Director of Nursing, PCIC and if required to pass information on to Mr I Grey who will raise with Chair of MHCL Committee

- In relation to Corporate Risk Assurance Framework, this will be discussed further at the Board Development Workshop on 27 April 2017 arranged to look at the Health Boards risk management system, which will be facilitated by an external expert.

AC: 17/020 URGENT BUSINESS

There was no urgent business

AC: 17/021 DATE OF NEXT MEETING

The **AUDIT WORKSHOP** is scheduled to take place at 9.00am on **Tuesday, 23 May 2017** in the Corporate Meeting Room, Headquarters, UHW

UNCONFIRMED MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON 23 MAY 2017 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Ivar Grey	Independent Member – Finance, Chair
John Antoniazzi	Independent Member - Capital
Stuart Egan	Independent Member – Trades Unions

In Attendance:

Robert Chadwick	Director of Finance
James Johns	Head of Internal Audit
Peter Welsh	Director of Corporate Governance
Mark Jones	Wales Audit Office
Craig Greenstock	Counter Fraud Manager
Simon Cookson	Director of Audit and Assurance, NWSSP
Sian Rowlands	Corporate Governance Manager
Ian Virgill	Deputy Head of Internal Audit
Carol Evans	Assistant Director of Patient Safety and Quality

Apologies:

John Herniman	Wales Audit Office

Secretariat: Glynis Mulford

AC: 17/035 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting and explained that this was an extra meeting to deal with the backlog in internal audit reports. the minutes of the previous meeting and action would be received at the next scheduled meeting.

AC: 17/036 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 17/037 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

AC: 17/038 INTERNAL AUDIT POSITION AND TRACKING REPORT

Mr James John, Head of Internal Audit, highlighted the individual position and progress on each report, stating out of the 13 reports two received Limited Assurance, three Substantial Assurance and eight Reasonable Assurance.

Waiting List Initiative – Limited Assurance: Mr James John, Head of Internal Audit, gave an update on the report highlighting some areas of concern. It was stated they had looked into a number of areas across the Health Board with the largest amount of expenditure. Although good practices were found, inconsistencies in the management approach had been identified Approval of payments needed to be strengthened as some claims had not been authorized at the appropriate level. Issues had been identified in relation to rates of pay being rewarded to some staff and whether these were correct.

Mr Steve Curry, Chief Operating Officer acknowledged the findings, stating it was essential to have an up to date protocol in use. Members were informed that the team had picked up on a range of recommendations highlighted in the report. One policy will be produced which will have a standard approach with appropriate approvals. There will be no local variation in the policy and it will reflect the three standard pay rates for consultants and registrars. He was satisfied the team had responded accordingly and will provide assurance to the Committee through follow up reports.

Continuing Health Care – Limited Assurance: The report looked at Primary Care and Women & Children Clinical Boards. There was guidance in place at an all Wales level around quality and assurance, although there was no framework for Women & Children. There were issues with ongoing monitoring processes which showed a lack of evidence of reviews for clients and care providers. It was identified that the process was not always compliant with guidance. There were further contractual risks as the Heads of Service Agreement was out of date. These needed completion with appropriate timescales.

Mr Steve Curry, Chief Operating Officer said that in terms of a Heads of Service Agreement the UHB had written to local authorities and a further meeting had been arranged. It was envisaged this would be concluded in June. Members were informed that there had been resource difficulties around Annual Reviews and resources had been moved from north to south area to achieve this. There had been discussion with the Clinical Boards around timeliness in regard to approval of packages. Mr Curry said he was satisfied that both Clinical Boards are moving forward and had taken issues seriously.

The Committee was informed that a Mental Health Assessor had been employed. In relation to Recommendation 8, it was asked for this to be reworded to ensure it stated clearly there would be a three month review.

ACTION: Recommendation 8 to be reworded

IT System – Trauma and Orthopaedics (Bluespier) – Reasonable Assurance: Weaknesses had been identified in the governance

arrangements. Regarding some of the issues with the system, there had been a number of key changes within the directorate and there was a need for strengthening around managers being trained on its application. The Directorate was not gaining full value of use of system and there was a need for key issues to be picked up and addressed. It was necessary for improvements to be made to passwords around control and access arrangements as the system sitting on the network did not meet the password criteria.

The Chair said he would pass the report on to Information Management and Technology sub-Committee for further monitoring.

ACTION: Report to go forward to IMT sub-Committee

Integrated Medium Term Plan (Workstreams) – Reasonable Assurance: This was in relation to Mental Health Services for Older People and Primary Care. Good controls were found in a number of areas including operational plans in how they are being developed and taken forward. It was noted there were differences between the two Clinical Boards with one having stronger arrangements. There were some delays in certain aspects of the plans.

Theatres Stock – Follow-up – Reasonable Assurance: This received Limited Assurance in the original review. Action had been taken to address issues. A considerable amount of work had been achieved to address the longstanding concerns and a programme was in place to take further.

Mental Health Clinical Board – Information Governance – Reasonable Assurance: There was some basis of a structure for the management of Information Governance. Directorates within the Clinical Board were putting a structure together to take the agenda forward as this was not fully developed. An Information Asset Register was being developed but the posts for Information Asset Administrators were not in place.

Medicine Clinical Board Specialing – Reasonable Assurance: Issues highlighted that procedures were not being followed through consistently and documents were missing or misfiled. There was evidence of gaps around some aspects. Paper SRAs were not being consistently replicated and there was lack of engagement of staff with patients. Concerns were raised around the documentation such as care plans not held at patients bed and DoLs authorization file expiring.

ACTION: C Evans to review report and policy and raise the weaknesses in record keeping with Executive Nurse Director. Findings to be triangulated with DoLs Limited Assurance report that had been received at an earlier meeting. To go forward to Quality and Safety and Mental Health Committees.

Health & Care Standards – Reasonable Assurance: Good progress had been made in terms of embedding arrangements. There was clear evidence Clinical Boards were actively engaging with process.

Specialist Services – Medical Staff Study Leave – Reasonable Assurance: This had been the third piece of work undertaken on Medical Staff Study Leave where a number of issues needed to be addressed and strengthened. The All Wales policy was out of date and should be renewed to reflect current practices. The User Guide was also out of date. The Annual appraisal revalidation MARs was monitored by the Clinical Directors. Uptake of study leave was low and not all costs had not been claimed within the allocated timeframe, as the forms had been submitted late. There was a need for consultants to take appropriate study leave in order to demonstrate Continued Performance Development (CPD).

Rookwood Relocation - Capital Scheme – Reasonable Assurance: Various aspects of the Capital Scheme were being looked at. Six areas were covered in the report with positive outcomes.

The Committee:
CONSIDERED and **NOTED** the Progress Report

AC: 17/039 LOSES AND SPECIAL PAYMENTS

Mr R Chadwick presented the report, which summarized the meetings of the panel. There were no concerns with content of report.

The Committee:

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

UNCONFIRMED MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON 1 JUNE 2017 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

4.3

Present:

Ivar Grey	Chair - Audit
Maria Battle	Chair UHB
Professor Marcus Longley	Vice Chair UHB
Margaret McLaughlin	Independent Member – Third Sector
Stuart Egan	Independent Member – Trade Union
John Antoniazzi	Independent Member – Business Planning
Susan Elsmore	Independent Member – Local Authority
Abigail Harris	Director of Strategic Planning
Fiona Kinghorn	Interim Director of Public Health Wales
Robert Chadwick	Director of Finance
Ruth Walker	Executive Nurse Director
Sharon Hopkins	Interim Chief Executive
Steve Curry	Interim Chief Operating Officer

In Attendance:

Peter Welsh	Director of Corporate Governance
James John	Head of Internal Audit
Richard Hurton	Assistant Finance Director
Christopher Lewis	Deputy Finance Director
John Herniman	WAO
Mark Jones	WAO
Richard Hurton	Assistant Finance Director
Carol Evans	Assistant Director Patient Safety and Quality
Glynis Mulford	Secretariat

Apologies:

Akmal Hanuk	Independent Member – Local Community
Fiona Jenkins	Director of Therapies
Eileen Brandreth	Independent Member - ICT
Elizabeth Treasure	Independent Member – University
Graham Shortland	Medical Director
Julie Cassley	Interim Director of Workforce and OD
Martyn Waygood	Independent Member – Legal
Craig Greenstock	Counterfraud Manager

AC: 17/044 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting.

AC: 17/045 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 17/046 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

AC: 17/047 COUNTERFRAUD ANNUAL REPORT FOR 2016/17

The Committee **RECEIVED** and **APPROVED** the Counterfraud Annual Report for 2016/17.

AC: 17/048 REPORT ON THE ANNUAL ACCOUNTS OF THE UHB 2016/17

Mr Christopher Lewis, Deputy Finance Director briefed the Committee on the Annual Accounts stating the Report set out the changes made to draft accounts and reviewed the financial performance of the UHB. He also advised Members on the role and responsibilities of the Audit Committee in reviewing the accounts.

The Accountability Report and Annual Accounts were scrutinized and considered at the Audit workshop session on 23 May 2017 where major judgments and estimates were also reviewed and any changes on the accounting policy.

The Committee was informed that there had been four major changes in the report which was explained, emphasizing this did not impact on the financial performance.

There were no significant uncorrected misstatements found in the accounts but Wales Audit Office had observed two less significant misstatements and as these were minor did not warrant inclusion in the Letter of Representation.

With regard to the financial performance against its Revenue Resource Limit, the three year Integrated Medium Term Plan was not approved by Welsh Government. In addition, the UHB did not break even over a three year period and had therefore breached on both counts its statutory financial duty.

On behalf of the Audit Committee the Chair thanked the Financial Team on the preparation of the accounts.

The Committee:

- **NOTED** the reported financial performance contained within the Annual Account and that the UHB has breached its statutory financial duties in respect of revenue expenditure.

- **NOTED** the changes made to the Draft Annual Accounts.

AC: 17/049 WALES AUDIT OFFICE (WAO) ISA 260 REPORT
John Herniman, Wales Audit Office presented the WAO report praising the team for the work done on the accounts stating there were no significant issues.

The Committee was informed that the accounts were true and fair and an unqualified audit opinion would be issued. In relation to the regularity opinion it was explained that this was the first year of the three year cycle the UHB was being assessed against the target. Due to the deficit a qualified opinion on regularity will be issued. Because of this qualification and failure to achieve the two targets, the Wales Audit Office will issue a substantive report on the account which summarizes the position.

The following points were highlighted:

- In regard to accuracy of numbers this was materially correct and stated anything raised which was significant had been addressed. Attention was drawn to the two less significant statements and explained that further testing showed this was not indicative of any systematic errors.
- In consideration of end of year pressure and complexity of the accounts, work on these would be brought forward earlier on in the year.
- Mr Herniman raised concerns in regard to the Public Sector Payment Policy, stating invoices in dispute were not managed correctly although it was acknowledged that the Oracle system did not allow for the recording of the 30 day clock for payment. Members were informed this could mean the Health Board's performance could be misstated.
- One significant matter was raised in 2015/16 in relation to procurement of a consultant contract and plan to issue a report shortly. An update will be presented at Audit Committee.
- Six recommendations had been raised from the financial audit work which had been agreed with management. These will go on to the Audit Committee Tracker.
- In regard to the Representation Letter there were no disclosures to report that would raise concern.

The Committee:
RECEIVED and **NOTED** the report

AC: 17/050 HEAD OF INTERNAL AUDIT ANNUAL REPORT FOR 2016/17

Mr James Johns, Head of Internal Audit, gave an overview of the report, stating the report delivered and summarised key outcomes of audit reviews around the assurance domains. The overall opinion gave Reasonable Assurance which was a positive outcome for the Organisation. The report considered individual audits,

how they feature in each domain and how they are structured. The sub opinion of each domain had also received Reasonable Assurance.

The Committee was pleased to note No Assurance reports had been received. Four Limited Assurance reports had been observed, all of which were being addressed and showed signs of improvement.

The Committee:

- **RECEIVED** and **NOTED** the report

AC: 17/051 LETTER OF REPRESENTATION

It was recognized that the Letter of Representation was consistent with the report.

The Committee **RECEIVED** and **NOTED** the Letter of Representation

AC: 17/052 AUDIT ENQUIRIES TO MANAGEMENT AND THOSE CHARGED WITH GOVERNANCE

The Committee **RECEIVED** and **NOTED** the letter and responses in the questionnaire.

AC: 17/053 ACCOUNTABILITY REPORT

Mr Peter Welsh, Director of Corporate Governance stated the report was a new approach with guidance from Welsh Government to streamline all the annual reports, explaining the changes.

Members were assured of the rigorous processes the report had been through and informed the Committee that over the next few weeks the Annual Report would be produced. The Annual Report will be combined with the Accountability Report and Annual Quality Statement. These reports will go forward as one document to the Annual General Meeting on 27 July 2017.

AC: 17/054 PRIVATE MEETINGS WITH THE DIRECTOR OF FINANCE, WALES AUDIT OFFICE AND INTERNAL AUDIT

The chair informed the meeting that Independent Members had met privately with the Director of Finance on 23 May, the Head of Internal Audit also on 23 May and the Wales Audit Office on 1 June. He confirmed that no issues had been raised that should be brought to the Committee's attention.

The Audit Committee, based on the reports received during the meeting, recommended that the Board:

APPROVE the Annual accounts for the twelve months ended 31 March 2017
APPROVE the Annual Accountability Report
APPROVE the Representation letter and
AUTHORISE the Chair, Chief Executive and Director of Finance to sign them where required once WAO had completed their work

The Audit Committee also **APPROVED** the Committee's Annual report to the Board and authorized the Chair to sign and present it to the Board.

AC: 17/055 URGENT BUSINESS

There was no urgent business.

AC: 17/056 DATE OF NEXT MEETING

The next Audit Committee meeting is scheduled to take place at 9.00am on **Tuesday 26 September 2017,** in the Corporate Meeting Room, Headquarters, UHW.

AUDIT COMMITTEE – ACTION LOG FOLLOWING APRIL AND MAY 2017 MEETING

Minute	Date of Meeting	Subject	Agreed Action	Action to	Status	
					Outstanding	Date for Completion
AC 17/025	23.05.17	Internal Report – Continuing Healthcare	Recommendation 8 to be reworded	S Curry		
AC 17/025	23.05.17	Internal Report – Medicine Clinical Board Specialling	To review report and policy and raise the weaknesses in record keeping with Executive Nurse Director. Findings to be triangulated with DOLs Limited Assurance report received at earlier meeting. To go forward to QSE and MHCL Committees	C Evans C Evans	Raised with Executive Nurse Director Raised with Medical Director QSE Considered action operational and removed from agenda	**COMPLETE**
AC 17/007	24.04.17	Llanishen Stores Follow-up	To enquire whether the Local Authority will be putting an IT system in West Point	J John	Confirmation received that system will be rolled out across both areas.	**COMPLETE**
AC 17/007	24.04.17	Medical Locum Follow-up	To bring back to Committee showing detailed follow-up date in Management Response	J John	The updating of the SLA is still to be completed and similarly the policy is again still to be completed. Firm timelines were unavailable.	To be subject to further follow up through IA's follow up process.
AC	24.04.17	Mental Health Clinical	To make enquiries with Director of	C Evans		

5

17/007		Board Out of Area	Nursing for PCIC in regards to Care Plans and patient reviews whether this had an impact on patient safety.			
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS						
AC 16/093	28.02.17	Internal Audit Position Report and Tracking Report	Medicines Cost Reduction – to continue conversation with pharmacy in relation to high value drugs	C Evans	Have discussed with Director of Medicines Management. Wastage of high value drugs is monitored, but it would be too onerous to put in place a system to monitor trends and themes	
AC 16/102	28.02.17	Clinical Audit Programme	Report requested to be submitted to Committee	Secretariat	To be reported at **September 2017** meeting	
AC 16/076	15.11.16	WAO Progress Against Plan	Resources in Corporate Governance Team to be raised at Board	I Grey	Resource allocation being reviewed by Management Executive. No action until outcome is known. To be raised at Governance Coordinating Group	
AC 15/008	24.02.15	Business Continuity Planning	Provider a follow up report in September 2015	J Johns	The follow up has been put back to the	

5

	8.12.15				17/18 plan at the request of the Executive Director	
COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)						
AC 16/094	28.02.17	WAO Structured Assessment – Consultant Contract	To liaise with P Welsh as action plan not complete	A Beegan		**COMPLETE**
AC 17/025	23.05.17	Internal Report – IT System – Trauma and Orthopaedics Bluespier	Report to go forward to IM&TSC	I Grey	**COMPLETE** On agenda for September meeting	
AC 17/007	24.04.17	Internal Audit Position Report and Tracking Report	To meet and discuss outstanding audits	P Welsh and J Johns	**COMPLETE**	
AC 16/017	12.04.16 15.11.16	DoLS	DoLS – Limited Assurance: The Medical Director to talk with Chair of MHCLC about risk management in relation to documentation and issues around culture and change in legislation	G Shortland	Action plan progressing however some key action e.g. around culture are taking longer to be delivered. It had been required that the IA will follow-up and be deferred until 17/18 plan to allow these actions to be delivered. As some of the actions were delayed, assurance was required that legal requirements were being met and	**COMPLETE** Item raised and risk reported through each MHCLC meeting

5

					patients were being looked after properly.	

INTERNAL AUDIT	
Audit Committee	**September 2017**

Executive Lead : Executive Director of Finance & Director of Corporate Governance
Author : Head of Internal Audit, NWSSP Audit & Assurance Service, UHW 42724
Caring for People, Keeping People Well :
Financial impact : n/a
Quality, Safety, Patient Experience impact : n/a
Health and Care Standard Number - ALL **CRAF Reference Number ALL**
Equality Impact Assessment Completed: n/a

8

RECOMMENDATION

The Audit Committee is asked to:

CONSIDER the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports and updates to the audit plan.

SITUATION

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

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

BACKGROUND

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

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

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

The report highlights some delays with the delivery of the audit plan during the current year and the reasons behind the delays.

The progress report highlights the conclusion and assurance ratings for audits finalised in that period. Reports that are given substantial or reasonable assurance are summarised in the progress report with the reports given. Nine report summaries are included within the progress report. The reports that have been allocated ratings have been assigned Reasonable or Substantial Assurance. One review due to is nature was not allocated a rating.

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

A revised follow up report has been prepared for the Committee is included at Appendix B.

ASSESSMENT AND ASSURANCE

The progress report provides the Committee with the level of assurance given to the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan, along with information regarding the necessary actions required to address control weakness identified. The report also sets progress with the delivery of the Internal Audit plan.

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee September 2017

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

8

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 Cwm Taf University Local 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

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

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

1.3 The plan for 2017/18 was agreed by the Audit Committee in April 2017 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

8

2. OUTCOMES FROM COMPLETED AUDIT REVIEWS

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

2.2 The first table includes the four reviews that weren't finalised in time for the prior year annual report. One of these reviews as marked in the table will form part of the 17/18 annual report and opinion. The second table includes finalised reviews from the 2017/18 annual plan.

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

AUDIT ASSIGNMENT (16/17)	ASSURANCE RATING	
Records Management Follow up	Reasonable	
Statutory Compliance (17/18 opinion)	Reasonable	
Medicine Clinical Board – Sickness and Rotas	Reasonable	
Specialist Clinical Board Private Patients	n/a	

AUDIT ASSIGNMENT (2017/18)	ASSURANCE RATING	
Annual Quality Statement	Substantial	
Charitable Funds	Substantial	
Environmental Sustainability Reporting	Reasonable	
Mental Health Clinical Board	Reasonable	
Quality & Safety Governance Follow up	n/a *	

*- Each of the previous eight Clinical Board reports were followed up. This report updates the status of each individual rating.

8

3. DELIVERY OF INTERNAL AUDIT PLAN

3.1 The four audits that were not finalised at the time of writing the previous year's annual report and opinion have now been finalised and are included in this report. One of those audits, Statutory Compliance, will be included in the 2017/18 opinion as it was not sufficiently completed to include in the previous opinion.

3.2 Five audits have been finalised to date against the 17/18 audit plan, with another twelve either at work in progress or draft report stage.

3.3 There have however been a number of audits where progress has been slower than planned or delayed for several reasons. The reasons include; time taken to obtain sign-off for the audit brief, queries regarding the appropriateness of assigned executive leads, time to get meetings with key staff through the UHB and subsequently obtaining information. One review has been delayed through the absence of Internal Audit staff.

3.4 The UHB have requested that two reviews; Cyber Security and Board Working are postponed, as other work is ongoing within the organisation or at an all Wales level. As a result the UHB will not be able to take any assurance from Internal Audit on either of these two areas during this year. The Committee is asked to acknowledge these two key postponements.

3.5 Time has been set aside within the plan to be utilised for work at discretion of the Chief Executive. The detail of the scope of this work

is still to be agreed, but will initially focus on issues raised in a recent external audit report and then other areas of work to be agreed.

3.6 The Audit Committee Chairman has requested that the review of Business Continuity is brought forward in order that it can be presented to the December Audit Committee

3.7 The details of the current year's audit plan along with progress with delivery and commentary against individual assignments regarding their status is included at Appendix A.

3.8 As part of ongoing planning and engagement with the Health Board, Internal Audit has had a series of meetings including with the Executive Director of Finance, Director of Corporate Governance, Audit Committee Chairman and Chief Executive. Other Executive Directors have been met with in relation to specific audit assignments.

3.9 FOLLOW UP PROCESS

The Internal Audit follow up process has been revised and a change to committee reporting had been made. The follow up report has been included at Appendix B giving details of assignments recently followed up and also a schedule of the status of current assignment follow ups.

4. FINAL REPORT SUMMARIES

4.1 Records Management Follow up

The follow up review of Records Management was completed in line with the Internal Audit Plan. The review sought to provide the Health Board with assurance that agreed actions from the previous review of Records Management have been implemented appropriately.

The initial Internal Audit report was finalised in May 2015 and highlighted a total of eight issues which resulted in an overall assurance rating of Limited Assurance.

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

8

Priority Rating	No of Management Responses to be implemented	Fully Actioned	Partially Actioned	Not Actioned
HIGH	4	-	4	
MEDIUM	4	3	1	
LOW	-	-	-	
TOTAL	**8**	**3**	**5**	

The follow up review concluded that based upon discussions with relevant management, review of the evidence provided and the results of re-testing where appropriate, there has been reasonable progress. There are a number of agreed management actions that need to be further progressed in order to fully address the original control weaknesses identified.

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

The updated Records Management Policy strengthens the strategic framework for records management and the Records Management Procedure broadly satisfies the need for guidance at an operational level. The audit notes that whilst these improvements have been made, there still remains some work to ensure implementation across the Health Board.

4.2 Statutory Compliance (Estates)

The audit was undertaken to evaluate the processes and procedures put in place by the University Health Board (UHB) to support the progression of the Estates statutory compliance programme.

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

RATING	INDICATOR	DEFINITION
Substantial	 GREEN	**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 concluded that three of the individual areas covered, Governance, Strategy and Resources has good systems in place gaining Substantial Assurance, with the forth area covered Implementation, gained reasonable assurance.

4.3 Medicine Clinical Board

The review of the management of Medical rotas and sickness within the Medicine Clinical Board was completed in line with the Internal Audit Plan.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with staffing 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 arrangements in place for developing rotas ensure that these are developed in advance with sufficient consideration of the required skill mix and that all medical staff work their contracted hours. Usage of locums in both directorates is appropriate and documented with the reason for using them stated. Rotas for staff are appropriate and ensure that Medical staff are working their contracted hours.

Processes for sickness management are in place, however not all are sufficient to ensure compliance with the Sickness Policy. Documentation was not available for some episodes of sickness, and self certification forms were not available for any of the episodes of sickness tested within Internal Medicine.

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4.4 Specialist Services Clinical Board - Private Patients Payments.

The review of the payments made to Cardiothoracic Registrars for private work was agreed as an additional internal audit. This was being undertaken due to anomalies in payments identified by the service.

Cardiothoracic Services undertake private work with patients being billed by the UHB for use of its facilities and staff, and separate billing in place for consultant time. It was recently identified that registrars have been paid for private work by both the UHB and the Consultant, which may indicate that duplicate payments have been made to them.

A second phase of Internal Audit work was required after feeding back the initial findings to management, where subsequent information was made available.

As a result of the two phases of audit work, Internal Audit concludes that payments were made twice to a number of registrars due to a breakdown of the governance process within the Directorate as the apparent decision made to change the payment process was not properly communicated to relevant staff involved.

The Clinical Board highlighted that they had subsequently been informed by the Clinical Director that he decided to make the change to the system as to how the registrars were paid, so all staff undertaking additional activity were paid by the UHB. However there was no physical evidence to substantiate this. As a result the Clinical Board now considered that the payments made by the UHB were appropriate; however they acknowledge that payments may have been made direct to the registrars by the consultants for this activity as well.

In addition, further weakness in the systems around the absence of procedures, the lack of clarity within the forms being used for the claims and also the fact that the same terminology is used on staff payslips for different types of additional activity payments, contributed to these issues occurring and also the difficulty in identifying that this had occurred.

A series of recommendations have been made below to strengthen the weakness that existed in systems to cover payments to staff for additional activity, to document this fully in a procedure and to inform staff involved that they would have received payments in a private capacity for activity they would have also been paid for by the UHB.

4.5 Annual Quality Statement

The review of the Annual Quality Statement (AQS) produced by Cardiff and Vale University Health Board (UHB) has been completed in line with the Internal Audit Plan.
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Annual Quality Statement 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 UHB has good processes in place to produce an Annual Quality Statement that largely complies with Welsh Government guidance and fairly represents the organisations position and performance in the

previous year. Our review has also noted that the linking of the AQS to the UHB's new Quality, Safety and Improvement Framework embeds the process into day-to-day activities rather than being stand alone at the end of the year.

Furthermore the statement is presented in a clear and user friendly format that should be easily understood by its audience.

4.6 Charitable Funds

The review of Charitable Funds was completed in line with the 2017/18 Internal Audit plan for Cardiff and Vale University Health Board.

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

8

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

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

The controls in place to manage the risks associated with charitable funds are of a substantial standard. The review noted good practice within all the areas covered, particularly; strong governance arrangements within the charitable funds committee and also the charitable funds bids panel. Accompanying this was a good standard of record keeping to support the income and expenditure audit trail.

However, the review did identify issues relating to the management of dormant accounts and one instance was identified of inappropriate expenditure. The majority of these issues have been raised within previous years reports.

There were no high priority findings noted within this report.

4.7 Environmental Sustainability Report

The review of the Sustainability Reporting process within Cardiff and Vale University Health Board (UHB) has been completed in line with the Internal Audit Plan.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Sustainability Reporting 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 audit identified that the UHBs Sustainability Report for 2016/17 complies with the required format set out in the Welsh Government guidance. The figures and narrative within the report represent a fair picture of the UHBs position.

The audit notes a considerable improvement in the quality of the draft report provided for audit in comparison to the prior year.

It has also been recognised that the development of data capturing has allowed the Health board to move away from estimating the figures required, to using actuals and therefore enhancing the reliability of the performance data reported.

Whilst the process for preparing the report has advanced, there are some further actions identified that, when implemented, will lead to a more robust procedure.

4.8 Quality & Safety Governance Follow up

The follow up review of Quality & Safety Governance was completed in line with the Internal Audit Plan. The review sought to provide the Health Board with assurance that agreed actions from the previous reviews of

each of the Clinical Boards on Quality & Safety Governance have been implemented appropriately. Eight individual reports with separate rating were issues ion the previous year.

In summary, progress against the 41 actions contained in the management responses that required implementation was as follows;

Clinical Board / Original Rating	Priority Rating	No of Actions	Fully Actioned	Partially Actioned	Not Actioned	Revised Assurance Rating
Medicine 	**HIGH**	0	0	0	0	
	MEDIUM	4	0	4	0	
	LOW	1	1	0	0	
Surgery 	**HIGH**	0	0	0	0	
	MEDIUM	5	2	2	1	
	LOW	1	0	1	0	
SPS 	**HIGH**	0	0	0	0	
	MEDIUM	5	3	2	0	
	LOW	0	0	0	0	
CD&T 	**HIGH**	0	0	0	0	
	MEDIUM	3	2	1	0	
	LOW	2	2	0	0	
C&W 	**HIGH**	0	0	0	0	
	MEDIUM	3	1	2	0	
	LOW	3	2	0	1	
MH 	**HIGH**	0	0	0	0	
	MEDIUM	4	2	2	0	
	LOW	1	0	0	1	
PCIC 	**HIGH**	0	0	0	0	
	MEDIUM	1	0	1	0	
	LOW	3	0	2	1	
Dental 	**HIGH**	1	0	0	1	
	MEDIUM	4	0	4	0	
	LOW	0	0	0	0	
TOTAL		**41**	**15**	**21**	**5**	

The follow up review concluded that based upon discussions with relevant management and review of the evidence provided, a reasonable level of progress has been made across the Health Board. There are however a number of agreed management actions that need to be further progressed in order to fully address the original control weaknesses identified.

On the basis of this follow up, the level of assurance that could be given as to the effectiveness of the system of internal control in place to manage the risks associated with Quality & Safety Governance has improved overall. The CD&T, Children & Women and PCIC Clinical Boards all remain at Substantial Assurance. The Specialist Services Clinical Board has increased their assurance rating from Reasonable to Substantial

Assurance. The Medicine, Surgery, Mental Health and Dental Clinical Boards all remain as Reasonable Assurance.

It should be noted that although there are 21 management actions that were only partially actioned at the time of the review, they all had medium or low priority ratings in the original reports. Whilst some of these actions only require a small amount of additional work to be fully complete, there are others that need more significant development.

4.9 Mental Health Clinical Board – Sickness Management & Rostering

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

8

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 Clinical Board has appropriate processes in place to ensure effective and consistent rostering is undertaken. Guidance has been produced for the Adult Mental Health Directorate and a more comprehensive procedure produced for the Older Adults Mental Health Directorate. It was evident that the rosters are being produced in advance and are forwarded to the Clinical Roster Coordinator along with the Bank requests.

Bank and Agency nurses are appropriately utilised where required and the shifts are verified and approved on the Rosterpro system. Testing did however identify that timesheets were not always available on the sampled wards to confirm the verification and approval of the hours worked.

Breaks should be taken by Nursing staff for any shifts that are longer than 6 hours. However, it was identified for some of the early and late shifts

that staff members are working and being paid for the full 7½ hour shift without taking a break.

The Audit did identify a number of more significant issues with the management of sickness absence within the Mental Health Clinical Board. The All Wales Sickness Policy was not being fully complied with on any of the four sampled wards. There were instances where sickness documentation had not been completed as required and there were delays in carrying out Return to Work interviews. Issues were also identified around the monitoring of sickness triggers, the completion of required interviews and the management of long term sickness.

Assignment Status Schedule Appendix A

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Committee
Corporate governance, risk and regulatory compliance							
Health and Care Standards	Director Nursing	Q2-Q4	Q2-Q4	Updated approach from 17/18 to monitor on a more ongoing basis through the year.	Planning.		April
Claims Reimbursement	Director Nursing	Q3/4	Q3	Review re WRP claims standard.	Planning		Dec
Board Working	Corporate Governance	Q2-3	n/a	n/a	Review deferred following discussions with DoF and CEO.		N/A
Annual Governance Statement	Corporate Governance	Q4	Q4	To review the content of the Statement.	Reported in annual report	n/a	Annual report
Governance, Leadership & Accountability Assessment	Corporate Governance	Q4	Q4	To review the process that has been adopted and evidence supporting the self-assessment.	Reported in annual report	n/a	Annual report

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Committee
Strategic planning performance management and reporting							
Business Continuity Planning Follow up	Director of Planning	Q4	Q2/3	Re Audit including follow up of agreed actions form previous Limited assurance report.	To be brought forward as per directive from Audit Committee Chairman.		Dec
Research & Development	Medical Director	Q1-2	Q2	Review controls in place to manage key risk areas within the process.	Fieldwork ongoing. Progress affected by delays on other reviews.		Dec
Wellbeing Objectives	Director of Public Health	Q3/4	Q3	Review process for setting, delivering and monitoring objectives.	Planned to commence Q3		Feb
Strategic Planning/IMTP	Director of Planning	Q4	Q4	Review on going delivery and monitoring of the plans.	Planned to commence Q4		April
Continuing Health Care	COO	Q3	Q3	Follow up from previous report.	To commence Q3		Feb

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Committee
Financial Governance and management							
UHB Core Financial Systems	Director of Finance	Q3/4		Review a selection controls in place to manage key risk areas across the range of the main financial systems.	To Commence Q3		Feb
Charitable Funds	Director of Finance	Q1-2	Q1-2	Review governance arrangements, including the management of expenditure and donations.	***Final Report***. *Substantial Assurance.*		Sept
Cost Improvement Programme	Director of Finance	Q3	Q3	Review the development and delivery of the improvement plans.	Draft brief prepared. Scope to be agreed		Feb
Costing	Director of Finance	Q3	Q3	Scope as per work agreed at all wales costing group.	Assignment Brief agreed. Finance requested fieldwork End Oct/ Nov.		Feb

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Committee
Clinical governance quality & safety							
Annual Quality Statement	**Director Nursing**	**Q1**	**Q1**	**Review content of AQS.**	**FINAL Aug.**		**Sept**
DOLS	Medical director	Q3-4	Q3/4	Follow up of agreed actions form previous Limited assurance report	To commence as per plan.		April
Serious Incidents Management	Nursing	Q2/3	Q2	Review Incident Closures	Fieldwork in progress.		Dec
Mortality Reviews	Medical	Q1-2	Q3	Review Process and actions taken.	Planning – brief prepared. Start delayed. Medical Director requested end of October for fieldwork.		Feb
Q&S Governance follow up	**Nursing**	**Q1-2**	**Q1-2**	**Follow up of each of the eight report from 16/17.**	**Final Report. Individual ratings updated for each Clinical Board. Reasonable or above.**	**As per report.**	**Sept.**

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Committee
Information Governance and Security							
IT Strategy	Director of Therapies	Q2	Q2/3	Strategic MTED deployment	WP		Feb
Virtulisation	Director of Therapies	Q3	Q3	Review the security and resilience of the updated virtualised environment.	Planning stage		April
Cyber Security	Director of Therapies	Q2/3	n/a		Review deferred at request of UHB.		n/a.
IT System	Director of Therapies	Q3/4	Q3	Welsh Patient Referral System	wip		Feb
Operational service and functional management							
Clinical Board - Medicine	COO	Q1-2	Q2/3	PADRS and Mandatory training	Delay in brief sign off. COO wanted further discussion regarding sign off of brief and appropriateness of exec lead. Work commenced late august.		Dec
Clinical Board - Surgery	COO	Q1-2		Anesthetists Rotas (initially to include staff	Delays in progress.		Dec

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Committee
				management as well)	Change of scope, work will now only cover anaesthetists' rotas as per discussions with COO.		
Clinical Board – Mental Health	**COO**	**Q1-2**		**PADRS and Rotas.**	**FINAL Report**		**Sept**
Clinical Board - C&W	COO	Q2		Medical Staff Study Leave.	*Delays with field work and scope reduced as unable to obtain information. Query over Exec lead. Work has now been completed. Draft report prepared for discussion.*		Dec
Accommodation/ Residences		Q1-2	Q3	Review arrangements in place for the management of residences.	Request to defer work to Q3 as new systems in place. Brief prepared.		Feb
WLI follow up	COO	Q2-3	Q3	Follow up on 16/17 report.	First part of Fieldwork in progress.		Feb
Neuroscience IT system follow up	COO	Q2-3		Follow up on 16/17 report.	Fieldwork in progress.		Dec
Stock control in localities follow up	COO	Q1	Q2/3	Follow up on 16/17 report.	Fieldwork in progress. Delay with IA.		Dec

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Committee
CD&T Additional Payments follow up	COO	Q2	Q2/3	Follow up on 16/17 work and briefing	Planned for commencement.		Dec
Specialist Services Private Patients	COO	Q2/3	TBA	Follow up on 16/17 work and briefing	Additional work required, prior to finalising old 16/17 report		n/a
PCIC incident management (rolled forward at request by PCIC)	COO	Q3/4	Q3/4	Review process for managing incident that cut across other areas.	To commence as per plan.		April
Workforce management							
Consultant Job Planning	Medical Director.	Q2-3	Q2-3	Review controls in place to manage key risk areas within the process.	Brief agreed. Planned for commencement. October / Nov		Feb
Nurse Revalidation	Nursing	Q2-3	Q2-3	Review controls in place to manage key risk areas within the process.	Fieldwork in progress		December
Organisational Values	Director of Workforce & OD.	Q3/4	Q3/4	Review controls in place to manage key risk areas within the process.	To commence Q3. Brief to be agreed.		April

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Committee
Capital and Estates							
Sustainability Reporting	Director of Planning	Q1-2	Q1-2	To provide an opinion that robust systems are in place to record and report minimum sustainability requirements as required by WG.	Final report Reasonable assurance. .		September
Model Ward	Director of Planning	Q1-2	Q3	Review arrangements following trial three month period	Brief agreed. Field work October/ November		February
Cleaning Standards	Director of Planning	Q1-2	Q2	Review current Service Provision.	Field work completed. Draft report being prepared.		December
Commercial Outlets	*Director of Planning*	*Q1-2*	*Q4*	Review arrangements for commercial outlets (inc. Aroma and spar UHL)	*Requested that work delayed until Q4 as internal work ongoing. Brief prepared.*		*April*
Carbon Reduction Commitment	Director of Planning	Q2/3		To ensure the Health Board complies with the requirements of the Order and that the information held is accurate, complete and the purchase of the	Draft report issued 7/9/17		December

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Committee
				credits is based upon actual usage or informed estimates.			
Neo Natal	Director of Planning	Q2/3		To review key aspects of the schemes	Planning. Field work September/October.		December
Rookwood Relocation	Director of Planning	Q2/3		To review key aspects of the schemes	planning		February
Shaping Future Wellbeing Schemes	Director of Planning	Q2/3		To review key aspects of the early part of a scheme.	planning		April

APPENDIX B

Follow-up Summary Report

1. Introduction

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

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

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

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

2. Summary of Findings

The current follow-up position for each of the individual reports that have been finalised since April 2016 is summarised within Appendix A below.

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

CUHB1718.01 - Risk Assurance

Finalised September 2016 with a rating of **Substantial** assurance. All agreed actions were planned to be implemented by November 2016.

As at 29/08/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	0	-	-	-
MEDIUM	0	-	-	-
LOW	2	1	-	1
TOTAL	**2**	**1**	**-**	**1**

An updated deadline of April 2018 has been given for the outstanding action.

CUHB17.03 - Policy Management

The report was finalised in September 2016 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by February 2017.

As at 30/08/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	1	1	-	-
MEDIUM	3	3	-	-
LOW	2	2	-	-
TOTAL	**6**	**6**	**-**	**-**

CUHB1617.06 - Public Health Targets- Obesity

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

As at 29/08/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	0	-	-	-
MEDIUM	3	1	-	2
LOW	0	-	-	-
TOTAL	**3**	**1**	**-**	**2**

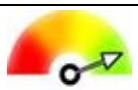
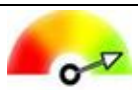
An updated deadline of February 2018 has been provided for completion of the 2 outstanding actions.

CUHB1617.17-22 – Quality & Safety Governance

As part of the 2016/17 Internal Audit Plan, reviews were completed looking at Quality & Safety Governance across each of the Clinical Boards. The 8 separate reports were finalised between June and September 2016 with a total of 41 issues highlighted.

The individual reports were all followed up during July 2017 and the detail of the progress made was recorded within a combined follow-up report that is included as a separate agenda item.

A summary of the current position for each Clinical Board is included within Table 1 below.

Clinical Board / Original Rating	Priority Rating	No of Actions	Fully Actioned	Partially Actioned	Not Actioned	Revised Assurance Rating
Medicine 	**HIGH**	0	0	0	0	
	MEDIUM	4	0	4	0	
	LOW	1	1	0	0	
Surgery 	**HIGH**	0	0	0	0	
	MEDIUM	5	2	2	1	
	LOW	1	0	1	0	
SPS 	**HIGH**	0	0	0	0	
	MEDIUM	5	3	2	0	
	LOW	0	0	0	0	
CD&T 	**HIGH**	0	0	0	0	
	MEDIUM	3	2	1	0	
	LOW	2	2	0	0	
C&W 	**HIGH**	0	0	0	0	
	MEDIUM	3	1	2	0	
	LOW	3	2	0	1	
MH 	**HIGH**	0	0	0	0	
	MEDIUM	4	2	2	0	
	LOW	1	0	0	1	
PCIC 	**HIGH**	0	0	0	0	
	MEDIUM	1	0	1	0	
	LOW	3	0	2	1	
Dental 	**HIGH**	1	0	0	1	
	MEDIUM	4	0	4	0	
	LOW	0	0	0	0	
TOTAL		**41**	**15**	**21**	**5**	

8

CUHB1617.29 – Children & Women's CB Staffing

The report was finalised February 2017 with a rating of **Reasonable** assurance. All agreed actions were planned to be implemented by March 2017.

As at 30/08/2017 the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	2	2	-	-
MEDIUM	1	1	-	-
LOW	0	-	-	-
TOTAL	3	3	**-**	-

Follow ups in progress

In addition to the completed follow-ups detailed above, a further 10 follow-up schedules have been issued to date. Responses have been received for 4 and these are currently being reviewed. Responses are also being pursued for remaining 6 follow-ups due.

Follow-up Summary Report

Table 1 – Follow-up position

Assignment Reference	Title	Assurance Rating	Final Report Issue Date	Proposed Follow Up Date	Follow Up Schedule Issued	Follow Up Completed	Total No. of Recs	No. of Recs Actioned	No. of Recs Partially actioned	No. of Recs Not Actioned
CUHB1617.01	Risk Assurance	Reasonable	Sep-16	Dec-16	18/08/2017	Sep-17	2	2	0	1
CUHB1617.03	Policy Management	Reasonable	Sep-16	Feb-17	18/08/2017	Sep-17	6	6	0	0
CUHB1617.04	Health & Care Standards	Reasonable	Sep-16	n/a			0			
CUHB1617.05	WRP Claims Reimbursement	Substantial	Feb-17	n/a			0			
CUHB1617.06	Public Health Targets - Obesity	Reasonable	Feb-17	Jun-17	23/08/17	Sep-17	3	1	0	2
CUHB1617.08	Patient Access	Substantial	May-17	Aug-17	05/09/17		3			
CUHB1617.09	Core Financials	Substantial	Apr-17	n/a			6			
CUHB1617.11	Waiting List Initiatives	Limited	May-17	Sep-17			11			
CUHB1617.12	Annual Quality Statement	Substantial	Oct-17	May-17	n/a	Yes	3	3	0	0
CUHB1617.13	Clinical Audit Follow up	Reasonable	Mar-17	n/a						
CUHB1617.15	Quality Governance - surgery	Reasonable	Sep-16	Jan-17	n/a	Aug-17	6	2	3	1
CUHB1617.16	Quality Governance - medicine	Reasonable	Sep-16	Jan-17	n/a	Aug-17	5	1	4	0
CUHB1617.17	Quality Goverance – c&w	Substantial	Sep-16	Jan-17	n/a	Aug-17	6	3	2	1
CUHB1617.18	Quality Governance - pcic	Substantial	Jul-16	Jan-17	n/a	Aug-17	4	0	3	1
CUHB1617.19	Quality Governance - mental health	Reasonable	Aug-16	Jan-17	n/a	Aug-17	6	2	2	1
CUHB1617.20	Quality Goverance - cdt	Substantial	Jul-16	Jan-17	n/a	Aug-17	5	4	1	0
CUHB1617.21	Quality Governance - sps	Reasonable	Sep-16	Jan-17	n/a	Aug-17	5	3	2	0
CUHB1617.22	Quality Goverance - dental	Reasonable	Jun-16	Jan-17	n/a	Aug-17	5	0	4	1
CUHB1617.24	Records Management Follow up	Reasonable	Jul-17	n/a			5			
CUHB1617.25	Blue Spier IT System	Reasonable	Apr-17	Jul-17	22/08/17		6			
CUHB1617.27	Surgery CB Med Staff Study Leave	Reasonable	Feb-17	Jun-17	24/08/17		7			
CUHB1617.29	Children & Women CB - Staffing	Reasonable	Feb-17	Jun-17	24/08/17	Sep-17	3	3	0	0

Follow-up Summary Report

Table 1 – Follow-up position

Assignment Reference	Title	Assurance Rating	Final Report Issue Date	Proposed Follow Up Date	Follow Up Schedule Issued	Follow Up Completed	Total No. of Recs	No. of Recs Actioned	No. of Recs Partially actioned	No. of Recs Not Actioned
CUHB1617.32	CD&T CB - Radiology Treat-In-Turn	Substantial	Apr-17	Aug-17	29/08/17		1			
CUHB1617.33	SPS CB - Patientcare IT System	Limited	Apr-17	Sep-17			8			
CUHB1617.34	Dental CB - Medicines Management	Reasonable	Apr-17	Jul-17	25/08/17		3			
CUHB1617.35	Cardiff Community Resource Team	Substantial	May-17	Sep-17			5			
CUHB1617.36	Med Locums / MEDACS Follow up	Reasonable	Apr-17	n/a			4			
CUHB1617.37	Leavers Management Follow up	Reasonable	Apr-17	n/a			2			
CUHB1617.38	Sustainability Report	Reasonable	Sep-17	May-17			7	5	2	0
CUHB1617.39	Safeguarding Children	Reasonable	Jan-17	Jul-17			5			
CUHB1617.40	PCIC CB - Locality Stock	Limited	Feb-17	Jul-17			8			
CUHB1617.41	Mental Health CB - Information Gov	Reasonable	May-17	Jul-17	25/08/17		3			
CUHB1617.42	CD&T CB - Information Governance	Substantial	May-17	Jan-18			3			
CUHB1617.43	Dental CB - Medical Devices	Reasonable	Jan-17	Aug-17	05/09/17		5			
CUHB1617.44	Estates Timesheets Follow up	Reasonable	Dec-16	n/a			6			
CUHB1617.45	Operational Services Rotas	Reasonable	Jan-17	Jul-17	29/08/17		4			
CUHB1617.46	Continuing Health Care (CHC)	Limited	May-17	Nov-17			8			
CUHB1617.47	IMTP	Reasonable	May-17	Jan-18			8			
CUHB1617.48	Medicine CB Specialling	Reasonable	May-17	Aug-17	05/09/17		8			
CUHB1617.49	Medicine CB - Med Rotas & Sickness	Reasonable	Sep-17	Dec-18			3			
CUHB1617.51	Theatres Stock Follow up	Reasonable	May-17	n/a			4			
CUHB1617.52	MH CB - CHC / Out of Area Patients	Reasonable	Apr-17	Aug-17	29/08/17		4			
CUHB1617.54	Llanishen Stores Follow up	Reasonable		n/a						
CUHB1617.56	Health & Care Standards	Reasonable	May-17	n/a						

Follow-up Summary Report

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

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WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

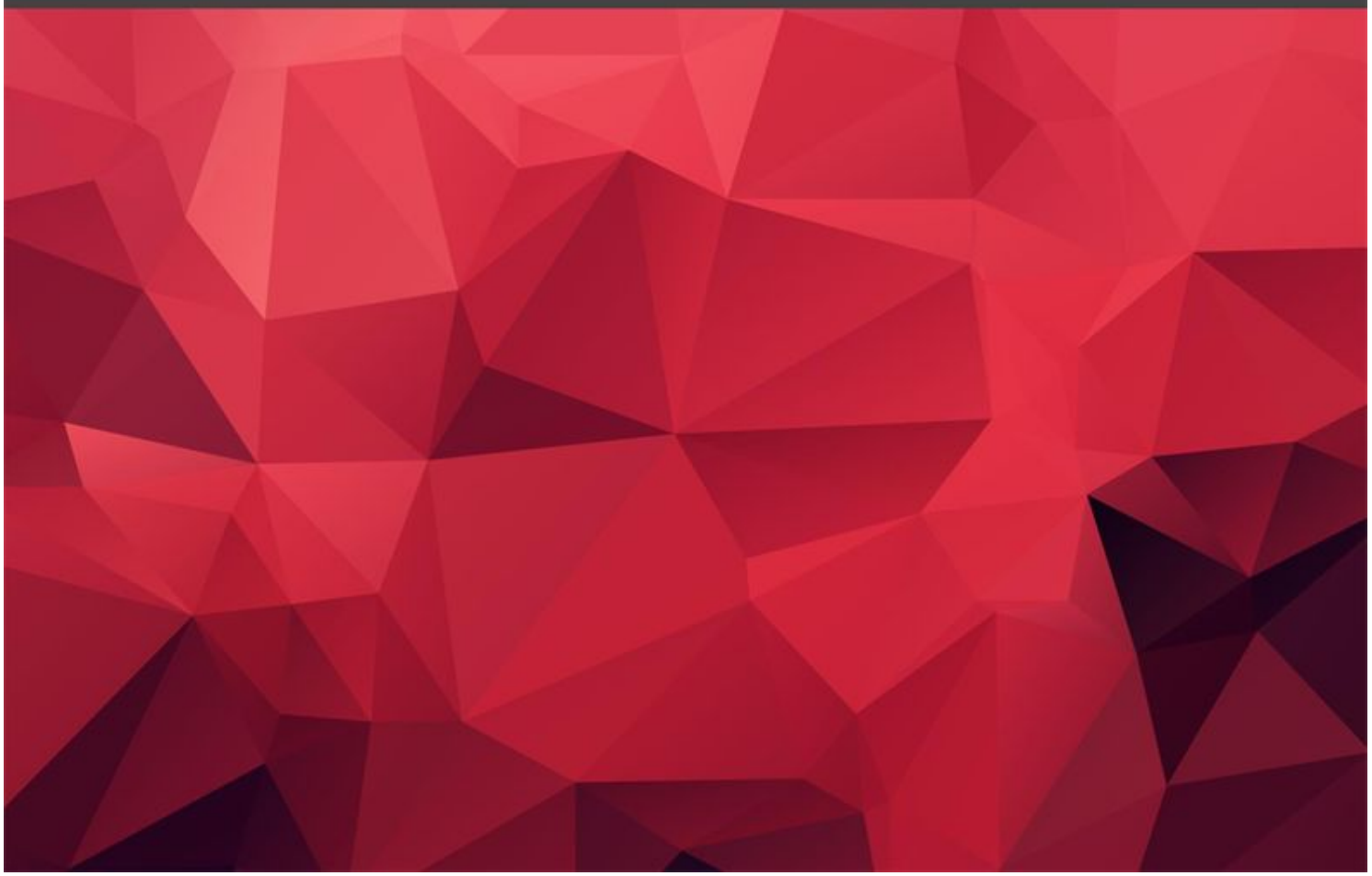
Archwilydd Cyffredinol Cymru
Auditor General for Wales

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

Date issued: September 2017

Document reference: CVACU2017

9



Contents

9

Summary report

About this document

1 This document provides the Audit Committee of Cardiff and Vale University Health Board (the Health Board) with an update on current and planned Wales Audit Office work. Financial and performance audit work is considered and information is also provided on the Auditor General's programme of national value-for-money examinations.

Financial audit update

Exhibit 1: Financial audit update

Work area	Progress	Conclusions
Annual Accounts and other financial-audit work		
We have concluded the audit of the 2016-17 Accounts and the Health Board's return in respect of the UK's Whole of Government Accounts. In terms of our accounts' work there are a small number of audit matters that we are likely to report, on a more informal basis, to finance officers. We have recently commenced our audits of the Health Board's grants and pooled budgets; and we are due to commence our audit of the Health Board's Funds Held on Trust Account. Later this year we will commence our planning of the 2017-18 financial audits. This work will be covered in our 2018 Audit Plan, which the Audit Committee considers in early 2018.		

9

Performance audit update

Work completed since the last Audit Committee update

Exhibit 2: Work completed since last Audit Committee update

Topic (year of Audit Plan)	Conclusions	Status	Executive lead	Considered by Audit Committee	Management response status
Thematic review – patient flow (out-of-hours) (2016)	The Health Board has strengthened the governance of GP out-of-hours but performance is mixed and risks remain in relation to the sustainability of the service. • The GP out-of-hours service has strengthened its monitoring and leadership arrangements and has recently written a business case to improve its strategic planning. • There are risks to the sustainability of the service because problems remain in filling GP shifts and spending is comparatively low. • Call taking performance is comparatively good but there is scope to improve the timeliness of home visits, appointments and especially call backs.	Final Report awaiting management response	Steve Curry	December 2017	Being developed

9

Work currently underway

Exhibit 3: Work currently underway

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Thematic review – patient flow	**Discharge planning:** • this work will review how health bodies are responding to previous external reviews of discharge planning arrangements, and examine whether improvements in discharge planning are being made.	Clearance comments received. Report currently being finalised	Ruth Walker	December 2017
Local project (2016)	**Follow-up outpatients progress update** • this work will track progress made by the Health Board in response to the follow-up outpatient appointments review published in 2015	Clearance comments received. Report currently being finalised	Steve Curry	December 2017
Thematic review – primary care (2017)	This work is being delivered in two phases. The first phase will build on existing data to provide an all-Wales data rich picture of primary care. Phase 2 will then focus on the work being undertaken by Health Boards to implement the strategic vision for primary care, drawing on the commitments set out within the 2014 Plan for Primary Care Services for Wales and other relevant national delivery plans, together with key enablers of change such as the development of primary care clusters and mechanisms to increase capacity and capability within primary care services.	Phase 1 underway. Phase 2 not yet started.	TBC	April 2018
Thematic review – intermediate	This work will focus on a service area which impacts on both health and local authority organisations. The area for consideration is likely to be the governance arrangements to	Early scoping.	TBC	April 2018

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
care fund (2017)	support the use of the intermediate care fund. The exact focus is yet to be determined.			
Structured Assessment (2017)	This work will continue to assess the robustness of NHS bodies' arrangements for corporate governance and financial management, and the progress that is being made in addressing issues and concerns identified in previous years' structured assessments. The work will also include a comparative assessment of aspects of governance which have presented challenges to most NHS bodies. The area of comparative analysis is currently being considered. This work will also be used to start to build up a picture of how NHS bodies are responding to their statutory requirements under the Well-being of Future Generations (Wales) Act 2015. This work will inform a national 'year-one commentary' across all relevant public sector bodies.	Fieldwork underway	Peter Welsh	December 2017
Local project (2017)	The precise focus of this work will be agreed with executive officers and the Audit Committee, and will be reflected in the regular updates that are produced for the audit committee. It is likely that the local work will include a progress update against recommendations raised in relation to previous work operating theatres and medical equipment.	Early scoping.	TBC	February 2018

Other Auditor General studies

Since the last Audit Committee we have published the following report which is of relevance to the NHS.

Exhibit 4: Auditor General Reports published since last audit committee

Product	Summary
Implementation of the NHS Finances (Wales) Act 2014 July 2017	The NHS Finances Act report focused on whether the Welsh Government has developed sound arrangements to support the implementation of the NHS Finances (Wales) Act to achieve the intended benefits. The report drew on local audit work to identify some common themes on planning and financial management across the NHS. The report found that: • In response to independent reviews, the Welsh Government has increased planned health spending but has continued to rely on additional in-year funding • The Welsh Government's oversight and accountability arrangements for integrated planning are generally sound • While there are signs of a greater focus on the longer term, at the end of 2016-17 four of the seven health boards failed to meet the duties under the Act https://www.wao.gov.uk/system/files/publications/nhs-finances-act-english-2017.pdf

Good Practice Exchange

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

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

Exhibit 5: Good Practice Exchange

Recent and forthcoming events
Recent events
Improving digital leadership and ownership – June 2017 (past) This seminar demonstrated the important role of digital in the delivery of effective public services that are fit for the 21st Century.
Building financial resilience in public services – August 2017 (past)

This webinar aimed to share new approaches to building financial resilience (including examples of good practice) and identify the key barriers and how to overcome them.
Forthcoming events
How different methods of engagement can help involve the citizen in public service delivery – 6 and 28 September 2017
How understanding Adverse Childhood Experiences (ACEs) can help integrated service delivery – 7 November 2017

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

9

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

AUDIT OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD'S CONTRACTUAL RELATIONSHIPS WITH RKC ASSOCIATES LIMITED AND ITS OWNER	
Name of Meeting: Audit Committee	**Date of Meeting:** 26 September 2017

Executive Lead: Chief Executive
Author: Director of Corporate Governance 029 2074 4230
Caring for People, Keeping People Well: This report underpins the "Values" element of the Health Board's Strategy.
Financial impact: As identified in the Wales Audit Office report
Quality, Safety, Patient Experience impact: Not applicable
Health and Care Standard Number: Governance, leadership and accountability and Standard 7.1 Workforce
CRAF Reference Numbers: 8 and 9
Equality and Health Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- The outcome of the Wales Audit Office Report.

RECOMMENDATION

The Committee is asked to:

- **NOTE** the contents of this report;
- **MONITOR** the progress of the action plan and
- **PROVIDE** the Board with the assurances required.

10

SITUATION

In October 2014, the UHB's Director of Workforce and Organisational Development was seconded to another NHS organization. Between December 2014 and March 2016, the UHB entered into 3 contracts for the provision of HR consultancy services with a private company whilst the Director was on secondment. In 2016 the owner of the company was appointed on a 1 year fixed term contract as the Director of Workforce and Organisational Development.

As part of the audit of UHB accounts, the Wales Audit Office became aware of the payment paid to the owner of RKC Associates.

Wales Audit Office then decided to undertake a review of the procurement process and management of the contracts.

BACKGROUND

In October 2014, the Director of Workforce and Organisational Development was seconded to another NHS Organisation. To cover some of her duties, 3 separate contracts for the provision of HR consultancy services between December 2014 and March 2016 were awarded. The cost of these contracts totaled £290,809 plus VAT.

In January 2016, the owner of the private company was appointed on a one year fixed term contract as the Director of Workforce and Organisational Development. The annual salary was £150,000.

The contract payments were identified during the audit of the UHB's accounts. This resulted in a full audit being carried out by Wales Audit Office.

This audit identified a number of serious issues relating to the consultancy contracts:

- The UHB failed to comply with its own procurement procedures when it awarded consultancy contracts to RKC Associates in November 2014 and June 2015 and in consequence both the contracts and payments made under them are potentially unlawful;
- The award of consultancy contracts to RKC Associates breached public procurement rules;
- The UHB failed to undertake due diligence checks of RKC Associates resulting in the UHB being exposed unnecessarily to financial and reputational risks;
- The UHB was in breach of its own Standing Financial Instructions when it agreed contracts with RKC Associates which had been drafted by the owner of RKC Associates.

Wales Audit Office considered it necessary to extend the scope of their review to examine the procurement processes for the third contract and the recruitment process that led to the appointment of the owner of the company as the UHB Director of Workforce and Organisational Development.

ASSESSMENT AND ASSURANCE

Assessment

The audit by Wales Audit Office was completed in July 2017. The process involved formal interviews with key service managers, audit of procurement and recruitment processes along with other documentary evidence.

In summary, the main findings of the Wales Audit Office are shown below:

- The way in which the UHB procured and managed the HR Consultancy contracts awarded to RKC Associates fell well short of the standard that the public have a right to expect;
- The way in which an HR Consultancy contract was awarded to RKC Associates, along with the actions of key decision makers, compromises the integrity of the procurement process;
- The process followed by the UHB that led to the appointment of the owner of RKC Associates to the Director of Workforce and Organisational Development was fundamentally compromised, lacked transparency and was poorly documented.

The full Wales Audit Office report is available via the link below:

http://www.audit.wales/system/files/publications/C%26V%20UHB%20PIR-eng.pdf

Assurance

A report was provided to the UHB's Board on 27 July 2017 where it was agreed that the Audit Committee would monitor the progress of actions and provide the Board with the assurances required.

The UHB, in conjunction with its colleagues in Procurement and Human Resources / Workforce, has developed a comprehensive action plan to make the necessary further improvements to ensure no similar incidents of this kind occur in the future.

This action plan is included with this report at Appendix 1 and seeks to provide the Board with the assurance that the UHB has learned fully from this incident and taken definite steps to avoid this happening again.

It should be noted that the Chair and Chief Executive attended the Public Accounts Committee on 25 September to discuss the Wales Audit Office report, and the action plan was provided to that Committee.

The action plan was presented to the UHB's Management Executive Team meeting on 21 August 2017 and its HSMB on 21 September 2017. The action plan has also been shared with the Wales Audit Office.

The UHB identified a number of additional improvements that are required in addition to those highlighted by the Wales Audit Office report and these are included within the action plan.

Appendix 1

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

Action Plan in Response to the Wales Audit Office Report in Respect of Cardiff and Vale University Health Board's Contractual Relationships with RKC Associates Ltd and its Owner

Conclusion 1 - The way in which the Cardiff and Vale University Health Board (UHB) procured and managed HR consultancy contracts awarded to RKC Associates fell well short of the standard that the public has a right to expect of a public body
a) The UHB failed to comply with its own procurement procedures when it awarded consultancy contracts to RKC Associates in November 2014 and June 2015 and in consequence both the contracts and payments made under them are potentially unlawful. b) The award of consultancy contracts to RKC Associates breached public procurement rules. c) The UHB failed to undertake due diligence checks of RKC Associates resulting in the UHB being exposed unnecessarily to financial and reputational risk. d) The UHB was in breach of its own Standing Financial Instructions when it agreed contracts with RKC Associates which had been drafted by the owner of RKC Associates. e) The UHB appointed the owner of RKC Associates to deliver consultancy projects, but the UHB utilised her as a senior member of staff and, in consequence, has potentially over-claimed VAT amounting to £58,162. f) As the Officer who signed the contracts with RKC Associates in November 2014 and June 2015, the UHB's Chief Operating Officer had a duty to ensure proper process had been followed. The failure to do so has cast doubt on whether the decisions to award these contracts were based entirely on valid considerations. g) The UHB did not exercise effective financial monitoring of its contracts with RKC Associates, with payments exceeding the contracted value and contractual expenses not being verified.

10

Dated: 8 September 2017

Appendix 1

UHB Response to Conclusion 1

Following publication of the Wales Audit Office report, a full report was received at the UHB's Board meeting on 27 July 2017 and discussion conducted in the public session of that meeting. In addition, the report has been raised at the meetings of our Management Executive (ME) and Health Systems Management Board (HSMB), and discussed with Senior Trade Union / Staff Side representatives and at our Local Partnership Forum (LPF).

As acknowledged by the Wales Audit Office, the UHB has a number of detailed policies and procedures covering this area. These have been developed to standardise processes based on best procurement practice and set out the governing principles for public procurement, for example, the Scheme of Delegation, Standing Orders, Standing Financial Instructions and Financial Control Procedures. Regrettably, these processes were not followed on this occasion, and there was no reference to the UHB's Head of Procurement as provided for in our Scheme of Delegation.

The Procurement Guide for Staff which was developed in conjunction with NHS Wales Shared Services Partnership Procurement Services, and approved through the All Wales Directors of Finance Sub Group in 2015, is provided to UHB staff as part of the training delivered by the UHB Procurement Department and will be further reinforced throughout the UHB.

Prior to the Wales Audit Office report, a review of our processes was already in train in response to changes to the IR35 legislation[23] relating to off-payroll working in the public sector. In addition, the process around requesting approval of contracts has been changed, a procurement checklist that sets out a defined approval hierarchy has been implemented to ensure compliance with Standing Orders and EC Regulations and that more than one signatory is obtained. All external Consultancy contracts are now signed off by the CEO.

The UHB, in conjunction with its colleagues in Procurement and Human Resources / Workforce, has developed this action plan to make the necessary further improvements to ensure no similar incidents of this kind occur in the future. The Action Plan will be presented to the UHB Board on 28 September 2017 and its Audit Committee on 26 September 2017 and will thereafter be monitored by the Audit Committee. The Action Plan has also been shared with Wales Audit Office.

1 Her Majesty's Revenue and Customs (HMRC) introduced the 'intermediaries legislation' commonly known as IR35or off-payroll rules in April 2000. This legislation is intended to combat tax abuse by an individual who would be treated as an employee were it not for the fact that they provide their services via their own company, called 'disguised employees' by HMRC. From April 2017, where a public sector organisation engages an off-payroll worker through their own limited company, that organisation will become responsible for determining whether the rules should apply, and, if so, for paying the right tax and National Insurance Contributions.

8 September 2017

Appendix 1

Conclusion 1 Action Plan	Lead	Completion	Update
Training			
1. Provide training for all Board members and Clinical Board Directors on the law, rules and regulations relating to employment and procurement at the August Board Development Day.	Director of Corporate Governance	August 2017	**Complete** Training delivered on 31 August 2017.
2. Cascade the training provided at Clinical Board senior management teams and throughout the organisation to Directorate Management level.	Executive and Clinical Board Directors	October 2017	Discussed at ME on 4 September 2017.
Review			
3. Undertake review of external consultancy categories in the purchase to pay system for period 2014-2017 to ensure compliance with procurement rules.	Head of Procurement	August 2017	**Complete** Reports received by CEO and Director of Finance.
4. Review the Procurement Guide for Staff and revise to reflect process changes connected with the IR35 legislation.	Head of Procurement	September 2017	**Complete**
Process			
5. Provide the Procurement Guide for Staff to the Management Executive Team meeting for cascading to Clinical Boards, and Corporate Departments.	Director of Finance	September 2017	To be presented to ME on 22 September 2017.
6. Publish the Procurement Guide for Staff across the UHB and place on intranet and internet for ease of staff access.	Director of Corporate Governance	October 2017	
7. Implement a no purchase order, no payment system to prevent the processing of manual payments.	Head of Procurement	March 2018	Phased implementation, commencing September 2017, full implementation by March 2018.
8. Develop and cascade process guidance for off-payroll working.	Head of Procurement	August 2017	**Complete** Approved by ME on 14 August 2017, taken to HSMB on 17 August 2017 for cascading by Clinical Board Directors.

10

8 September 2017

Appendix 1

Conclusion 2 - The way in which an HR consultancy contract was awarded to RKC Associates in February 2016, along with the actions of key decision-makers, compromised the integrity of the procurement process
a) The UHB embarked upon a procurement process for a contract and invited and evaluated tenders for that contract, despite the fact that RKC Associates had been engaged in advance of the tender process. b) The robustness and integrity of the advertised procurement process was compromised in several key respects and the UHB's Chief Operating Officer participated in the process despite knowing that RKC Associates had already been engaged in advance of the procurement process commencing. c) The Procurement Department failed to keep adequate documentation of the procurement process. d) The UHB delayed seeking formal written approval for the fixed-term appointment of a new Director of Workforce and Organisational Development, resulting in the UHB incurring unnecessary expenditure on a consultancy contract.
UHB Response to Conclusion 2 The UHB has taken steps to strengthen its existing processes and extend training at all levels to reinforce the requirements in relation to these areas. We recognise however that policies / procedures and training, whilst the foundation of good practice, are part of a bigger picture that includes a culture of sound behaviours and values, adherence to the rules at all levels of the organization, checks to ensure this is happening and an environment that enables individuals to confidently highlight departure from any rules no matter how senior those involved. As part of the communication with the UHB following receipt of this report, the CEO has asked staff to share any concerns they may have with him and provided assurance that anything raised will be explored to provide reassurance regarding our systems / processes and decisions made. Procurement compliance reports are already presented to the UHB's Audit Committee outlining for example Contract Extensions and Single Quotation or Single Tender Actions. Steps are also being taken to put in place more vigorous checks around our processes to flag potential issues and to achieve more robust oversight and business scrutiny by our Management Executive Team, Board and its Committees. Strengthening our contract for services will enable us to utilise temporary employment contracts rather than consultancy contracts in these circumstances.

8 September 2017

Appendix 1

Conclusion 2 Action Plan	Lead	Completion	Update
Training			
1. Develop and deliver an enhanced training programme for procurement staff focusing on the conclusions of the Wales Audit Office report.	Head of Procurement	September 2017	Training underway
2. Obtain quality management accreditation for the Procurement Department in respect of its tendering processes.	Head of Procurement	November 2017	Applied for accreditation, assessment taking place in October 2017.
3. Develop a Procurement flowchart for use by Board and Senior Managers.	Head of Procurement	September 2017	Draft developed, for presentation to September Audit Committee.
Audit			
4. Enhance existing audit processes within the Procurement Department to verify compliance with contract procedure.	Head of Procurement	September 2017	Frontline Audit Review Guidance produced, 30 audits completed to date with no significant issues highlighted.
5. Review Internal Audit Programme to include audits relevant to the issues highlighted in this report and to test compliance with new processes.	Director of Finance	September 2017	Appropriate Internal Audit days identified in programme for 2018.
Assurance			
6. Enhance the statutory compliance report provided at each Audit Committee to include our compliance with and exceptions to recruitment requirements, Standing Orders and Standing Financial Instructions.	Directors of Finance and Workforce and Organisational Development	September 2017	Report to be presented to September Audit Committee and further developed.
7. Review the Terms of Reference for the Remuneration and Terms of Service Committee to include reporting of any Executive level secondments and Consultancy appointments is being undertaken.	Director of Corporate Governance	October 2017	

10

8 September 2017

Appendix 1

Conclusion 3 - The process followed by the UHB that led to the appointment of the owner of RKC Associates to the position of Director of Workforce and Organisational Development in April 2016 was fundamentally compromised, lacked transparency and was poorly documented.
a) It is unclear why the UHB decided to proceed with a recruitment process for a Board level position with only a single candidate who had not applied for the position when it was originally advertised. b) The recruitment process was poorly documented and, as a consequence, it is not clear when the person who had been overseeing the recruitment exercise became a candidate. c) The integrity of the recruitment process was compromised because the sole candidate had access to some of the assessment questions in advance of being interviewed for the position. d) The information provided to the Board and its Remuneration and Terms of Service Committee regarding the appointment was inaccurate, incomplete and inconsistent.
UHB Response to Conclusion 3 High level appointments are not as frequent as other positions within the UHB and are often challenging due to small numbers of applicants with the relevant skills and experience, which can result in an inability to recruit. As a result of this report, the UHB has looked at how these senior appointment processes are conducted and how the office of the Chief Executive and Director of Workforce and Organisational Development can work better together to ensure compliance with processes and that satisfactory documentation is maintained. We also recognise that we can better support our Independent Board Members in relation to their Committee roles, to equip them to confidently scrutinise decisions and hold us to account.

8 September 2017

Appendix 1

Conclusion 3 Action Plan	Lead	Completion	Update
Review			
1. Review the procedures used to recruit Executive Directors and other Senior Managers.	Assistant Director of Workforce and Organisational Development	July 2017	**Complete**
2. Review the quality of information and its presentation to the Remuneration and Terms of Service Committee.	Chair and Director of Corporate Governance	September 2017	
Process			
3. Revise the Executive recruitment process to include a clear defined role for the Director of Workforce and Organisational Development which can be delegated to their Deputy or Director of Corporate Governance if circumstances require or a conflict arises.	Chief Executive	August 2017	**Complete** Used for the recruitment of the substantive Director of Workforce and Organisational Development in August 2017.
Training			
4. Arrange training for Independent Board Members, including those sitting on the Remuneration and Terms of Service Committee, covering their roles and responsibilities. This should also provide them with example questions they may wish to ask and the minimum information they may require to assist them in discharging their role.	Director of Corporate Governance	August 2017	**Complete** Included in the programme for the August Board Development Day.
5. Provide legal and governance training for all Board members on their roles and responsibilities at the October Board Development Day.	Director of Corporate Governance	October 2017	Training confirmed and programme planned.

8 September 2017

Appendix 1

Additional Improvements			
Action Plan	**Lead**	**Completion**	**Update**
Whistleblowing			
1. Review current Procedure for NHS Staff to Raise Concerns which includes whistleblowing to ensure it is fit for purpose and easy for staff to raise any concerns regarding non-compliance.	Director of Workforce and Organisational Development	October 2017	As this is an All Wales Procedure, to be raised at the Directors of Workforce and Organisational Development Group.
2. Develop an internal protocol providing a system for senior leaders to raise concerns, with clear lines of reporting should a concern relate to the Chair, Vice Chair or Chief Executive.	Director of Corporate Governance	October 2017	To be raised at the August All Wales Board Secretaries Group to explore best practice.
Governance and Accountability Framework			
3. Revise the UHB Governance and Accountability Framework to reflect any amendments by the Directors of Finance All Wales Group to the Standing Financial Instructions and Standing Orders.	Director of Corporate Governance	March 2018	Update provided to Audit Committee in September 2017 and each subsequent meeting.
4. Review and revise the UHB's Scheme of Delegation.	Director of Finance	October 2017	
5. Circulate a bulletin to the UHB Board and throughout the UHB reinforcing the Nolan principles of Good Governance and duties of probity / candour and the Values and Standards of Behaviour Framework.	Directors of Corporate Governance and Communications	October 2017	Communications strategy agreed.
Communication			
6. Communicate openly and transparently with staff about the findings of this report, the actions being taken by the UHB and their progress. This will include public meetings of Board / Audit Committee and meetings of LPF, Clinical Board Directors, HSMB and publishing of the action plan on the intranet for access by all staff, supplemented by other communication bulletins.	Chief Executive and Chair	October 2017	Reports at Board, ME, HSMB, LPF. Continued dialogue with Senior Trade Union / Staff Side representatives and CEO communication placed on intranet and internet.

10

8 September 2017

Independent Review of Financial Governance Within Cardiff and Vale University Health Board Undertaken by Deloittes - Recommendations/Action Plan 2017

1st Draft 08.08.17

Summary of Findings/Recommendations (as reported to Audit Committee)	Executive Lead	Management Response to date	Status (Describe)	Assurance Committee	Date Reported to Assurance Committee
Implement an Executive Director (ED) Team Development Programme to focus on further developing an effective team	Chief Executive	The Chief Executive is considering team development for later in the year. In the first instance, a weekly two hour Executive Director's "time out" - was established in July 2017. This will provide opportunities for Executive Team development	In progress	Formal Management Executive Meeting	Monthly review
Consider the appropriateness of the current ED responsibilities for Informatics and Information Technology	Chief Executive	Review to be completed by November 2017	In progress	Strategy & Engagement	Dec-17
Ensure there is allocated time within the current Board Development Programme to provide training and support to interpret financial management information, particularly for the new IMs	Executive Director of Finance	Supplementary training sessions introduced in 2017 for new IM's with further sessions planned this year.	Sessions started and to be completed for new Independent Members	Governance Coordinating Group	Dec-17
Introduce monthly Board meetings in addition to bi-monthly Board Development sessions to provide an opportunity for BMs to receive and challenge assurance reports, particularly from the Finance Committee	Chair	Not required. We have a monthly Finance Committee meeting which is working effectively and providing the financial scrutiny required. These assurances are then provided to each meeting of the Board	No further action required	Finance Committee/Board	Nov-17
Update the terms of reference of the Finance Committee to ensure that the Board Chair is not a member or the Chair of this committee, and all committee Terms of Reference to state that the Board Chair should attend each committee on a rolling basis	Chair	To be reviewed by end of October 2017 when new Independent Members identified. This will include review of Committee Membership including Chair of this Committee.	Awaiting new IMs to start to undertake review of Committee membership and Chairs	Board	Oct-17
Improve the committee reporting process to Board by ensuring the assurances or gaps in assurance are clearly drawn out from committee meetings, and co-locate the committee minutes/Executive Summary with the relevant ED report	Executive Directors	The Board and Committees paper template has a section on assurances to be provided and be further emphasized. In addition the governance coordinating group review regularly cross committee working and this recommendation will be also be brought to their attention	Completed	Board	Sep-17
Address areas for development identified within the Board and Finance Committee finance reports, such as inclusion of the underlying financial position, increased insight driving narrative, and greater integration of financial, operational performance and CIP information	Executive Director of Finance	Recent improvements will continue to be developed to incorporate issues highlighted	In progress	Finance Committee	Apr-18
Develop more detailed budget setting guidance, supporting increased transparency in budget allocation to Clinical Boards, directorates and cost centres and strengthened ownership for delivery. This should include more direct linkage between expenditure budgets and activity and productivity targets	Executive Director of Finance	Consideration for incorporation into 2018/19 budget setting process. Budget setting guidance to be developed and to be introduced in January 2018 for implementation in new financial year linked to activity	In progress	Finance Committee	Jan-18
Introduce a formal budget sign-off process at Clinical Board and directorate level, supporting increased understanding of budgets allocations and more explicit ownershp for delivery	Executive Director of Finance	The practicality of this will be explored v benefits derived	In progress	Finance Committee	Apr-18
Consider simplification of the range of Cost Reduction Programmes, articulating and communicating the objectives of individual initiatives and their interrelationship across the organisation	Executive Director of Finance	Primary budget holder will be requested to provide information in performance meetings and implemented from January 2018	In progress	Finance Committee	Jan-18
Investigate and assess cross-cutting and transformational cost reduction opportunities, including identification of underpinning initiatives and quantification of financial impact. Prioritise initiatives and develop plans for implementation, including mechanisms to support and incentives cross-CB implementation at pace	Executive Director of Finance	1. Cross Cutting items forecast reduction already in place. 2. Transformation opportunities will be part of this implementation including cross CB working.	Completed	Finance Committee	October 2017
Define future finance function focus, required skills and capabilities, to allow the function to act as a key enabler for implementation of the IMTP	Executive Director of Finance	Ongoing as part of all Wales NHS finance staff development, clear working with planning department established	Completed	Finance Committee	Oct-17

Independent Review of Financial Governance Within Cardiff and Vale University Health Board Undertaken by Deloittes - Recommendations/Action Plan 2017 **1st Draft 08.08.17**

Determine future planning function required in the organisation to both develop an approved IMTP, with balanced financial plan and deliver its implementation	Chief Executive	Strengthen planning function to enable additional finance planning capacity. Review of Corporate resources being undertaken in October 2017	In progress	Management Executive	Nov-17
Determine the future PMO function, including focus, skills and capabilities, establishing a function that will act as a critical enabler for implementation of the IMTP and financial recovery at increased pace	Executive Director of Strategic Planning	Review to be implemented and completed by end of October 2017. For discussion with the Chief Executive	In progress	Director of Planning / Chief Executive	Nov-17
Develop an enhanced financial strategy taking account of expected demand, capacity, service, corporate and wider transformational changes (short, medium and longer term)	Executive Director of Finance	Will be incorporate into an integrated improved IMTP process	As per IMTP implementation dates	Management Executive/Board	Nov-17
Ensure regular Board level scrutiny of financial risks within the 2017-18 financial plan and actions in place to mitigate these	Executive Director of Finance	Scrutiny taken place already but level of scrutiny to be increased - training planned for Board memebers October 2017. Risk Register and assurances provided to the Board by Chair of Finance Committee	Completed	Board	Nov-17
Create opportunities for Clinical Board leadership teams to share information to ensure that good practice can be shared widely. The EDs have a role to play in this as part of their oversight of operational structures	Executive Directors	To be included in Performance Reviews, commencing September 2017	Completed	Management Executive	Nov-17
Ensure that there is a coordinated approach to leadership development for the Clinical Board and Clinical Directorate leadership team, including arrangements for specific finance focused training	Chief Operating Officer	To be discussed with the new Director of Workforce and Organisational Development when in post (October 2017)	In progress	Performance Reviews	Jan-17
Clarify the trigger point(s) for a Clinical Board to be placed into protected administration, and ensure that all CB leadership teams understand this	Chief Executive	Discussed at Executive Directors 'Time Out' on 28 July 2017. Chief Executive review of escalation processes in progress	In progress - further reviewed planned	Audit Committee	Nov-17
Ensure the Clinical Board Performance Review Meetings are both challenging and supportive, and focused on clear, timely actions to address areas of concern	Chief Executive	Management Executive to review performance reviews	In progress	Management Executive	Oct-17
Use the opportunity of the new CEO to reconsider the focus of Health Services Management Board to ensure that it fulfils its role as the key forum to oversee all aspects of operational delivery	Chief Executive	HSMB to be reviewed by Chief Executive by end of October 2017	In progress	Management Executive	Oct-17
Improve the quality of Clinical Board performance information, including drilling down to directorate level metrics with a supporting narrative	Chief Operating Officer	To be considered as part of the Performance Reviews	In progress	Management Executive	Nov-17

WALES AUDIT OFFICE TRACKING REPORT – September 2017

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" element of the Health Board's Strategy.
Financial impact : N/A
Quality, Safety, Patient Experience impact : The areas reviewed by the WAO may have an impact on quality, safety and patient experience.
Health and Care Standard Number – Governance, Leadership and Accountability **CRAF Reference Number –** Areas that are subject to review will be captured in a range of risks on the CRAF**.**
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** this report and the arrangements for ensuring that all WAO actions have been tracked.

SITUATION

The Cardiff and Vale University Health Board (the UHB) has arrangements in place to ensure that reports produced by the Wales Audit Office (WAO) are received by the Board or an appropriate Committee(s). This is in support of the WAO NHS Performance Work Protocol which was considered by the Audit Committee in February 2014. The purpose of this report is to update the Committee regarding the arrangements for formally receiving and responding to WAO reports received since the last committee meeting.

12

BACKGROUND

In response to the WAO NHS Performance Work Protocol the UHB and the Audit Committee is required to establish and maintain its own arrangements in terms of tracking progress in response to audit recommendations. To achieve this, the Board or the appropriate Committee is required to consider the detail of WAO reviews undertaken, together with the action plan.

There are three specific issues to be brought to the committee's attention:

- In January a draft Wales Audit Office Annual Audit Report and Structured Assessment reports were received and discussed at Management Executive meeting. The draft was agreed on 6 February 2017. The Management Response was approved at Management Executive in February, which was reported to Audit Committee in April 2017 and to the Board in March 2017. A progress report on each of the recommendations will be brought to the next meeting of the Audit Committee.
- Since the last meeting of the Committee, the Wales Audit Office report on the Audit of Cardiff and Vale University Health Board's Contractual Relationships with RKC Associates Limited and Its Owner, has been received and included on the tracker. A separate report on this audit is included on the agenda.
- Following receipt of the Wales Audit Office Annual Report, the UHB will be looking at 'best practice' regarding audit tracking / monitoring tools with the intention of this new system being introduced in 2017. This has been raised at the All Wales Board Secretaries meeting to consider and share best practice.

ASSESSMENT

This tracking report provides assurance that the Board or the relevant Committee/sub-Committee has received reports and action plans in response to the WAO reports received during 2014/15 and 2015/16 as set out in the Appendix. Whilst this demonstrates that there are arrangements in place to ensure that the actions identified continue to be monitored until they have been satisfactorily resolved the WAO have asked for this to be considered further. A more robust approach has been agreed with the Chair. The Board Secretary will ensure that reports are not removed from the Tracking Log or Board and Committee work plans until:

- all actions have been completed or,
- it has been determined that no further action is possible a robust assessment has been undertaken to identify any remaining risk to the Health Board. Where appropriate a decision may be made to tolerate the risks.

Date of Report	Title of Review	Summary of Findings/Recommendations (as reported to Audit Committee)	Executive Lead	Management Response to date	Status (On-going /Complete)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Jan 2014	Combined follow-up review of progress made against recommendations relating to disaster recovery, data back-up arrangements, Caldicott and data quality (Local Work 2013)	The WAO work summarised the key messages and recommendations raised from their previous work on waiting lists, data quality, disaster recovery and business continuity, Caldicott, and data backup and recovery arrangements. It also concluded that there are a number of issues facing the UHB's IM&T service: • Financial investment in IM&T has been low historically, and the UHB's own figures indicate it compares unfavourably with the Welsh NHS as a whole. As a result, much of the IT infrastructure is now approaching the end of its useful life. • The IM&T risk assessment process does not seem to be escalating risks appropriately to a corporate level. WAO recent work in several areas had highlighted this issue. • The structure of the IM&T Department is uneven, with a concentration of expertise residing in a small number of individuals. • The replacement programme for aging servers is not keeping pace with need so the volume of obsolete and unsupported equipment is rising. • The UHB's strategic approach to IM&T is unclear. There is an Implementation programme but this has not been formally agreed and falls between the functions of a strategy and an operational plan, in WAO view satisfying neither. Without such a strategy, it will be difficult both to prioritise work and to evaluate progress.	Director of Finance	Action Plan produced and received by PPD Committee in January 2014. Recognised that there was a need for additional investment which were captured in the Integrated Medium Term Plan and Capital Plan as appropriate. The IM&T Programme Board and the Information Governance (IG) Group were both re-established in 2014/15 as sub-Committees of the PPD Committee under the Chair of the Independent Member - Information, Communication and Technology. This has ensured that appropriate scrutiny has started to be provided. A follow up review has been undertaken and the final report was received on 10 February 2015 (see below)	On-going	People, Performance and Delivery - Prof Marcus Longley/Information Governance sub-Committee - Eileen Brandreth	28/01/2014 - initial report 26/02/2015 - Follow-up Report See below for update. IGSC 23.03.16
01 Jan 2015	Structured Assessment (2014)	The UHB's Medium Term Plan addresses the £19.177 million deficit incurred in 2013-14, but operational pressures and a failure to deliver planned cost savings mean it is now forecasting a deficit of £24.9 million at the end of 2014-15 Overall governance arrangements have continued to evolve and mature, although some aspects of arrangements need to be further improved - The UHB has adopted a clear and robust approach to strategic planning although a slow pace of change and financial constraints is affecting its delivery - The organisational structure is maturing but there are a number of risks which impact on its effectiveness to support operational delivery - Board effectiveness, assurance and internal controls continue to be strengthened and are largely effective although there remain some important areas which need to be addressed - Performance management arrangements have been strengthened with a specific focus on the top five priorities but some services are becoming disengaged and there is a need for the organisation to more explicitly challenge its performance and delivery - The UHB continues to focus positively on quality and safety but there remains a number of issues to address, including capacity to support shared learning and responding to concerns in a timely manner. - The UHB has continued to provide the mechanisms to facilitate change but the ability to sustain change is a concern. - The Board is now much better informed of the significant risks associated with its assets but resources are limited.	Board Secretary	The majority of actions have been completed and previously reported to the Audit Committee. Only outstanding actions relate to the role of the People, Planning and Performance Committee re monitoring performance and the resources within the Governance Team. Both were highlighted in the 2015 Structured Assessment (see below). The Committee will be appraised of action under that report in future.	On-going	Chair of Board and Committees	To be reported to the Audit Committee and relevant Committees of the Board. Audit 12.04.16
01 Jan 2015	Arrangements for responding to and tracking progress against recommendations (2014)	This work sought assurance that the UHB has appropriate corporate processes for responding to Wales Audit Office reports, tracking implementation of audit recommendations and reporting to the appropriate committee. It found that there are generally effective arrangements in place to manage and respond to audit recommendations although there are opportunities for a more consistent approach to the management responses, and not all action plans are monitored through to completion. Good progress is being made against audit recommendations with many of them completed in a timely manner, however as some recommendations are not always tracked through the committees, particularly in relation to my recommendations relating to ICT arrangements, we are unable to comment on whether all of previous recommendations are being actioned.	Board Secretary	Report considered by Board on 27th January 2015 as part of Structured Assessment. Action Plan drafted and shared with Executive leads. Discussions held with the Chair and Board Secretary to discuss and agree a more robust approach to tracking. The reports are not "Complete" until all actions have been completed or a position has been reached where no further action is possible and the resulting risk will be assessed and if appropriate tolerated. The Board Secretary and the Committee secretariat ensure, as far as is practicable that Committee's are clear and record when they expect to receive assurance reports.	On-going	Audit - Ivar Grey	As above 12.04.16
01 Feb 2015	Orthopaedics (2012)	Orthopaedic services are generally coping with demand, which is consistently low, but MRI waits are long, the inpatient pathway needs to be improved to make better use of resources and although outcomes are generally positive, revision rates and missed follow-up appointments are some of the highest in Wales - Investment in primary care services is increasing and there is a consistently lower rate of GP referrals, although the impact of the Clinical Musculoskeletal Assessment and Treatment Service (CMATS) is unclear. - Outpatient and physiotherapy services are generally meeting demand, although a reduction in did not attend rates for outpatient appointments and the availability of direct access to physiotherapy could further improve waiting times. Access to MRI for GP referred patients is problematic. - More timely pre-operative assessment, increased day surgery rates, maximised bed occupancy and a reduction in prosthetic costs could improve the use of inpatient resources; and - Patients generally have positive outcomes with the exception of revision rates, which are some of the highest in Wales and not all patients are followed-up.	Chief Operating Officer	Report received and action plan approved by PPP Committee in July 2015. Interim report received in January 2016 and a full report in 12 months February 2017)	On-going	People, Planning and Performance - Prof Marcus Longley	21/07/2015 18.01.16
01 Feb 2015	Combined follow-up review of Informatics and Communication Technology Audits (2013)	The combined follow-up review examined progress against recommendations relating to the WAO previous work on disaster recovery and business continuity, data back-up arrangements, Caldicott and data quality (see above). The UHB has made progress in addressing some of the issues raised in previous reviews but the WAO have made seven new recommendations to ensure that key areas continue to be addressed - The Information Governance Committee and Data Quality Group are in their infancy but provide a good foundation to provide the Board with assurance on data quality - The UHB does not have a standard approach to disaster recovery and business continuity planning, with plans less established in clinical departments, than in the ICT department. Testing of disaster recovery and business continuity plans and training in clinical areas is also limited - Caldicott governance arrangements have been strengthened but there remains a need to develop training on Caldicott, data protection and information confidentiality - Clinical departments and ICT have agreements in place to identify data owners and responsibilities for backups but some agreements remain unsigned and the testing of backups remains ad hoc	Director of Therapies and Health Science (IM&T)/Director of Public Health (Data Quality)/Director of Strategic Planning (Business Continuity Planning)/Medical Director (Information Governance and Caldicott)	As the report related to a number of different areas of work agreement of the action plan took longer than anticipated. The PPP Committee received and approved the action plan on 10 November 2015. It was agreed that responsibility for monitoring the implementation of the actions would be remitted to the Information Governance sub-Committee and the Information Management and Technology sub-Committee as appropriate.	On-going	Information Management and Technology sub-Committee/Information Governance sub-Committee - Eileen Brandreth	10/11/2015 IM&T 7.03.16 IM&T 10.06.16 IGSC 18.12.16

Date of Report	Title of Review	Summary of Findings/Recommendations (as reported to Audit Committee)	Executive Lead	Management Response to date	Status (On-going /Complete)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Jun 2015	Medicines Management (2014)	The work reviewed medicines management arrangements in the acute sector to assess scope for making improvements in relation to the quality and efficiency of services. The review concluded that there are strengths in the way the Health Board managed medicines but there were also issues associated with the strategic approach, storage facilities, transfer of medicines information and performance monitoring. - There was clear executive leadership, regular financial monitoring and improved clinical engagement but there was scope to raise pharmacy's profile, clarify accountabilities and strengthen the strategy. - Pharmacy staff costs per bed day were lower than the Welsh average and workload pressures were similar to the rest of Wales. There was scope to dedicate more resource to training and improve access to the pharmacy team outside normal hours. - Pharmacy facilities largely comply with key requirements although there were risks associated with storage of medicines, monitoring the temperature of ward fridges and infrequent audit of injectable medicine preparation on the ward. - There were some strengths to medicines management processes but there were risks related to information transfer between primary and secondary care, timeliness of reconciliations, non-medical prescribing and supporting patients to take their medicines properly. - There is scope to improve performance reporting, mixed evidence about the effectiveness of learning processes and a need to understand more about the root causes of the pharmacy team's safety interventions.	Medical Director	Report agreed and action plan developed. Action plan presented to and agreed by the PPP Committee in January 2016. Whilst the Committee did not agree when a follow-up would be received it will be added to the workplan for February 2017 by which time most actions will have been completed.	On-going	People, Planning and Performance - Prof Marcus Longley	18.01.16 This is now under the Resource and Delivery Committee (5 August 2017)
01 Oct 2015	Management of follow-up of outpatient appointments (2014)	The WAO review concluded that from a difficult starting point, the Health Board was taking appropriate action to identify the volume of its outpatient follow-up need but too many patients are delayed, the trend is worsening and it needs to do a lot more to develop sustainable follow-up outpatient services. The reason for their conclusion was that: - The Health Board has taken a pragmatic approach to determining the volume of outpatient follow-up demand, but it needs to better understand clinical risks to patients. - While follow-up waiting lists are more accurate, too many patients are delayed, the trend is worsening, and scrutiny and assurance arrangements needs strengthening - The Health Board is improving the administration of follow-up waiting lists but needs to develop a planned approach to modernise outpatient services.	Chief Operating Officer	Action plan approved by the PPP Committee on 10 November 2015. The Committee received a further report regarding Outpatients Follow-ups in March 2016 where it was agreed to receive a report at every meeting. The Committee has been advised that further work is required regarding pathway redesign and the Committee will be kept appraised of this via the regular reports. To report to Private Session of Board 28 July 2016 Reported to QSE on 20 June 2017. Minute QSE 17/105	On-going	People, Planning and Performance - Prof Marcus Longley	10/11/2015 & 15/03/16 12.07.16 QSE 20.06.17
01 Nov 2015	Diagnostic review of IT capacity (2014)	This high-level diagnostic work assessed whether budgetary pressures were affecting capacity within informatics teams and the IT infrastructure, and provided an independent comparative analysis of the capacity of IM&T teams and resources across Wales. Despite above-average investment in ICT, their diagnostic work indicated that there were some weaknesses in the Health Board's arrangements and its clinical ICT infrastructure was not fully effective in supporting the delivery of healthcare. - Overall spend on ICT is just above the all-Wales average but remains below the recommended level of spend despite substantive additional funding in the past year. - Staffing levels for ICT are some of the lowest in Wales. - The Health Board is committed to ICT but there is a mixed level of integration of both systems and resources, and doctors' perception of IT facilities is not as positive as others across Wales. - The Health Board has a low number of devices and access to PCs was perceived as problematic. - A considerable amount of ICT equipment has reached its end of life and, although systems were generally reliable, downtime records were incomplete for many systems. - Despite some positive aspects, refresher information governance training was not mandated and training arrangements for some temporary staff were weak. - The mainstream clinical ICT systems were not fully effective in supporting doctors to provide patient care.	Director of Therapies and Health Science	Report received by UHB on 24 Nov 2015. Management response has been developed and considered by the Information Management and Technology sub-Committee. It will be received by the PPP Committee in May 2016 when the arrangements for receiving assurance regarding completion of all action highlighted will be agreed. There will be a workshop at end of September 2016 for all clinicians	On-going	Information Management and Technology sub-Committee/Information Governance sub-Committee - Eileen Brandreth	02.05.16 (PPP)
26 Jan 2016	Review of Operating Theatres (Jan 2016)	1) The theatre improvement project is driving change through a clear focus on improving processes and performance management to improve efficiency 2) Theatre utilisation and productivity have improved but the Health Board has not clearly demonstrated that its investment has led to cashable financial savings. 3) Problems with staff engagement and workforce capacity mean there are risks to maintaining momentum 4) The focus on utilisation has not been matched by a strong enough focus on quality, although staff have positive views about surgical safety.	Chief Operating Officer	To be considered by the PPP Committee in May 2015 To report to PPP Committee January 2017 meeting.	On-going	People, Planning and Performance - Prof Marcus Longley	02.05.16 12.07.16
27 Jan 2016	Structured Assessment 2015	1) Further refine the People, Planning and Performance Committee to strengthen its ability to provide appropriate levels of assurance to the Board. 2) The Health Board should review its governance capacity, to ensure that there is sufficient capacity to enable the governance team to provide greater support to Clinical Boards around risk management, to ensure that all external action plans are appropriately monitored and that written assurances are provided to the Board on key matters arising from Committees. 3) Attendance by the nominated Executive Officer at Clinical Board meetings needs to be improved to ensure that in their capacity as 'Independent Member' they provide appropriate scrutiny and challenge at a Clinical Board level. 4) The condition of the Health Board's estate is a significant risk. The Health Board now needs to accelerate its actions to ensure that its estate is fit-for-purpose and specifically, that it is compliant with statutory requirements.	Director of Governance	Management response was presented to the Audit Committee on 12 April 2016.	On-going	Audit - Ivar Grey	12.04.16
01 Sep 2016	Consultant Contract: Follow-up of previous audit recommendations	1) Processes to review job plans annually 2) Guidance and training 3) Appropriate involvement 4) Information and outcome setting 5) Appraisal 6) Monitoring arrangements 7) Service improvement 8) Supporting processional activities 9) Wider benefits realisation	Medical Director	Draft being prepared. To go forward to PPP in May 2017	Ongoing	People, Planning and Performance - Prof Marcus Longley	Audit 28.02.17
01 Nov 2016	Review Delayed Transfers of Care	1) Discharge Planning Audit - address the findings from the Delivery Units discharge planning audit either by: developing an action plan; or incorporating actions into existing service improvement action plans. 2) Imtermediate Care Fund (ICF) - Explore ways of mainstreaming services funded through the ICFG to ensure services remain resilient	Chief Operating Officer	Draft being prepared. To go forward to next QSE meeting in April 2017.	Ongoing		Audit 28.02.17

12.1

Audit Committee - September 2017

Date of Report	Title of Review	Summary of Findings/Recommendations (as reported to Audit Committee)	Executive Lead	Management Response to date	Status (On-going /Complete)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Jan 2017	Review of Estates	1) To ensure thte estates service is represented at board level, priortise recruiting an independent board member for estates. 2) Create a central log of estates related issues and actions resulting from Clinical Board meetings. 3) Develop a fully costed Estates Management Strategy. 4) Develop a zero based estates budget that makes provision for likely revenue costs arising from changes to the Health Board estate, such as new buildings. 5) Introduce a system to inspect a percentage of repairs each month. 6) Strengthen performance management by: extending the performance dashboard to include Key Performance Indicators (KPIs) for the other serices covered by the Service Board; and making greater use of the data captured through the Backtraq repairs maintenance system. 7) To ensure repairs are correctly priortised: run Backtraq refresher training for helpdesk staff; and review questions on call handlers' script	Director of Strategic Planning	Draft being prepared. To go forward to next PPP meeting in May 2017	Ongoing	People, Planning and Performance - Prof Marcus Longley	Audit 28.02.17 This is now under Strategy and Engagement Committee (25 July 2017)
01 Jan 2017	Structured Assessment 2016	1) Financial Reporting - strengthen financial reporting arrangements: a dashboard summarising performance against against key financial performance indicators and the issues and detail of actions being taken to manage overspend and deliver necessary savings by clinical area 2) Development of Plans: clear connectivity between the medium term plan and its longer term strategy, as well as its other strategic plans 3) Monitoring and scrutiny of plans 4) Planning capacity 5) Board and assurance framework 6) Transparency of public reporting 7) Board membership, vacancies to be filled and support quorate running of committees 8) Scrutiny of performance: Establish new Resources and Delivery Committee as a matter of urgency to ensure robust scrutiny is given to HBs performance and ensure relevant information is provided to Committee including sharing of clinical board reviews to focus attention on areas which need greatest scrutiny. 9) Governance capacity: to undertake further evaluation. The views of IMs on what assurances are needed should be sought as part of evaluation 10) Tracking arrangements: Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee	Director of Governance	Draft being discussed by the Management Executive and prsnted to Audit Committee in April	Ongoing	Audit - Ivar Grey	28.02.17 24.04.17
01 Jan 2017	Annual Audit Report	Key findings from the Annual Report included: 1) Comments on financial management 2) Governance and asssurance arrangements 3) Performance audit reviews 4) Internal controls 5) Arrangements for securing efficiency , effectiveness and economy in the use of services 6) Issues relating to estates management 7) Capacity of the corporate governance team 8) Monitoring of previous recommendations	Director of Governance	Management Executive provided comments on the draft report and two meetings were arranged to discuss with WAO. Final version agreed. Presented to the Board 30 March 2017 and to be 'tracked ' by Committees	Ongoing	Audit - Ivar Grey	28.02.17 30.03.17 - Board
01 Feb 2017	Discussion Paper: The Governance Challenges Posed by Indirectly Provided, Publicly Funded Services in Wales	No recommendations Its contents are relevant to policymakers, officials, practitioners and academics, as well as those who oversee, provide and receive indirectly provided services that are funded with public money. This paper will help to spread good practice, generate new ideas, support beneficial change and so contribute to the good governance of public services in Wales		To be taken to the Management Executives Team to note and consider.		Audit - Ivar Grey	24.04.17
01 Feb 2017	Radiology Services	1) Develop an action plan detailing how reporting backlogs will be managed sustanability. 2) Over the next year, increase appraisal rates for non-clinical radiology staff to at least the level of all other radiology staff. 3) Over the next year, increase mandatory training rates for all radiology to staff at least eh Health Board target of 85%. 4) Liaise with referring clinicians when developing and reviewing referral guidance. Ensure all referring clinicians know ehre to access up to date versions of guidance. 5) To develop a radiology strategy over the next 12 months. 6) Develop a workforce plan alongside the radiology strategy which identifies the baseline capacity needed to sustainably meet radiology demand in a timely and safe way. 7) By mid-way 2017 develop an equipment replacement plan. 8) Strengthen directorate performance management	Medical Director	Reported at Audit Committee on 26.09.17		People, Planning and Performance - Prof Marcus Longley	26.09.17
Jul-17	Contractual Relationships with RKC Associates Ltd and its Owner	1) Board members and senior officials with significant financial responsibility should be on the organisations payroll, unless there are exceptional circumstances - in which case the Accounting Officer should approve the arrangements - and such exceptions should exisit for no longer than six months. 2) Engagements of more than six months in duration for more than a daily rate of £220, should include contractual provisions that allow the department to seek assurance regarding the income tax and NICS obligations of the engagee - and to terminate the contract if that assurance is not provided; and 3) These measures should be implements within three months - and implementation will be monitored after one year, reporting back to hte Chief Secretary to the Treasury and the Minister for the Cabinet Office; and if it emerges that any departments have not abided by these rules, sanctions will apply - wiht departmental resource budgets reduced by up to five times the payment in question	Medical Director	Action plan to be presented at Audit Committee 26.09.17 and Board Meeting 28 September		Audit - Ivar Grey	Audit - 26.09.17 Board - 28.09.17

12.1

Cardiff & Vale University Health Board

Post Payment Verification Progress Report

For the period: 1st April 2017 to 30th September 2017

Cardiff & Vale University Health Board

Issued: September 2017
Prepared by: Mr Scott Lavender (PPV Location Manager)

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

Cardiff & Vale University Health Board

1. Introduction

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

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

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

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

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

2. Post Payment Verification process

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

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

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

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

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

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

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

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

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

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

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

3. Summary of findings and observations

General Medical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
11	4	7	4	0

During the period 1st April 2017 to 30th September 2017, the PPV team has visited 4 GMS contractors as per the visit plan agreed with Cardiff & Vale UHB. The PPV team have recovered £1,990.76 from completed visits to GMS contractors in the Cardiff & Vale UHB area due to errors identified in contractor's enhanced service claims. Recoveries are also to be made from on-going visits. These recoveries have not been included in the above total as they have not been authorised by the UHB. A summary of the GMS visits can be found in appendix one of this report.

The overall claim error rate for the locality was 9.92% from all claims sampled. A graphical representation of the claim error rates following GMS visits can be found in appendix two of this report.

As has been previously reported, the PPV team are still identifying GMS errors in relation to Near Patient Testing, Anti-coagulation monitoring and Minor Surgery.

General Ophthalmic Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
15	9	6	9	0

During the period 1st April 2017 to 30th September 2017, the PPV team have visited 9 GOS contractors as per the visit plan agreed with Cardiff & Vale UHB. The PPV team have recovered £2,469.00 from completed visits to GOS contractors in the Cardiff & Vale UHB area due to errors identified in contractors' GOS claims. A summary of the GOS visits can be found in appendix three of this report.

The overall claim error rate for the locality was 4.40% from all claims sampled. A graphical representation of the claim error rates following GOS visits can be found in appendix four of this report.

The majority of claim errors identified so far this financial year are consistent with previous year's findings and relate to EHEW examination claims.

General Pharmaceutical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
22	10	12	10	0

During the period 1st April 2017 to 30th September 2017, the PPV team has visited 10 GPS contractors as per the visit plan agreed with Cardiff & Vale UHB. The PPV team have recovered £559.32 from completed visits to GPS contractors in the Cardiff & Vale UHB area due to errors identified in contractor's Medical Review Use claims. A summary of the GPS visits can be found in **Appendix 5** of this report.

The overall claim error rate for the Health Board was 2.71% from all claims sampled.

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

The majority of claim errors identified so far this financial year are in relation to MUR's.

4. Collaborative working

Discussions have taken place with the UHB regarding the implementation of a process to deal with practices who persistently submit erroneous claims despite training and guidance being provided. As part of this process it was suggested that a joint visit would be conducted by the Counter Fraud Manager, Head of Primary Care and PPV Manager. The meeting is made by prior arrangement and includes the Senior Partner/Ophthalmic Contractor, Practice Manager and any other staff members nominated by the contractor. The purpose of the meeting is to highlight the erroneous claiming patterns identified by the PPV process, discuss the reasons for these errors and the measures the practice have or will put into place to prevent them occurring in the future. The seriousness of this matter is explained and the potential for a full fraud investigation should these errors continue following this visit.
It is anticipated that the implementation of this process in conjunction with the revision of enhanced service specifications by the Primary Care team will in time reduce the number of errors identified.

5. Conclusions and recommendations

The PPV team have been working tirelessly with the Primary Care team and the Contractors themselves to make improvements across the board. We promote heavily the survey, frequently asked questions and general help that we can offer practices to aid them in their claiming process.

The PPV team will continue to assist the UHB in providing training, advice or informally meeting with contractors or their staff to discuss PPV related issues.

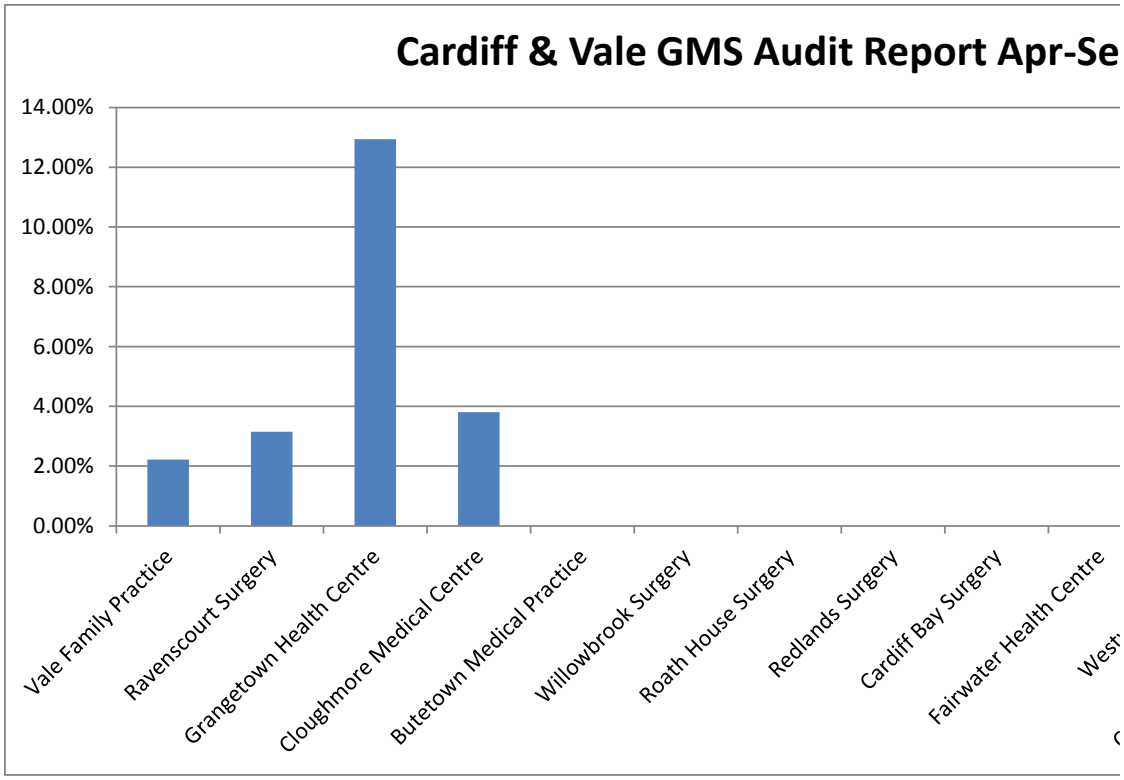
Cardiff & Vale University Health Board
GMS PPV Progress Report: 2017/18

Completed GMS visits

Practice Name	Practice Code	Visit Status	Visit Date	Date initial report sent to contractor	Date final report sent to HB	Report agreed by HB (DOF)	File closed by PPV	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery
Vale Family Practice	W97614	Routine	4/19/2017	4/27/2017	6/15/2017	6/15/2017	6/26/2017	180	10	3.33%	2.22%	£80.90
Ravenscourt Surgery	W97046	Routine	4/24/2017	5/8/2017	6/26/2017	6/29/2017	7/6/2017	254	21	5.12%	3.15%	£492.99
Grangetown Health Centre	W97616	Routine	4/27/2017	5/18/2017	7/3/2017	7/7/2017	7/12/2017	170	45	13.53%	12.94%	£888.62
Cloughmore Medical Centre	W97007	Routine	5/30/2017	6/8/2017	7/13/2017	7/25/2017	7/28/2017	263	10	0.00%	3.80%	£528.25
Butetown Medical Practice	W97291	Routine	6/6/2017	6/13/2017								
Willowbrook Surgery	W97069	Routine	7/5/2017	7/27/2017								
Roath House Surgery	W97034	Routine	7/13/2017	7/21/2017								
Redlands Surgery	W97003	Routine	7/31/2017	8/7/2017								
Cardiff Bay Surgery	W97044	Routine	8/3/2017	8/4/2017								

Fairwater Health Centre	W97047	Revisit	8/15/2017	8/21/2017								
Westway Surgery	W97017	Routine	8/31/2017	9/1/2017								
Cardiff & Vale UHB average								**867**	**86**		**9.92%**	**£1,990.76**

Main error areas
3 x Near patient testing, 1 x Administration of gonadorelins
1 x Anti-coagulation monitoring, 1 x Substance misuse, 1 x Flu vaccination, 2 x Learning disability, 1 x Minor surgery. 1 x Near patient tesing, 1 x Administration of gonadorelins
9 x Near patient testing, 5 x Minor Surgery, 8 x Nursing Home
3 x Anti-coagulation monitoring, 6 x Learning disability, 1 x Flu vaccination


Cardiff & Vale GMS Audit Report Apr-Se
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Vale Family Practice
Ravenscourt Surgery
Grangetown Health Centre
Cloughmore Medical Centre
Butetown Medical Practice
Willowbrook Surgery
Roath House Surgery
Redlands Surgery
Cardiff Bay Surgery
Fairwater Health Centre

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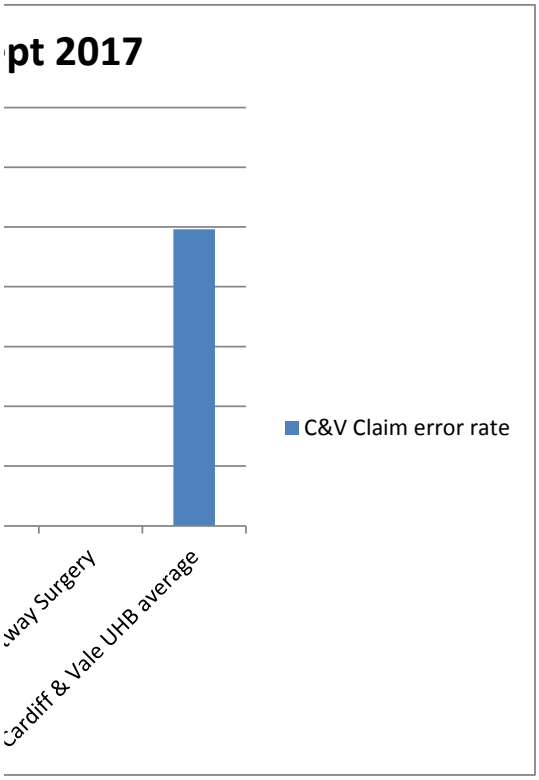
pt 2017
C&V Claim error rate
way Surgery
Cardiff & Vale UHB average

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Cardiff & Vale University Health Boa
GOS PPV Progress Report: 2017/1

Completed GOS visits

Practice Name	Practice Code	Visit Status	Visit Date	Date initial report sent to contractor	Date final report sent to HB	Report agreed by HB (DOF)	File closed by PPV
Specsavers Barry	418	Routine	4/3/2017	4/11/2017	5/2/2017	5/10/2017	5/10/2017
City Road Opticians	492	Revisit	4/18/2017	5/19/2017	6/16/2017	7/28/2017	7/28/2017
Cardiff Uni Eye Clinic	355	Revisit	5/2/2017	6/14/2017	7/28/2017	7/28/2017	7/28/2017
Specsavers Queen Street	352	Routine	5/11/2017	5/12/2017	7/6/2017	7/7/2017	7/10/2017
Arbuthnot Opticians	300	Routine	5/22/2017	5/25/2017	7/14/2017	7/25/2017	7/26/2017
Specsavers Penarth	471	Revisit	5/25/2017	5/26/2017	6/30/2017	7/7/2017	7/14/2017
Specsavers Llanishen	582	Routine	6/13/2017	6/15/2017	7/7/2017	7/7/2017	7/10/2017
J R Lane	479	Routine	6/15/2017	6/26/2017	7/21/2017	7/25/2017	7/28/2017
Asda Opticians Barry	545	Routine	7/3/2017	7/12/2017	8/11/2017		
Eye Centre Llanrumney	371	Routine	7/24/2017	7/24/2017	8/11/2017	8/15/2017	8/15/2017
Optical Health Limited	420/211/452	Routine	8/21/2017				
Costco Leckwith Rd	573	Routine	8/29/2017	8/30/2017			
Pearce & Bowler	515	Routine	8/30/2017	8/31/2017			
S Greenberg Llandaff	326	Routine	9/6/2017				
Direct Eyecare	504	Routine	9/12/2017				
Cardiff & Vale UHB average							

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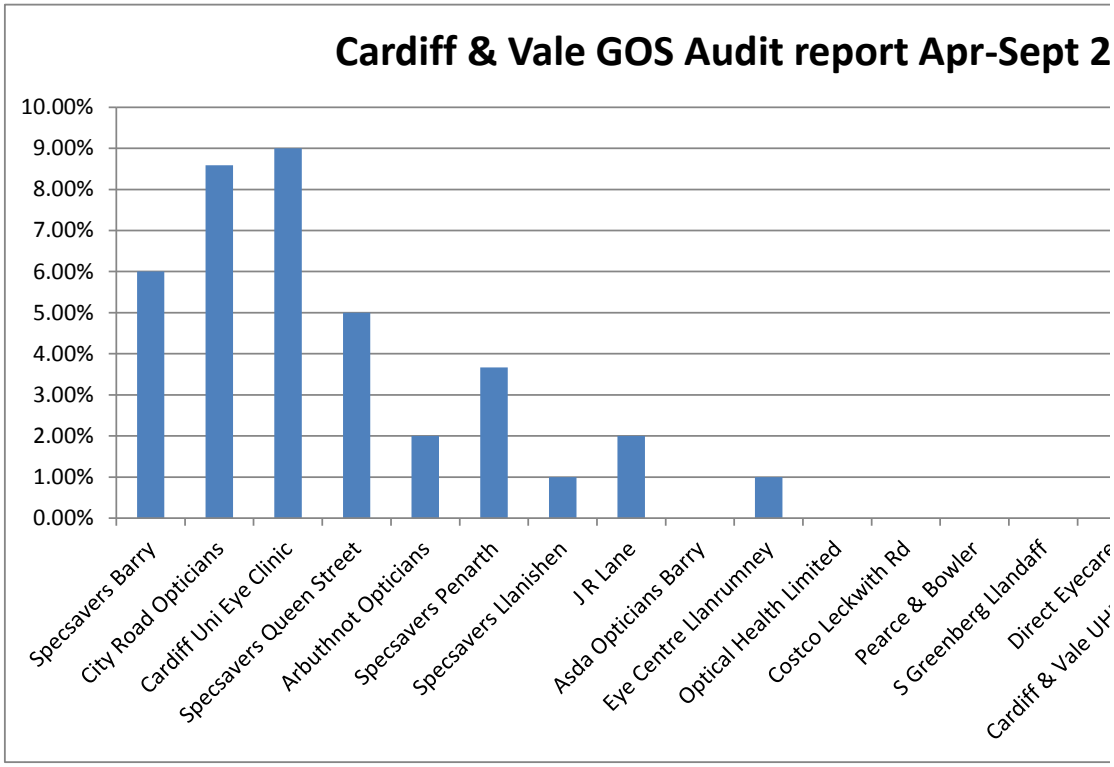
Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
100	6	19.00%	6.00%	£179.20	4 x EHEW, 2 x GOS 3
300	11	0.00%	8.59%	£93.40	11 tint claims that were deemed not clinically necessary
300	27	0.00%	9.00%	£1,260.00	27 x EHEW
100	5	0.00%	5.00%	£188.80	4 x EHEW, 1 x GOS 3
100	2	36.00%	2.00%	£80.00	2 x EHEW
300	11	0.00%	3.67%	£540.00	11 x EHEW
100	1	20.00%	1.00%	£40.00	1 x EHEW
100	2	2.00%	2.00%	£98.70	1 x EHEW, 1 x GOS 4
100	1	9.00%	1.00%	-£10.20	Adjustment of £10.20 in practice favour
1,500	**66**		**4.40%**	**£2,469.90**	


Cardiff & Vale GOS Audit report Apr-Sept 2
10.00%
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Specsavers Barry
City Road Opticians
Cardiff Uni Eye Clinic
Specsavers Queen Street
Arbuthnot Opticians
Specsavers Penarth
Specsavers Llanishen
J R Lane
Asda Opticians Barry
Eye Centre Llanrumney
Optical Health Limited
Costco Leckwith Rd
Pearce & Bowler
S Greenberg Llandaff
Direct Eyecare

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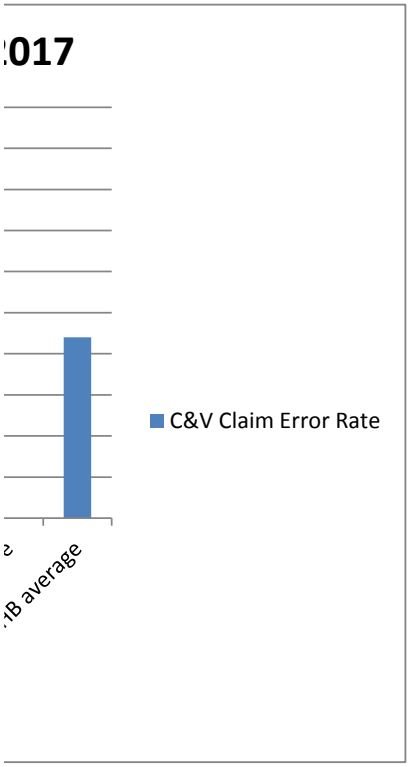

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Cardiff & Vale University He
GOS PPV Progress Report

Completed GPS visits

Practice Name	Practice Code	Visit Status	Visit Date	Date initial report sent to contractor	Date final report sent to HB	Report agreed by HB (DOF)
Mayberry Pharmacy Penarth	602422C	Routine	4/12/2017	4/13/2017	5/24/2017	6/6/2017
Boots UK Ltd Penarth	602816L	Routine	4/12/2017	4/13/2017	5/10/2017	5/11/2017
Lloyds Pharmacy Rhiwbina	602807B	Routine	4/25/2017	4/26/2017	6/15/2017	6/16/2017
Well Pharmacy Rhiwbina	602853H	Routine	4/25/2017	4/28/2017	5/19/2017	6/6/2017
Asda Pharmacy Coryton	602806F	Routine	5/3/2017	5/9/2017	6/15/2017	6/15/2017
Lloyds Pharmacy Park Rd	602807C	Routine	5/3/2017	5/9/2017	6/14/2017	6/15/2017
Central Pharmacy	602004B	Routine	5/8/2017	5/10/2017	7/3/2017	7/11/2017
Boots UK Ltd Albany Rd	602816H	Routine	5/8/2017	5/9/2017	6/20/2017	6/29/2017
Boots UK Ltd Cowbridge Rd	602816J	Routine	6/16/2017	6/22/2017	7/21/2017	7/25/2017
Well Pharmacy Bute St	602855M	Routine	6/16/2017	6/20/2017	7/18/2017	7/25/2017
Boots UK Ltd Cardiff Bay	602818G	Routine	6/21/2017	6/29/2017	8/11/2017	8/31/2017
Tesco Stores Ltd Culverhouse Cross	602870D	Routine	6/21/2017	6/30/2017	8/24/2017	8/24/2017
Clifton Pharmacy	602139B	Routine	7/4/2017	7/5/2017	7/17/2017	7/25/2017
Well Pharmacy Upper Clifton St	602856L	Routine	7/4/2017	7/7/2017	7/28/2017	
M W Phillips Splott Rd	602545L	Routine	8/22/2017			
Boots Uk Ltd Queens St	602816M	Routine	8/22/2017			
Sylvia Williams Chemist Cowbridge	602755C	Routine	9/4/2017			
Lloyds Pharmacy Stirling Rd	602807E	Routine	9/4/2017			

13.1

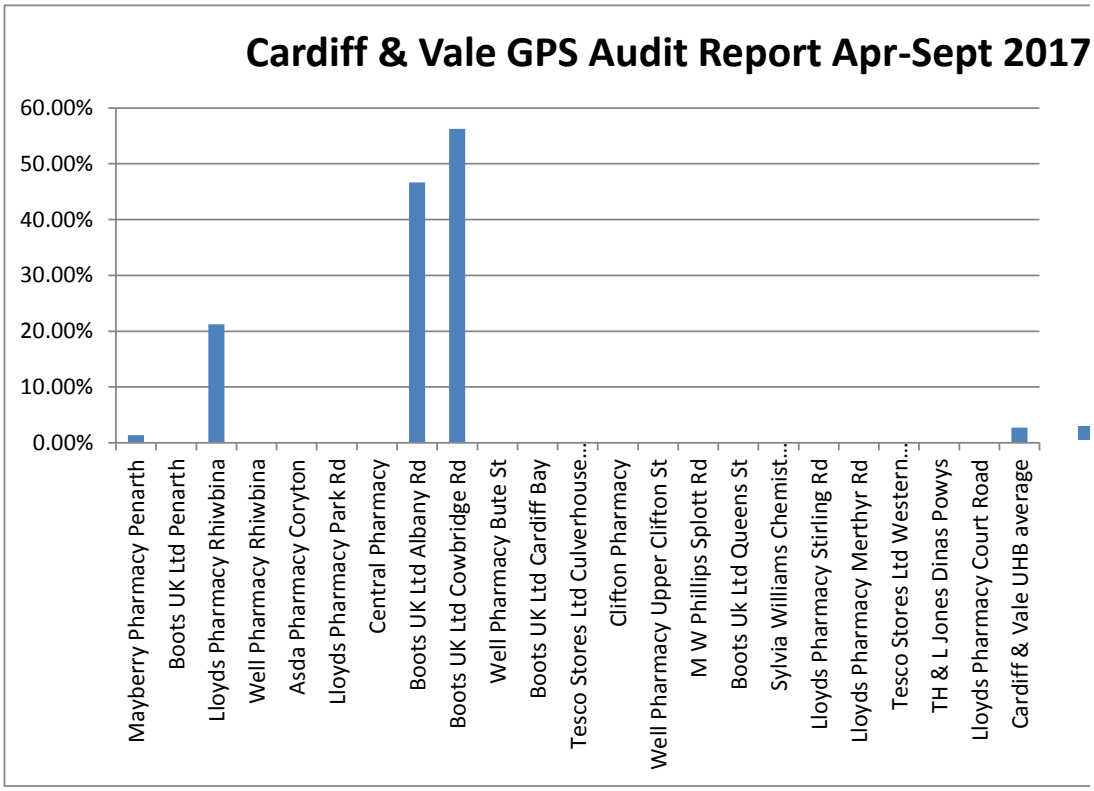
Lloyds Pharmacy Merthyr Rd	602807K	Routine	9/8/2017			
Tesco Stores Ltd Western Avenue	602870M	Routine	9/8/2017			
TH & L Jones Dinas Powys	602381B	Routine	9/18/2017			
Lloyds Pharmacy Court Road	602808G	Routine	9/18/2017			
Cardiff & Vale UHB average						

alth Board
: 2017/18

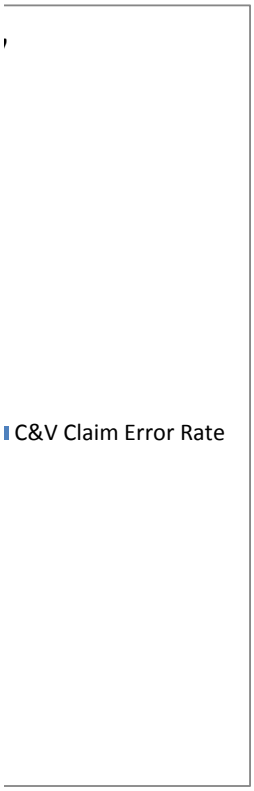
File closed by PPV	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
6/15/2017	73	1	4.11%	1.37%	£28.00	1 x MUR
5/12/2017	100	0	28.75%	0.00%	£0.00	All claims verified
6/19/2017	100	8	18.75%	21.25%	£187.88	5 x MUR, 3 x Flu
7/3/2017	100	0	6.25%	0.00%	£0.00	All claims verified
6/15/2017	88	0	11.36%	0.00%	£0.00	All claims verified
6/15/2017	100	0	16.25%	0.00%	£0.00	All claims verified
7/11/2017	100	0	54.54%	0.00%	£0.00	All claims verified
7/3/2017	99	2	6.27%	46.65%	£43.95	1 x MUR, 1 x Flu
8/9/2017	100	15	22.50%	56.25%	£298.23	5 x MUR, 10 x Flu
8/11/2017						
8/31/2017						
8/30/2017						
7/26/2017	100	0	55.00%	0.00%	£0.00	All claims verified

13.1

	960	**26**		**2.71%**	**£559.32**	


Cardiff & Vale GPS Audit Report Apr-Sept 2017
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Mayberry Pharmacy Penarth
Boots UK Ltd Penarth
Lloyds Pharmacy Rhiwbina
Well Pharmacy Rhiwbina
Asda Pharmacy Coryton
Lloyds Pharmacy Park Rd
Central Pharmacy
Boots UK Ltd Albany Rd
Boots UK Ltd Cowbridge Rd
Well Pharmacy Bute St
Boots UK Ltd Cardiff Bay
Tesco Stores Ltd Culverhouse...
Clifton Pharmacy
Well Pharmacy Upper Clifton St
M W Phillips Splott Rd
Boots Uk Ltd Queens St
Sylvia Williams Chemist...
Lloyds Pharmacy Stirling Rd
Lloyds Pharmacy Merthyr Rd
Tesco Stores Ltd Western...
TH & L Jones Dinas Powys
Lloyds Pharmacy Court Road
Cardiff & Vale UHB average

13.1


C&V Claim Error Rate

Service Type	Practice Name	Practice Code	Visit Status	Sample prepared by PPV	Visit Date	Date initial report sent to contractor	Date final report sent to HB
GMS	Vale Family Practice	W97614	Routine	3/21/2017	4/19/2017	4/27/2017	6/15/2017
GMS	Ravenscourt Surgery	W97046	Routine	3/22/2017	4/24/2017	5/8/2017	6/26/2017
GMS	Grangetown Health Centre	W97616	Routine	3/31/2017	4/27/2017	5/18/2017	7/3/2017
GMS	Cloughmore Medical Centre	W97007	Routine	5/4/2017	5/30/2017	6/8/2017	7/13/2017
GMS	Butetown Medical Practice	W97291	Routine	5/16/2017	6/6/2017	6/13/2017	
GMS	Willowbrook Surgery	W97069	Routine	6/8/2017	7/5/2017	7/27/2017	
GMS	Roath House Surgery	W97034	Routine	6/12/2017	7/13/2017	7/21/2017	
GMS	Redlands Surgery	W97003	Routine	6/12/2017	7/31/2017	8/7/2017	
GMS	Cardiff Bay Surgery	W97044	Routine	7/1/2017	8/3/2017	8/4/2017	
GMS	Westway Surgery	W97017	Routine	7/5/2017	8/31/2017	9/1/2017	
GOS	Specsavers Barry	418	Routine	3/9/2017	4/3/2017	4/11/2017	5/2/2017
GOS	City Road Opticians	492	Revisit	3/15/2017	4/18/2017	5/19/2017	6/16/2017
GOS	Cardiff Uni Eye Clinic	355	Revisit	4/4/2017	5/2/2017	6/14/2017	7/28/2017
GOS	Specsavers Queen Street	352	Routine	4/20/2017	5/11/2017	5/12/2017	7/6/2017
GOS	Arbuthnot Opticians	300	Routine	4/10/2017	5/22/2017	5/25/2017	7/14/2017
GOS	Specsavers Penarth	471	Revisit	5/3/2017	5/25/2017	5/26/2017	6/30/2017
GOS	Specsavers Llanishen	582	Routine	5/19/2017	6/13/2017	6/15/2017	7/7/2017
GOS	J R Lane	479	Routine	5/22/2017	6/15/2017	6/26/2017	7/21/2017
GOS	Asda Opticians Barry	545	Routine	6/2/2017	7/3/2017	7/12/2017	
GOS	Eye Centre Llanrumney	371	Routine	6/22/2017	7/24/2017	7/24/2017	8/11/2017

GOS	Optical Health Limited	420/211/452	Routine	6/20/2017	8/21/2017		
GOS	Costco Leckwith Rd	573	Routine	8/7/2017	8/29/2017	8/30/2017	
GOS	Pearce & Bowler	515	Routine	8/7/2017	8/30/2017	8/31/2017	
GOS	S Greenberg Llandaff	326	Routine	8/11/2017	9/6/2017		
GOS	Direct Eyecare	504	Routine	8/9/2017	9/12/2017		
GPS	Mayberry Pharmacy Penarth	602422C	Routine	3/14/2017	4/12/2017	4/13/2017	5/24/2017
GPS	Boots UK Ltd Penarth	602816L	Routine	3/14/2017	4/12/2017	4/13/2017	5/10/2017
GPS	Lloyds Pharmacy Rhiwbina	602807B	Routine	3/15/2017	4/25/2017	4/26/2017	6/15/2017
GPS	Well Pharmacy Rhiwbina	602853H	Routine	3/16/2017	4/25/2017	4/28/2017	5/19/2017
GPS	Asda Pharmacy Coryton	602806F	Routine	4/25/2017	5/3/2017	5/9/2017	6/15/2017
GPS	Lloyds Pharmacy Park Rd	602807C	Routine	4/24/2017	5/3/2017	5/9/2017	6/14/2017
GPS	Central Pharmacy	602004B	Routine	4/25/2017	5/8/2017	5/10/2017	7/3/2017
GPS	Boots UK Ltd Albany Rd	602816H	Routine	4/25/2017	5/8/2017	5/9/2017	6/20/2017
GPS	Boots UK Ltd Cowbridge Rd	602816J	Routine	5/22/2017	6/16/2017	6/22/2017	7/21/2017
GPS	Well Pharmacy Bute St	602855M	Routine	5/15/2017	6/16/2017	6/20/2017	7/18/2017
GPS	Boots UK Ltd Cardiff Bay	602818G	Routine	5/23/2017	6/21/2017	6/29/2017	8/11/2017
GPS	Tesco Stores Ltd Culverhouse Cross	602870D	Routine	5/17/2017	6/21/2017	6/30/2017	8/24/2017
GPS	Clifton Pharmacy	602139B	Routine	6/20/2017	7/4/2017	7/5/2017	7/17/2017
GPS	Well Pharmacy Upper Clifton St	602856L	Routine	6/20/2017	7/4/2017	7/7/2017	7/28/2017
GPS	M W Phillips Splott Rd	602545L	Routine	8/7/2017	8/22/2017		
GPS	Boots Uk Ltd Queens St	602816M	Routine	8/7/2017	8/22/2017		

GPS	Sylvia Williams Chemist Cowbridge	602755C	Routine	8/15/2017	9/4/2017		
GPS	Lloyds Pharmacy Stirling Rd	602807E	Routine	8/15/2017	9/4/2017		
GPS	Lloyds Pharmacy Merthyr Rd	602807K	Routine	8/15/2017	9/8/2017		
GPS	Tesco Stores Ltd Western Avenue	602870M	Routine	8/15/2017	9/8/2017		
GPS	TH & L Jones Dinas Powys	602381B	Routine	8/16/2017	9/18/2017		
GPS	Lloyds Pharmacy Court Road	602808G	Routine	8/16/2017	9/18/2017		

		PPV KPI's		
Report agreed by HB (DOF)	**File closed by PPV**	**Visits against Visit plan programme**	**File closed 3 months from visit date**	**Sample prepared 2 weeks in advance**
6/15/2017	6/26/2017	✓	✓	✓
6/29/2017	7/6/2017	✓	✓	✓
7/7/2017	7/12/2017	✓	✓	✓
7/25/2017	7/28/2017	✓	✓	✓
		✓		✓
		✓		✓
		✓		✓
		✓		✓
		✓		✓
		✓		✓
5/10/2017	5/10/2017	✓	✓	✓
7/28/2017	8/4/2017	✓	✖	✓
7/28/2017	7/28/2017	✓	✓	✓
7/7/2017	7/10/2017	✓	✓	✓
7/25/2017	7/26/2017	✓	✓	✓
7/7/2017	7/14/2017	✓	✓	✓
7/7/2017	7/10/2017	✓	✓	✓
7/25/2017	7/28/2017	✓	✓	✓
		✓		
8/15/2017	8/15/2017	✓	✓	✓

		✓		✓
		✓		✓
		✓		✓
		✓		✓
		✓		✓
6/6/2017	6/15/2017	✓	✓	✓
5/11/2017	5/12/2017	✓	✓	✓
6/16/2017	6/19/2017	✓	✓	✓
6/6/2017	7/3/2017	✓	✓	✓
6/15/2017	6/15/2017	✓	✓	✓
6/15/2017	6/15/2017	✓	✓	✓
7/11/2017	7/11/2017	✓	✓	✓
6/29/2017	7/3/2017	✓	✓	✓
7/25/2017	8/9/2017	✓	✓	✓
7/25/2017	8/11/2017	✓	✓	✓
8/31/2017	8/31/2017	✓	✓	✓
8/24/2017	8/30/2017	✓	✓	✓
7/25/2017	7/26/2017	✓	✓	✓
		✓		✓
		✓		✓
		✓		✓

		✓		✓
		✓		✓
		✓		✓
		✓		✓
		✓		✓
		✓		✓

Comments
All KPI's met
All KPI's met
All KPI's met
All KPI's met
All KPI's met
Closure of file delayed due to practice wanting OPH advisor to visit premises
All KPI's met
All KPI's met
All KPI's met
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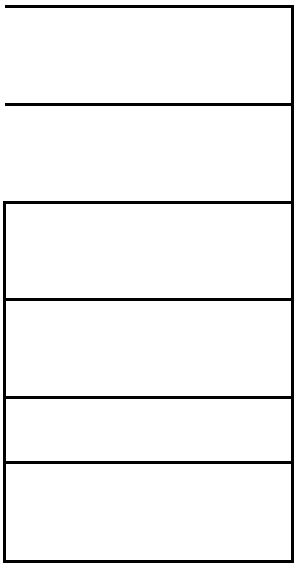

13.1

REPORT OF THE DIRECTOR OF CORPORATE GOVERNANCE	
Name of Meeting : Audit Committee	**Date of Meeting:** 22/09/2017

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance
Caring for People, Keeping People Well : This paper supports our Value and Behaviour which is an integrated part of our Strategy
Financial impact : N/A
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard Number …
CRAF Reference Number : 1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE
is provided by:

- Report requested by the Chair of the Audit Committee

The Board is asked to:

- **NOTE** the paper

SITUATION

Following discussion with the new Chair of the Audit Committee, it has been proposed that we introduce a Report from the Director of Corporate Governance at each meeting of the Audit Committee.

BACKGROUND

The Audit Committee received regular reports on governance at each meeting of the Committee. Traditionally this has been provided in the sections of the Agenda for the meeting called “Committee Governance”. This includes:

- The Corporate Risk and Assurance Framework
- External Audit Tracking Reports
- Reports on Hospitality Registers and Declarations of Interest
- Wales Audit Office Reports.

It is now suggested by the Chair of the Audit Committee that we include a Report from the Director of Corporate Governance in this section as a standing agenda item.
In summary this report will:

- Strengthen the governance reporting to the Committee
- Escalate relevant governance issues to the Audit Committee in an open and transparent manner
- Provide a forward plan for key governance issues and provide the Committee the opportunity to influence these
- Ensure greater linkages and connectivity on governance issue between the Audit Committee and other Committee of the Board.

ASSESSMENT AND ASSURANCE

The purpose of the Report of the Director of Corporate Governance is summarized below.

The report will provide the opportunity for the Director of Corporate Governance to raise any concerns/issue directly to the Committee. The introduction of this is also in line with the White paper service. Fit for the Future – Quality in Governance in Health and Care in Wales".
This paper specifies that the role of the Director of Corporate Governance (Board Secretary) is:

i. Crucial to the ongoing development and maintenance of a strong governance framework within NHS organisations. As principal advisor to the Board and the organization, they are a key source of advice and support on all aspects of good governance and the assurance framework.

ii. The Board Secretary is not a Board member, and the Independence of the role is an important element of the assurance mechanism to ensure that the Board is properly equipped to fulfill its responsibilities and meet its statutory duties.

iii. The importance of the separation and accountability of the Board Secretary role is understood and consideration should be given to providing statutory protection for the role.

iv. There is the potential statutory protection to have a Board Secretary and for the role, there is protection to cover raising concerns and independently challenging the decisions of the Chief Executive and the Board more widely.

v. The Board Secretary should be able to highlight in a report when/if there is a key issue of concern to either the Board Chair or Chief Executive, depending on where the concern lies;

The report will provide the opportunity to provide the Committee with a forward looking "Corporate Governance Plan" over the next 6 month period.

From September 2017 to March 2018 the following work is to be progressed and updates on progress brought to each Committee meeting:

- Review of Standing Orders;
- Review of 3 important policies i.e. Standards of Behaviour Framework Policy and those relating to UHB Policies and our Risk Management. In addition, we are strengthening our Corporate systems of policy oversight and continue to provide support throughout the UHB regarding policy review and renewal to reduce the number of outdated policies.
- Introduction of a new Internal Audit tracking system for follow up actions/management responses to Internal Audit Reports;
- Progress on Wales Audit Office Structured Assessments recommendations;
- Review of the Corporate Risk and Assurance Framework;

  The Board Development session on 27 April 2017 was focused on risk management and our current process. The session was well attended and included Clinical Board representatives, Assistant Directors, risk leads and representatives from Internal Audit and the Community Health Council. The outcome of the session was the agreement that our current process, and way we view risk requires review and renewal to reflect the principles demonstrated during the session. The Board agreed the proposals for review on 25 May 2017 and this work is being progressed-engagement is underway with Clinical Boards and Corporate areas to support review and amendment of their registers and a short, simple procedural guide has been produced to share with all areas to support the review and ongoing maintenance of registers.
- Review of Committee working;
- A new approach to Integrated Governance and Accountability Report;
- Board Induction and Training.

MONITORING OF DECLARATIONS OF INTEREST AND GIFTS, HOSPITALITY AND SPONSORSHIP	
Name of Meeting : Audit Committee	**Date of Meeting : 26 September 2017**

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance
Caring for People, Keeping People Well: This, underpins the Health Board's "Values", element of the Strategy
Financial impact : N/A
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard Number : 1
CRAF Reference Number : 1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION this will provide the basis of the minute

ASSURANCE is provided by:

- Regular or reminders to manage to ensure declarations are made

The Committee is asked to:

- **NOTE** Declarations of interest
- **AGREE** to receive an update on progress for March 2017 to September 2017 (at the September meeting)

SITUATION

In accordance with the Annual Work plan of the Audit Committee a report providing an update regarding the implementation of the Standards of Behaviour Policy, incorporating Gifts, Hospitality and Sponsorship was scheduled for presentation to the September meeting. A further update is scheduled for February 2018.

BACKGROUND

The Board approved the Standards of Behaviour Policy incorporating Declarations of Interest, Gifts, Hospitality and Sponsorship (the Framework) in June 2014. The aim of this Policy is to ensure that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture

public acceptability of behaviours of those working in the public sector so that the University Health Board (the UHB) can be seen to have exemplary practice in this regard.

ASSESSMENT AND ASSURANCE

The Gifts, Hospitality and Sponsorship Register has been maintained throughout this period. Extracts from the Register for the period March 2017 – September 2017 to date is attached as an Appendix.

The UHB remains committed to ensuring that it is open and transparent. The Declarations of Interest Register is published on the UHB Internet and Intranet sites. There are plans to publish the Gifts, Hospitality and Sponsorship Register early in the New Year.

The Standards of Behavior Policy is due for review in January 2018. It is suggested that this would be an appropriate time to re-invigorate the policy.

Designation	Clinical Board/ Corporate Directorate	Date Form Completed	Date Approved by Director	Date Received/ Recorded by Governance Department	Start Date of Event (if applicable)	End Date of Event (if applicable)	Form Completed before event	Description	Gift/ Hospitality or Sponsorship	Name of Doner / Sponsor	Value (if known)	Study Leave	Comments
Consultant Cardiothoraic Surgeon	CT Surgery	08/05/2017	SENTBACK FOR COMPLETION	09/05/2017					Gift	Mr Raymond Deville			
Consultant Cardiothoraic Surgeon			SENTBACK FOR COMPLETION	09/05/2017									
Engagement Lead	Planning	15/05/2017	15/15/2017	19/05/2017	20/05/2017	20/05/2017	Yes	Invitation provided as partnership working "Music to our Ears". Ticket to opening night	Hospitality	Welsh National Opera Wales Millenium Centre Bute Place Cardiff	£8.50 - £44.50	No	
Consultant Anaesthectics	Surgery	25/05/2017	20/06/2017	26/07/2017	22/05/2017	23/05/2017	No	Two day study course and wet lab course. Mlaur Fasda why and how to move from full sternogomy to mini, sponsorship includes course fee, travel, stay and dinner.	Sponsorship	Edwards Life Science Ltd 3 The Sector Newbury Business Park Berkshire RG14 2PZ	£500.00	Yes	

REGULATORY AND REVIEW BODIES TRACKING REPORT **1 April 2017 – 31 SEPTEMBER 2017**	
Audit Committee	**26 SEPTEMBER 2017**

Executive Lead : Director of Corporate Governance
Author :
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: Not applicable
Quality, Safety, Patient Experience impact: Not applicable
Health and Care Standard Number: Governance, Leadership and Accountability Standard
CRAF Reference Number: 8.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE is provided by:

- Receiving reports and information regarding inspections undertaken by the various inspection / review bodies.

The Committee is asked to:

- **NOTE** the Regulatory and Inspections Visits Tracking Report

SITUATION

This report is presented to the Committee to track the relevant Board Committees are receiving reports and information regarding inspections undertaken by the various inspection / review bodies as a key source of assurance. The report provides information for the period April 2017 to September 2017 and includes:

a) New inspections undertaken during the period as recorded in the post log or notified by Clinical Boards
b) Formal reports received during the period. Some reports are received a number of months after the actual inspection.

BACKGROUND

The statutory obligations of the University Health Board (the UHB) are wide ranging and complex; the UHB must comply with general law as well as NHS specific legislation. The majority of regulatory visits monitored by the Health and Safety Committee fall into the following categories:

- Food hygiene inspections undertaken by the Local Authorities
- Inspections undertaken by the Health and Safety Executive
- Fire Safety inspections undertaken by South Wales Fire and Rescue Service

ASSESSMENT AND ASSURANCE

The attached report provides evidence that each category of review is assigned to an appropriate Board Committee or sub-Committee. It contains a summary of inspection or regulatory visits of which updates on outstanding actions are provided.

Health and Safety Executive Enforcement Notice

There was nothing of note to report for this period.

Fire Service Informal Notices

These are reported to and monitored by the Fire Safety Group which then provides assurances to the Health and Safety Committee.

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 August 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
2	**Cardiff Council**								**Health and Care Standards** **Theme 1: Staying Healthy** ***Standard 1.1 Health Promotion, Protection and Improvement*** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.5 Nutrition and Hydration***							
3	14th July 2017	13th July 2017	Rookwood Main Kitchen and Ward Kitchens	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address minor issues raised. To be monitored by the PFI/Compliance Manager on behalf of Director of Capital, Estates and Facilities	Director of Strategic Planning		Action Plan Developed	Completed	Health and Safety - Martyn Waygood				**No**
4	23-Mar-17	10-Mar-17	Lakeside CPU, UHW	Planning	Food Hygiene Inspection	Food Hygiene scored 5. There were no contraventions in relation to food hygiene and safety procedures - score 0. Structural / Cleaning issues: high standard of compliance with statutory obligations - risk score 5.	All recommendations will be actioned	Director of Strategic Planning			Ongoing	Health and Safety - Martyn Waygood				
5	8 August 2016	28 July 2016	Food Production, Restaurant Services and Wards, UHL	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 4 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised. To be monitored by PFI/Compliance Manager on behalf of the Director of Capital, Estates and Facilities	Director of Capital, Estates and Facilities		Action plan developed		Health and Safety Committee - Martyn Waygood		11 October 2016		
6	8 August 2016	4 August 2016	Teddy Bear Nursery, UHL	Workforce and OD	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 4 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised.	Director of Workforce & OD		Action plan developed		Health and Safety Committee - Martyn Waygood		11 October 2016		
7	Not known	16 June 2015	Central Production Unit, UHW	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 2 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Operational Services.	Director of Strategic Planning		Action plan developed.	On-going	Health and Safety - Martyn Waygood	Private Board Meeting - 7 July 2015	28 July 2015		No
8	Not known	30 June 2015	Heathfields Restaurant, Catering outlet in Theatres, Aroma Coffee Unit in Childrens Hospital and the Teddy Bear Nursery	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 2 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Operational Services.	Director of Strategic Planning		Action plan developed.	On-going	Health and Safety - Martyn Waygood	Private Board Meeting - 7 July 2015	28 July 2015		No
9	**Vale of Glamorgan Council**								**Health and Care Standards** **Theme 1: Staying Healthy** ***Standard 1.1 Health Promotion, Protection and Improvement*** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.5 Nutrition and Hydration***							
10																
11																

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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12	**Natural Resources Wales**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety***							
13																
14	**Community Health Council**								**Health and Care Standards** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk*** **Theme 4: Dignified Care** ***Standard 4.1 Dignified Care*** **Theme 6: Individual Care** ***Standard 6.2 People's Rights,***							
15	Visits captured via different reporting system and assurance provided via Quality, Safety and Experience Committee.															
16	**Health Inspectorate Wales**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 6: Individual Care** ***Standard 6.2 People's Rights, Standard 6.3 Listening and Learning from feedback*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care*** **Theme 4: Dignified Care** ***Standard 4.1 Dignified Care*** **Theme 2: Safe Care** ***Standard 2.3 Falls Prevention, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk, Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.4 Infection Prevention and Control and Decontamination***							
26	24 February 2015	5 February 2015	E3 Whitchurch	Mental Health	MH Act Monitoring Visit.	No breaches of the Act. Some improvements required in Environment of	Estates issues resolved; Directorate Management Team	COO	18 April 2015	Estates issues resolved; Directorate Management Team	Partially completed.	Mental Health and Capacity Legislation		19 May 2015	Not specified	Yes
27		18 July 2017	G O'Keefe and J Jones Dental Surgery									Quality & Safety				
28		17 July 2017	Mydentist, Llanrumney									Quality & Safety				
29		28 June 2017	Restore Dental Group									Quality & Safety				
30		21 June 2017	Hillcrest Dental Practice									Quality & Safety				
31		12 & 13 June 2017	Children's Hospital for Wales									Quality & Safety				
32		started 06/2017			Thematic Review of CMHTs							Quality & Safety				
33		8 May 2017	Calgary Dental Practice									Quality & Safety				
34		Started 05/07			Thematic Review of discharge processes Phase 2							Quality & Safety				
35																
36	**Health and Safety Executive**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety*** **Theme 3: Effective Care** ***Standard 3.5 Record Keeping***							
37	29 May 2015	14 May 2015	UHW	Various	Visit to consider compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations	Many areas of good practice found but also some failures which resulted in the serving of an Improvement Notice.	Action plan developed and Task and Finish Group formed.	Director of Strategic Planning	Original date = 27 August 2015. Extension sought and granted to 27 September 2015	Progress being made to ensure compliance by the 27 September 2015. Further update to be provided to the Health and Safety Committee on the 6th October 2015	Partially completed.	Health and Safety - Martyn Waygood		28 July 2015		Yes
38	19 September 2016	19 September 2016	Hydrotherapy Pool - Rookwood Hospital	Capital, Estates and Facilities/Clinical Diagnostics and Therapeutics Boards	Visit in conjunction with Environmental Health	A number of issues were raised in relation to the maintenance and management of the hydrotherapy pool.	Action Plan developed, documentation has been sent to the HSE	Director of Capital, Estates and Facilities/Head of Physiotherapy	On-going	Awaiting further communication the HSE.	On-going	Health and Safety - Martyn Waygood		11th October 2016		
39	22 September 2016	23 September 2016	University Hospital of Wales	Capital, Estates and Facilities	Fall of Contractor from Women's Unit	Currently being investigated internally and by the HSE.	Investigation commenced	Director of Capital, Estates and Facilities/Head of Health and Safety	On-going	Investigation commenced	On-going	Health and Safety - Martyn Waygood		11th October 2016		

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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40	**Human Tissue Authority (HTA)**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety*** **Theme 3: Effective Care** ***Standard 3.5 Record Keeping***							
41	No visits during period															
42	**Medicines and Health Care Regulatory Agency (MHRA)**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.9 Medical Devices, Equipment and Diagnostic Systems*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.5 Record Keeping***							
43		30 April 2015	Radiopharmacy	Clinical Diagnostics and Therapeutics Clinical Board		0 Critical, 0 Majors and 8 Others	Action plan close out date agreed with Regulators - September 2015.	Medical Director	Sep-15			Quality, Safety and Experience Committee - Prof Elizabeth Treasure	CD&T Quality and Safety sub-Committee	16 June 2015		No
44		1 June 2015	Pharmacy	Clinical Diagnostics and Therapeutics Clinical Board				Medical Director				Quality, Safety and Experience Committee - Prof Elizabeth Treasure				No
45	**South Wales Cancer Network**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.6 Medicines Management, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk, Standard 2.8 Blood Management*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.2 Communicating Effectively, Standard 3.4 Information Governance and Communications Technology, Standard 3.5 Record Keeping, Standard 3.3 Quality Improvement, Research and Innovation*** **Theme 4:** ***Dignified Care Standard 4.1 Dignified Care, Standard 4.2 Patient Information*** **Theme 6: Individual Care** ***Standard 6.1 Planning Care to Promote Independence, Standard 6.2 People's Rights, Standard 6.3 Listening and Learning from Feedback***							
46	3/9/2016		Haematology Cancers		HIW & South Wales Cancer Network - Haematology Cancer Peer Review			Medical Director	01 May 2016			Quality & Safety Experience Committee - Prof Elizabeth Treasure				
47	11 December 2014	24 September 2014	Head and Neck Cancers		Peer review for quality assurance against a framework of standards of care.	Good new patient processes but insufficient capacity to manage follow ups. Insufficient access to theatre lists to meet demand. Cohesive team providing high quality service. team should be commended for their collective approach to the information and supporting evidence provided as part of the peer review self assessment process. cohesive team who had developed good working relationships both within the MDT and with colleagues across south east Wales. The MDT delivers a patient centred service to the population of Cardiff and Vale as well as providing a specialist surgical tertiary service for patients across south east Wales	Theatre capacity project under way. Action plan developed to meet minor concerns.	Medical Director		Most actions completed. Review of theatre allocation within South Wales Plan and continuing GP education on-going.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		Not known - evidence of written report.		

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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48	31 March 2015	30 January 2015	Gynae-oncology		Peer review for quality assurance against a framework of standards of care.	Surgical capacity limited. Brachytherapy service jeopardised owing to staffing issues. No lead nurse for cancer. Comprehensive information and supporting documentation submitted in support of the self assessment component of the Peer Review process. Collaborative approach to the information submitted. Team has good mix of professional groups and a strong relationship with oncology provided via a different organisation. The team displayed good interaction between each other and clear self awareness of the issues that faced the team. Serious concerns about maintaining oncology resource and MDT not adequately fulfilling its regional specialist function. Data management requires improvement. MDT needs more time.	Action plan developed.	Medical Director	Actions should be completed between July and November 2015.	On-going.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		21 April 2015 (verbal report) and written report 1 September 2015.		Yes
49	10 June 2015	12 May 2015	Breast		Peer review for quality assurance against a framework of standards of care.	No workforce plan to address staff shortages. Limited MRI capacity. Large well resourced team with inbuilt resilience. Hosts the only Consultant Breast Cancer Nurse in Wales Concerns regarding the single handed oncology nurse in/from Velindre who cares for breast patients in need of oncological intervention. It was noted that the follow up protocol in use was not compliant with NICE guidance - the team had their own data in support of their preferred follow up protocol. It is recommended that the team share their findings with the relevant NSAG in order to discuss/formalise their approach. Some of the resource issues raised by the team alluded to infrastructure and noting the size and practice of the team this was felt to be an important part of the service to be delivered.	Action plan developed.	Medical Director				Quality, Safety and Experience Committee - Prof Elizabeth Treasure		21 April 2015 (verbal report)		Yes
50	19 October 2015	19 October 2015	Skin Cancer Peer Review													email on CE post log. Not saved in HQ filing
51					Haematology Cancer Peer Review	Reports will be formally published idn May 2016		Medical Director								
52	**South Wales Fire and Rescue**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety***							
53	5 January 2015	11 and 17 December 2014	Wards E10, 12, 14, 16 and 18 (MHSOP UHL)	Mental Health	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order	Awaited	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	1 issue outstanding	CLOSED OUT	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
54	27 January 2015	19 November 2014	Whitchurch Hospital	Mental Health	Scheduled inspections for high risk premises	Enforcement Notice issued (EN56/14). Issues with compartmentation, furniture, smoking, emergency routes		Director of Strategic Planning	27 July 2017	SWFRS recognise that Whitchurch site will be closed as a hospital; 2 year completion date set. Occupation extended SWFS agreed extension till 27/07/2017	Enforcement notice withdrawn	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	13 January 2015		Yes but not logged as an Enforcement Notice
55	26 February 2015	23 February 2015	Tenovus Building	Cardiff University	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		On-going	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
56	9 April 2015	8 April 2015	Community Mental Health Centre Cowbridge Road West	Mental Health Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Remains on-going	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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57	10 September 2015	9 September 2015	Service Tunnels, UHW	Estates	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Ongoing	Ongoing	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
58	22 January 2016		34 Wordsworth Avenue, Roath	Mental Health	Scheduled inspections for high risk premises	Fire Safety Notice		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been		Ongoing	Health and Safety - Martyn Waygood			N/A	
59	12 February 2016		Cardigan House	Exec	Scheduled inspections for high risk premises	Fire Safety Notice		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check		Complete	Health and Safety - Martyn Waygood			N/A	
60	12 February 2016		Services Accommodation Centre, UHW	Exec	Scheduled inspections for high risk premises	Fire Safety Notice		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been		Ongoing	Health and Safety - Martyn Waygood			N/A	
61	8 March 2016		Ward B3 ICU UHW	Specialist Services Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order	Outstanding Capital issues that are being addressed in phased programme of remediationOutstanding Capital issues that are being addressed in phased programme of remediation	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Ongoing	Health and Safety - Martyn Waygood			N/A	
62	15 March 2016		Lansdowne Ward, St David's Hospital		Scheduled inspections for high risk premises	Fire Safety Order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Complete	Health and Safety - Martyn Waygood			N/A	
63	15 March 2016		Rhydlafa Ward, St David's Hospital		Scheduled inspections for high risk premises	Fire Safety Order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Complete	Health and Safety - Martyn Waygood			N/A	
64	18 March 2016		Stroke Unit, UHL	Medicine Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice.		Complete	Health and Safety - Martyn			N/A	
65	5 April 2016		Longcross House Health Unit, Physiotherapy Unit	CD&T	Scheduled inspections for high risk premises	Fire Safety Notice		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Vacated	Health and Safety - Martyn Waygood			N/A	
66	2 June 2016	25 May 2016	West 6 UHL	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x Compliance 5 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	1 x Compliance - Completed 2 x Management - Completed 3 x Management - Outstanding	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	19 July 2016 11 October 2016	N/A	
67	9 June 2016	6 June 2016	Ward A5 UHW	Surgery Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 4 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	4 x Management - Outstanding	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	19 July 2016 11 October 2016	N/A	
68	12 October 2016		Ward B4, UHW	Specialist Services Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order	Outstanding Capital issues that are being addressed in phased programme of	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check		Ongoing	Health and Safety - Martyn Waygood			N/A	
69	12 October 2016		Ward A4, UHW	Medicine Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order	Outstanding Capital issues that are being addressed in phased programme of	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check		Ongoing	Health and Safety - Martyn Waygood			N/A	
70	17 November 2016		Ward C4, UHW	Specialist Services Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order	Outstanding Capital issues that are being addressed in phased programme of remediationOutstanding Capital issues that are being addressed in phased programme of remediation	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Ongoing	Health and Safety - Martyn Waygood			N/A	
71	3 May 2017	27 April 2017	Ward B6 & C6 UHW	Surgery Clinical Board Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2 x Management		Director of Planning	IN02: non-compliance but insufficient for enforcement notice. May return to check works have been done.	2 x Mangement actions dismissed by Fire Officer	On-going	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	18th July 2017		No
72	14 June 2017	8 June 2017	Hafan Y Coed Adult Mental Health Unit UHL	Mental Health	Audit of Fire Safety Arrangements	Failure to comply with the Regulatory Reform (Fire Safety) 2005		Director of Planning	Enforcement Notice	12 Point Action Plan developed	2 action points outstanding	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	18 July 2017	60 days from date of notice	Yes
73	20 July 2017	12 July 2017	Llanishen Clinic (upper) CF14 5DB	Primary, Community Itermediate Care	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 3 x Management 1x Estates 3 x Compliance		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.			Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting			Yes

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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74	24 July 2017		Llanishen Upper			Fire Safety Order		Director of Strategic Planning			Completed					
75	24 July 2017		Whitchurch Hospital			Fire Safety Order		Director of Strategic Planning			Extension					
76	24 July 2017		Llanishen Lower			Fire Safety Order		Director of Strategic Planning			To be completed this week					
77	14 August 2017			Mental Health Clinical Board		Fire Safety Order	HYC Adult Mental Health UHL application for an extension has been approved	Director of Strategic Planning			Enforcement notice withdrawn 12.09.17	Health and Safety - Martyn Waygood				

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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78	**National Patient Safety Agency (NPSA)/Patient Safety Wales**								**Health and Care Standards** **Theme 6: Individual Care** ***Standard 6.2 People's Rights, Standard 6.3 Listening and Learning from feedback*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Quality Improvement, Research and Innovation*** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety***						
79	5 February 2007				Patient Safety Notice NPSA/2007/16: Early identification of failure to act on radiological imaging reports	Update to WG in July 2015: the UHB reported non-compliance in January 2015				The UHB has undertaken benchmarking work to establish how other organisations are achieving full compliance. Systems and processes rely on manual audit. Radiology has protocols in place but a review of systems in the Clinical Boards was not rigorous. In the absence of an electronic solution, the UHB needs to establish an audit process and consider whether a policy on this matter is required.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
80	3 July 2007				Patient Safety Notice 24: Standardising wristbands improves patient safety	Update to WG in July 2015: Partial compliance; an electronic solution would ensure compliance and the UHB will reconsider funding a potential solution in the next financial year				The UHB has undertaken benchmarking work and concluded that other organisations have achieved compliance by implementation of an electronic solution. Investment in an electronic solution is necessary for the UHB to achieve compliance. Continued non-compliance with this Patient Safety Notice should be recorded formally on the corporate risk register. Reinforcement of the relevant patient identification policies will still be required even if electronic wristband solutions are funded.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
81	24 June 2009				Patient Safety Notice NPSA/2009/SPN002 : Risk to patient safety of not using the NHS number as the national identifier for all patients	Update to WG in July 2015: Partial compliance; an electronic solution would ensure compliance and the UHB will reconsider funding a potential solution in the next financial year				Investment in an electronic wristbands solution would assist progress in achieving compliance with this alert also. However, it should be noted that there is significant reliance on use of the local hospital number in favour of the NHS number.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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82	12 September 2014				Alert PSA/002: The prompt recognition and initiation of treatment for sepsis for all patients	Update to WG July 2015: non-compliant			28 November 2014	Actions required to achieve compliance: • Implementation of NEWS in community hospitals – Resuscitation Service report staffing resource as a barrier to progress •Identify a clinical lead to participate in the national work to agree the systems and tools required to promote the early identification and treatment for sepsis in children – response outstanding from Children and Women Clinical Board An organisational lead for Sepsis has just been appointed to progress this work		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
83	18 July 2014				Notice PSN002: the surgical management of urinary incontinence and pelvic organ prolapse	Update to WG July 2015: non-compliant			31 July 2014	Actions required to achieve compliance: • The Assistant Clinical Director for Obs & Gynae is finalising plans to enable the reporting of all mesh related adverse events to the MHRA. This will facilitate the retrospective reporting from 2014 and allow prospective reporting going forward. The aim is for this to be in place by September 2015.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
84	24 July 2015				Notice PSN015: The storage of medicines Refrigeratiors		Actions to achieve compliance are being led the Medication Safety Executive Group.		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure	Internal audit report (Limited Assurance) on this went to Audit Committee 26 May and management action plan on 22 September.	1 September 2015		No
85	24 July 2015				Notice PSN016: Risk of inadvertently cutting in-line (or closed) suction catheters		Actions to achieve compliance are being led by the Lead Nurse for Acute Child Health and Lead Nurse for Adult Critical Care.		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
86	27 July 2015				Notice PSN014: Residual anaesthetic drugs in cannualae and intravenous lines		Actions to achieve compliance are being led by the Clinical Director for Anaesthetics		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
87	29 July 2015				Notice PSN017: Risk of using vacuum and suction drains when not clinically indicated		Actions to achieve compliance are being led by the Senior Nurse for Perioperative Directorate.		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
88	29 July 2015				Notice PSN018: Risk of severe harm and death from unintentional interruption of non-invasive ventilation		Further to correspondence from the Clinical Director Internal Medicine, the UHB will be able to report compliance with this notice.		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

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89	**Wales Audit Office**															
90	Reports monitored via separate tracking report															
91	**ACCREDITATION VISITS**															
92	**Home Office**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.9 Medical Devices, Equipment and Diagnostic Systems*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.5 Record Keeping***							
93	Annual application made for licence to hold and test controlled drugs in the Toxicology laboratory. Licence applied for in February 2014 and received in July 2014. Licence has never been refused and there are no actions for the UHB to undertake as long as compliance is maintained. No report centrally captured.															
94	**British Standards Institute**															
95	No reports received															
96	**UK Accreditation Service (UKAS)**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.9 Medical Devices, Equipment and Diagnostic Systems*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.5 Record Keeping***							
97	No inspections during period															
98	**General Medical Council (GMC)**								**Health and Care Standards** **Theme 7: Staff and Resources** ***Standard 7.1 Workforce***							
99	Medical Director meets regularly with Local GMC representative. No routine inspections conducted.															
100	**Deanery Training Report**															
101	Medical Director meets regularly with Local Deanery representative. No routine inspections conducted. Questionnaires completed by students; if any major issues identified, Deanery discusses with Medical Director.															
102	**SGS United Kingdom Ltd**															
103	No reports captured.															
104	**WELSH RISK POOL**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.4 Infetion Prevention and Control and Decontamination, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.5 Record Keeping*** **Theme 6: Individual Care** ***Standard 6.3 Listening and Learning from Feedback***							
105	19 and 20/11/2014	24/06/2015 (emailed to GS, RW, Kieron Bhal and Eirlys Ferris)	Maternity Services		Annual review of high risk areas	Documentation Score: 99%, Interview Score 80%, Over all Assessment Score: 89%			Most actions to be completed by end 2015. Impact of South Wales Programme to inform implementation Sept 2016 1 April 2017. Birth Rate Plus data to inform correct staffing levels has been requested.			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

17

	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 31 August 2017 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Complete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
INFORMATION COMMISSIONER'S OFFICE									**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk*** **Theme 3: Effective Care** ***Standard 3.4 Information Governance and Communications Technology, Standard 3.5 Record Keeping*** **Theme 4: Dignified Care** ***Standard 4.2 Patient Information***							
	13 May 2015	February and March 2015	UHB- wide on-line survey	UHB-wide	Information Governance training review	A number of areas require attention, all of which indicate the need for a strengthened training framework. The UHB has a significant amount of work to do to meet the standards. It is required to develop a comprehensive training framework and integrate all current training delivery. This should be done in line with the Information Governance Policy and organisational arrangements.	The UHB's Learning, Education and Development department are fully involved in considering the outcome of the report and advising on the way forward.	G Shortland	No date specified	The UHB's Learning, Education and Development department are fully involved in considering the outcome of the report and advising on the way forward.	On-going	People, Performance and Planning - Prof Marcus Longley	Information Governance sub-Committee	IGSC 22/06/15 PPP on 21/07/15 via IGSC minutes		No
JACIE (Joint Accreditation Committee-ISCT (Europe) & EBMT)									**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 1: Staying Healthy** ***Standard 1.1 Health Promotion, Protection and Improvement*** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.4 Infection Prevention and Control and Decontamination, Standard 2.8 Blood Management, Standard 2.9 Medical Devices, Equipment and Diagnostic Systems*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.3 Quality Improvement, Research and Innovation, Standard 3.5 Record Keeping*** **Theme 4: Dignified Care Standard 4.2 Patient Information** **Theme 5: Timely Care** ***Standard 5.1 Timely Access*** **Theme 6: Individual Care** ***Standard 6.1 Planning Care to Promote Independence***							
Inspection at 4 year intervals. Annual reports required to be submitted.																

On-going
Complete

Audit Committee - Ivar Grey
Quality & Safety - Prof Elizabeth Treasure
Strategic Planning & Performance - Prof Howard Young
Workforce & Organisational Development - Prof Howard Young
Mental Health Act Monitoring - Mutale Merrill

Charitable Funds - Martyn Waygood

Health and Safety - Martyn Waygood
Other

Cardiff Council
Clinical Pathology Accreditation (UK) Ltd
Environment Agency
General Medical Council (GMC)
Health and Safety Executive
Healthcare Inspectorate Wales
Human Fertilisation & Embryology Authority
Human Tissue Authority
Medicines and Healthcare
South Wales Fire and Rescue
Vale of Glamorgan Council
Wales Audit Office
Other

CORPORATE RISK AND ASSURANCE FRAMEWORK – UPDATE REPORT	
Name of Meeting: Audit Committee	**Date of Meeting:** 26 September 2017

Executive Lead: Director of Corporate Governance
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk
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: Where a risk is financial this should be clear from the Corporate Risk and Assurance Framework (CRAF) and known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact: The CRAF includes a number of risks that impact on quality, safety or patient experience.
Health and Care Standard Number: 2.1
CRAF Reference Number: Not applicable
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Mitigation of our risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF requires strengthening.

The Audit Committee is asked to:

- **CONSIDER** the CRAF Update Report and the extreme and high risks assigned to the Committee;
- **CONSIDER** whether the risk descriptors and controls identified are adequate to provide assurance to the Committee.

SITUATION

The Board Development session held on 27 April 2017 focused on risk management and our current process. The session was well attended and included Clinical Board representatives, Assistant Directors, risk leads and representatives from Internal Audit and the Community Health Council. The outcome of the session was the agreement that our current process and way we view risk requires review and renewal to reflect the principles demonstrated during the session.

A report was presented to the UHB's Board on 25 May 2017 and the proposals for review and renewal of the Risk Management Process were agreed.

A large part of the review process is engaging with Clinical Boards and Corporate areas to support review and amendment of their registers so that we can strengthen the risk descriptor and controls narrative, and address the lack of change in the risk scores from month to month. Duration of risks is also being looked at, as this is not always apparent from the CRAF. A significant amount of work is required throughout the UHB to improve our risk management process.

A short, simple procedural guide is being produced to share with all areas to support the review and ongoing maintenance of registers. This guide will include some key messages about risk identification and use of clear language when describing the risk and control measures.

BACKGROUND

Each risk contained within the CRAF is assigned to Board or a Lead Committee for oversight.

The Board agreed the production of more visual, less text based standardized reports and this report is prepared with that aim in mind albeit the detail is extracted from the CRAF in its current format (updated 11 September 2017). As work progresses, the Board, its Committees and our stakeholders should more easily be able to gain assurance from the CRAF.

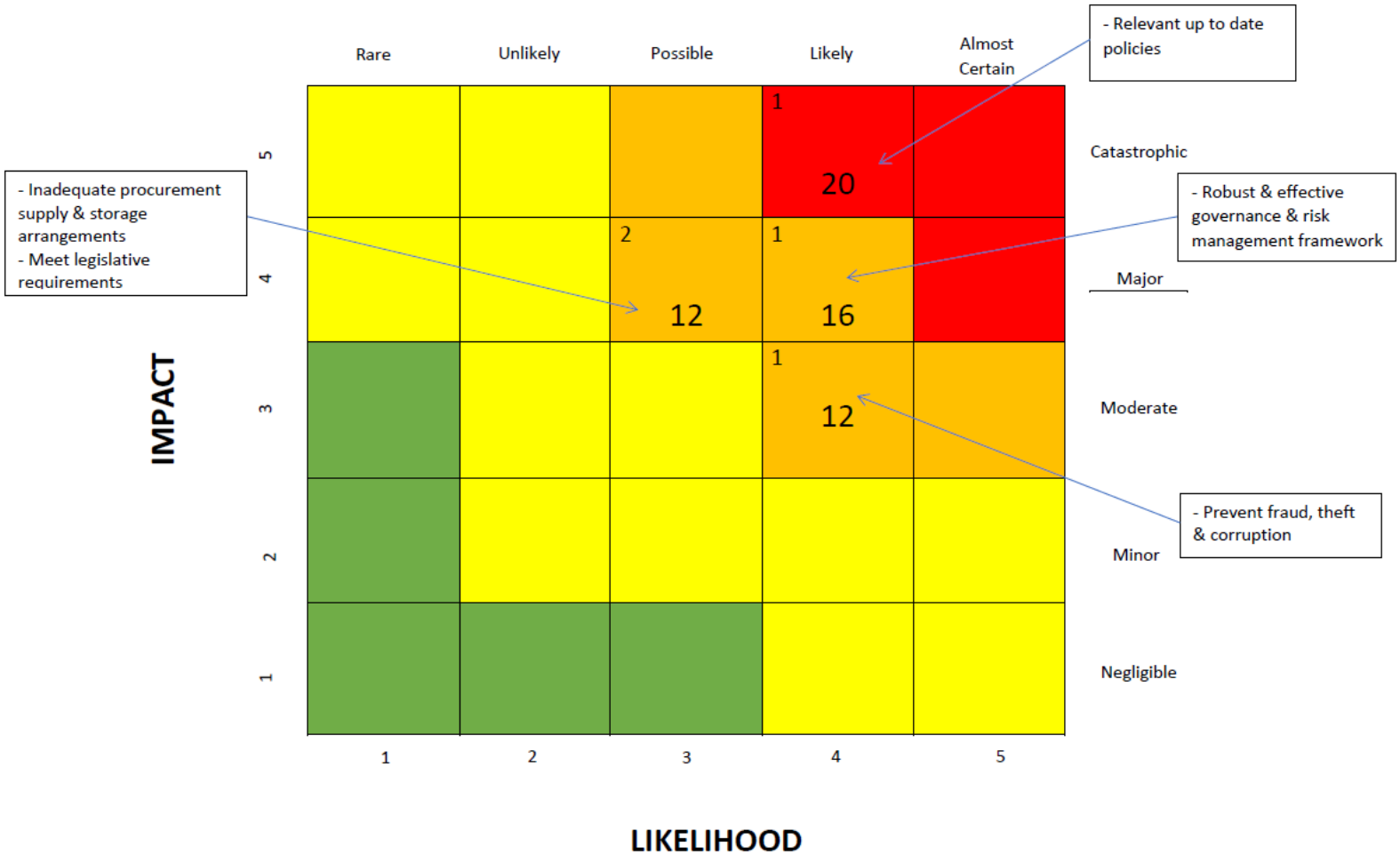
ASSESSMENT AND ASSURANCE

The Heat Map at Appendix 1 provides the profile of all risks currently assigned to the Committee.

The table at Appendix 2 provides the detail behind the risks.

The latest version of the full CRAF can be found at:

http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/248865


- Relevant up to date policies
- Inadequate procurement supply & storage arrangements
- Meet legislative requirements
- Robust & effective governance & risk management framework
- Prevent fraud, theft & corruption
Rare
Unlikely
Possible
Likely
Almost Certain
Catastrophic
Major
Moderate
Minor
Negligible
IMPACT
LIKELIHOOD
1
2
3
4
5
20
12
16
12

Appendix 2							
		Risks assigned to the Audit Committee					
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee/ Exec**
Objective 6 - 2014/15 - Resources - All the UHB's resources: money, staff, estates and equipment are maximized to deliver the best possible care.							
b) Estates and facilities							
1.	6.5	Procurement, supply and storage (including pathological storage) arrangements do not meet service needs	O4E enablers project on Better Value Supply Chain Increased clinical engagement in procurement arrangements Clinical Board Account Managers established	12		↔	Audit DoF
Objective 8 - 2014-15 - Governance - To have effective governance arrangements ensuring the UHB is compliant with relevant legal and regulatory frameworks and its processes for decision making are robust.							
2.	8.1	Meet Legislative requirements	Important documents control process ensuring all inspections are recorded and compliance monitored. Detailed Scheme of delegation. Register of Executive responsibilities covering all	12		↔	Audit DoCG

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee/ Exec
			legal requirements. Reports presented to appropriate assuring Committee detailing any regulatory visits and tracking report also presented to the Audit Committee on a regular basis.				
3.	8.2	Failure to have and deliver robust and effective governance framework including system of risk management and assurance resulting the lack of a co-ordinated and targetted response to risk	Corporate Risk and Assurance Framework, Risk policies and procedures Risk Management training Executive oversight of risk registers Health and Care Standards 2.1 - Managing Risk and Promoting Health and Safety Clinical Boards contributing to the Corporate Risk and Assurance Framework although it is accepted that they are at varying stages of development. Audit Committee Sponsored Board Development Session reviewed "extreme risks" in Aug 2015 Each risk contained within the CRAF is assigned to Board/a Lead Committee for oversight Board Development Session April 2017 included Clinical Boards Board agreed in May 2017 to review & renew process.	16		↔	Board Audit DoCG

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee/ Exec
4.	8.2.3	Comply with relevant, up to date and accessible policies, procedures and other control documents	Policy on Policies and other written control documents - revised in July 2014 to make process much simpler. New format approved for all other documents in September 2014. Staff training and awareness Intranet and internet access arrangements Re-enforced with all Clinical Boards the need to have arrangements in place to respond to Royal College and other documents. Proforma sent to them all for them to complete or advise of alternative format. Information regarding review of database presented to Lead Executive for their advice and oversight regarding their regarding their on-going review and maintenance. Specialist Services - Non standardisation of policy and protocols in satellite dialysis units. Risk in relation to patients moving from one satellite unit to another and particularly those with complex disease being transferred from in house unit i.e. Suite 19 to satellite unit: Controls - Directorate Manager and Lead Nurse have visited all satellite units to start discussions around standardisation. Every satellite unit has associated named Consultant Nephrologist.	20		↔	Audit DoCG

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee/ Exec
5.	8.3	Prevent fraud, theft and corruption	Fraud and bribery policies and procedures. Counter-fraud awareness programme. National Fraud Initiative and annual work plan.	12		↔	Audit DoF
		Total		**5**		**0**	

21.1

Records Management Follow Up

FINAL INTERNAL AUDIT REPORT 2016/2017

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

Review reference:	CUHB1617.24
Report status:	Final
Fieldwork commencement:	March 2017
Fieldwork completion:	May 2017
Draft report issued:	25th May 2017
Management response received:	22nd June 2017
Final report issued:	25th July 2017
Auditor/s:	Kimberley Rowe
Executive sign off :	Graham Shortland, Medical Director / Caldicott Guardian
Distribution:	Peter Welsh, Director of Corporate Governance Paul Rothwell, Senior Manager Performance & Compliance Sion O'Keefe, Directorate Manager Keeley Baker, Health Records Manager
Committee:	Audit Committee

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

Please note:

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

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

1. EXECUTIVE SUMMARY

The follow up review of Records Management was completed in line with the Internal Audit Plan. The review sought to provide the Health Board with assurance that agreed actions from the previous review of Records Management have been implemented appropriately.

The initial Internal Audit report was finalised in May 2015 and highlighted a total of eight issues which resulted in an overall assurance rating of Limited Assurance.

The risks considered in the previous review were as follows:

- Breach of Data Protection Act due to inappropriate access to records / information.
- Unavailability or inaccuracy of records impacts on UHB's ability to deliver services and make effective clinical decisions.

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

- The Records Management Policy and procedures will be reviewed and updated for October 2015 and will include explicit reference to the Records Inventory, strategy and procedure.
  The records inventory strategy and procedure will be developed in line with the policy and will include retention and audit procedures. (Finding 1, High Priority);
- The Records Management Policy and procedures will be reviewed and updated for October 2015 and will include explicit reference to the management of all areas of the record life cycle including those in this recommendation. (Finding 2, Medium Priority);
- The Health Records Department are working with estates to secure additional records storage. The solution is to be agreed by June 2015. Corporate records must also be reviewed and addressed.

  The Chief Operating Officer has commissioned a report and proposals to address this area of concern. It will be presented to the People, Performance and delivery Committee May 12th 2015.

  The Records Management Policy and procedures will be reviewed and updated for October 2015 and will include explicit reference to the management of all areas of the record life cycle including those in this recommendation. (Finding 3, High Priority);
- An action plan for addressing the detailed recommendations will be developed as part of the corporate records' work plan

  The improvement plan developed for PPD includes both destruction of records and digital archiving solutions. Other Clinical Boards are seeking advice on an ongoing basis for the archiving of devolved

records from the Health Records Department. (Finding 4, High Priority);

- A joint review between PCIC Clinical Board, Children's and Women's Clinical Board supported by CD+T clinical board and the Head of information governance will be undertaken in order to develop an action plan for community records. (Finding 5, Medium Priority);
- The Information Governance Policy and organisational arrangements has been agreed but needs to be formally and effectively embedded.

  The Records Management Policy and procedures will be reviewed and updated for October 2015 and will include explicit reference to this recommendation. It will include:

  - Roles and responsibilities in line with the Information Governance policy. This will inform job descriptions in the future and
  - Procedures for monitoring, reporting and auditing the quality of records including performance and remedial actions.

  (Finding 6, High Priority);
- The Records Management Policy and procedures will be reviewed and updated for October 2015. Responsibilities will be set out in line with the Information Governance Policy. An action plan will be developed to support and deliver the policy.

  The controlled document framework that flows from this overarching document will be reviewed and all procedures, guidance and protocols replaced or updated in a rolling programme. The recommendations of this audit report will inform that work.

  The responsibility for implementing the policies and procedures lies with the information asset managers within the Clinical Boards and corporate services. (Finding 7, Medium Priority);
- The UHB will have a training procedure in place that sets out the requirements for all staff training in regard to Information Governance.

  The mandatory IG e-learning tool is now in place and training started in late March for the foundation level.

  Managers will be reminded that this is mandatory for all staff and that further training needs assessment needs to be undertaken for specific job roles/ specialist training.

  All training must be recorded on the Employee Staff Record from which training levels can be established. (Finding 8, Medium Priority)

2. CONCLUSION AND FINDINGS

In summary, progress against the eight actions 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	-	4	
MEDIUM	4	3	1	
LOW	-	-	-	
TOTAL	**8**	**3**	**5**	

The follow up review concluded that based upon discussions with relevant management, review of the evidence provided and the results of re-testing where appropriate, there has been reasonable progress. There are a number of agreed management actions that need to be further progressed in order to fully address the original control weaknesses identified.

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

The updated Records Management Policy strengthens the strategic framework for records management and the Records Management Procedure broadly satisfies the need for guidance at an operational level. The audit notes that whilst these improvements have been made, there still remains some work to ensure implementation across the Health Board.

The new storage facility based at Treforest following the decommissioning of Whitchurch and Lansdowne Hospitals, will address the major weaknesses of physical security and adequacy identified previously.

The management actions completed and / or partially completed to date can be summarised as follows:

- The revised Records Management Policy and Procedure were approved in September 2016. Within the procedure there is a section on 'Inventory of Record Collections, this states that the UHB is to develop mechanisms to register the records they are maintaining and to ensure it is complete, accurate and up to date. This has only been partially implemented throughout UHB. (Finding 1 – Partially Actioned);
- The definition of 'records' has been clearly stated in the revised Records Management Policy and Procedure. The procedure gives

guidance for throughout the record life cycle (Creation, Quality Assurance, Retention & Disposal, it also gives explicit guidance on: naming conventions, filing structures, referencing & cross-referencing, tracking & tracing and record management system. (Finding 2 – Fully Actioned);

- The Records Management Procedure does refer to the need for Storage Accommodation to be clean & tidy, prevent damage to the record and should provide a safe working environment for staff, but does not go into any more detail than this.

  A paper containing proposals for records stored at Whitchurch and Lansdowne has been received by the Information Governance Sub Committee.

  The Central Medical Records Department is project managing the transfer of a range of medical records to a purpose built facility in Treforest. Whilst this has not happened yet, the audit notes this is a positive step forward for the storage of records currently at these sites. (Finding 3, Partially Actioned);

- The Records Management Procedure includes a detailed section on Tracking and Tracing, providing mechanisms for all records to be found and monitored (Finding 5, Fully Actioned);

- The revised Records Management Policy and procedure explicitly links in with the Information Governance policy and related procedures where roles and responsibilities are described consistently.

  The ICO mandated an audit in May 16 which resulted in an in depth action plan which the Health Board are in the process of completing. (Finding 6, Partially Actioned);

- The management and organisational responsibility is set out in the Records Management Policy which also states each of the responsible officers' positions. The appendices of the Information Governance Procedure detail the profiles of these roles.

  The Health Board has established a Medical Records Management Group (MRMG), Medical Records Operational Group (MROG) and Non Health Records Management Group (NHRMG).

  The Controlled Document Framework (CDF) provides the Information Governance Committee with the position in regard to the action plan for developing, reviewing and updating the policy framework to meet the Caldicott Assessment Standards, the H&C standards and the Information Governance Toolkit.

  Information Asset Owners and Information Asset Administrators are being put in place throughout the Health Board for each information asset; however this is not fully accomplished. (Finding 7, Partially Actioned).

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

- The revised Records Management Procedure does have greater emphasis on archiving and destruction and also the need to document the decisions made. It however references the Records Retention and Destruction Protocol which was due for review in September 2015 and is therefore out of date.

  Archiving or destruction of records that are currently held at Whitchurch or Lansdowne will be carried our post-move to Treforest therefore might exceed the planned dates. (Finding 4, Partially Actioned);

- The UHB has an Information Governance Training Policy that sets out the required training. At March 17, IG training to date attended by the staff with designated IG responsibilities were high throughout the Clinical Boards (Deputy SIROs = 87.5%, IAOs = 85.7%, IAAs = 93.3%), but low in Corporate Departments (Deputy SIROs = 16.6%, IAOs = 45.7%, IAAs = 78.5%). Mandatory training levels were also low with a compliance level of 63.87%. (Finding 8, Partially Actioned.)

Records Management Follow-Up

Cardiff and Vale University Health Board

21.1

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.

21.2

Statutory Compliance

Final Internal Audit Report

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS Page

Review reference:	SSU_CVU_1617_05
Report status:	Final Report
Fieldwork commencement:	25th January 2017
Fieldwork completion:	14th May 2017
Draft report issued:	23rd May 2017
Management response received:	27th June 2017
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Management Agreement:	7th September 2017
Final report issued:	11th September 2017
Auditor/s:	Eifion Jones Emily White Matthew Smith
Executive sign off	Abigail Harris, Executive Director of Planning
Distribution	Geoff Walsh, Director of Capital, Estates and Facilities Tony Ward, Head of Discretionary Capital & Compliance
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

The audit was undertaken to evaluate the processes and procedures put in place by the University Health Board (UHB) to support the progression of the Estates statutory compliance programme.

Resulting from the findings of an independent compliance review commissioned in 2013, the UHB established a compliance programme to address the requirement for statutory inspections in 44 individual areas of Estates compliance (for example, legionella, ventilation, fire doors etc.).

The programme to complete the initial asset identification and condition surveys for each of the areas was originally programmed over a two-year period - this has since been extended due to the number of assets identified and the amount of remedial works required.

A budgetary requirement of circa £3.9m per year was identified, to enable full compliance with statutory and mandatory inspection and testing requirements. This included the establishment of a dedicated Estates compliance team, to manage and deliver the compliance programme.

2. Scope and Objectives

The assignment originated from the 2016/17 internal audit plan. The subsequent report will be submitted to the Chief Executive and conclusions reported to the Audit Committee.

The scope and remit of the audit review were limited to the following aspects:

- **Governance arrangements** - Assurance that adequate governance arrangements existed, including clearly defined roles & responsibilities, accountability & delegation and monitoring & reporting arrangements;
- **Strategy -** Assurance that appropriate mechanisms were in place to determine key priorities for inclusion in the programme, ensuring that appropriate procurement routes were adopted and that capital / revenue expenditure was appropriately applied;
- **Implementation -** Assurance that inspection processes confirmed that remedial work addressed identified non-compliances;
- **Resources -** Assurance that adequate resources were applied to the programme including in-house estates, financial and external support as required; and
- Identification of **any other issues** material to the successful achievement of the programme's objectives.

3. Associated Risks

The potential risks considered in the review were as follows:

- Inadequate organisational and governance arrangements were in place;
- Roles and responsibilities had not been developed and assigned to appropriate individuals;

- Priority areas were not addressed within the programme;
- Inappropriate procurement routes were followed;
- Capital monies were inappropriately utilised;
- The extent of non-compliance with statutory requirements was unacceptably high; and
- Inadequate resources were applied to the programme.

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 Statutory Compliance is **Substantial Assurance.**

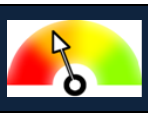
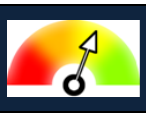
RATING	INDICATOR	DEFINITION
Substantial	 GREEN	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or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

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.

Further information on assurance ratings is available within **Appendix B**.

5. Assurance Summary:

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

Assurance Summary					
1	Governance Arrangements				✓
2	Strategy				✓
3	Implementation			✓	
4	Resources				✓

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

Design of Systems/Controls (D)

The findings from the review have highlighted **1** issues that are classified as weaknesses in the system control/design.

Operation of System/Controls (O)

The findings from the review have highlighted **0** issue that is classified as a weakness in the operation of the designed system/control.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Governance Arrangements

The review sought assurance on the governance arrangements to determine whether the control framework operated effectively.

Sound governance arrangements were observed with appropriate reporting through the organisation up to the Board.

Detailed reports are produced and discussed at various forums e.g. the Capital Management Group and Operational Service Board. Scrutiny and challenge regarding performance was noted at the Capital Management Group, indicating a clear focus on improving statutory compliance.

We did not identify any weaknesses that would require reporting to the Audit Committee.

Accordingly, a **substantial** level of assurance was determined.

Strategy

Assurance was sought to determine the adequacy of the strategy to achieve their objectives.

As mentioned in the introduction to this report, 44 individual areas of Estates compliance (for example, legionella, ventilation, fire doors etc.) were identified from an independent compliance review commissioned in 2013.

A paper was subsequently prepared for the Executive Team which outlined the risk, proposed approach and funding requirements. Subsequently, funding had been provided to deliver the proposed strategy and a dedicated Estate Compliance team had been appointed to develop a comprehensive asset data base and progress implementation activities.

At the time of this review, implementation was at a mid-point. Reporting provided more explicit detail with regards to the strategy for prioritising investment and clarification on the remaining risks.

Noting the above, a **substantial** level of assurance was determined.

Implementation

The review sought to gain assurance on the compliance implementation management processes.

All compliance works information was recorded and monitored within a master Microsoft excel spreadsheet, supported by a range of other excel sheets, which was regularly updated by the Head of Discretionary Capital & Compliance. A small number of anomalies were identified in the

transposition of data between the various spreadsheets (**Recommendation 1**).

A suitable software solution with seamless integration had been identified and was in the process of being piloted to replace the spreadsheets noted above. This would help reduce the risk of human and transposition errors.

The audit also sought to review the processes followed and records retained in relation to any procurement arising from the implementation of the strategy, and a full record of the lettings was observed.

Generally, the issue identified did not materially impact the achievement of the objectives, but the recommendation will help improve the accuracy, reliability and effectiveness of the area reviewed. Accordingly, a **reasonable** level of assurance has been determined.

Resources

The review sought to gain assurance on the adequacy of resources to support processes.

A restructure and recruitment initiative had seen the capital estates department employ an additional 3 compliance staff, a specialist for each area of electrical, mechanical and building. As mentioned previously, there is also an agreed provision of recurring funding to address the identified risks.

The only aspect raised in relation to the resource is whether further economy/ efficiency could be gained from automating the current systems (See **Recommendation 1**).

A **substantial** level of assurance has been determined.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	**0**	**1**	**0**	**1**
Recommendations Closed Since Audit Fieldwork	**0**	**0**	**0**	**0**
Remaining Recommendations Agreed to be Implemented	**0**	**1**	**0**	**1**

It is management's responsibility to develop and maintain sound systems of risk management, internal control, governance and for the prevention and detection of irregularities/fraud.

We shall endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Implementation

Finding 1	Risk
Data accuracy and integrity is of paramount importance to an organisation as it provides an insight into operational requirements. Good quality data can help management improve their everyday decision making. At present, reliance is placed on a series of spreadsheets maintained by the Head of Discretionary Capital and Compliance to manage the compliance works. The spreadsheets are manually updated to reflect output from inspections undertaken. Any resulting performance reporting is based on manual extraction of information from these spreadsheets. This process increases the potential for human error, evidenced by a small number of minor anomalies between the remedial works figures being included at reports as compared to those held on the master progress sheet. Separately, there was no evidence of any Quality Assurance (QA) check being performed by additional staff to verify the accuracy of the data manipulation process. For 2017/18, the UHB is piloting a software package solution (which also captures asbestos register information, condition surveys and maintenance schedules) to assist in negating/ reducing the risk of human error and transposition errors.	Information is considered unreliable due to error.
Recommendation 1	**Priority level**

1. Processes will be implemented to reduce the exposure to human/ transposition errors in monitoring and reporting outputs. **(D)**	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
Agreed. As outlined, a software solution is presently being piloted through August and will be reviewed for adequacy in September 2017.	Director of Capital, Estates and Facilities September 2017

Statutory Compliance Audit Assurance & Priority Rating

Cardiff & Vale University Health Board

21.2

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.

Follow up - All recommendations implemented and operating as expected.

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

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

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

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

 **No Assurance** - The Board 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

Follow up - No action taken to implement recommendations.

Prioritisation of Recommendations

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

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

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

21.3

Medicine Clinical Board Medical Rotas & Sickness Management

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS Page

Review reference: CUHB 17.49
Report status: Final
Fieldwork commencement: 17th February 2017
Fieldwork completion: 22nd March 2017
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Final report issued: 8th September 2017

Auditor/s: S George

Executive sign off: Steve Curry, Chief Operating Officer

Distribution: Patsy Spence, Director of Operations
Richard Evans, Clinical Board Director
Loretta Reilly, Directorate Manager
Cari Randal, Directorate Manager

Committee: Cardiff and Vale Audit Committee

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

Please note:

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

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

1. Introduction and Background

The review of the management of Medical rotas and sickness within the Medicine Clinical Board was completed in line with the 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 rotas and sickness 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 procedures are applied consistently across staff groups. So that rotas are appropriately developed to ensure coverage and hours worked and that the management of staff sickness is appropriate.

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

- The Clinical Board has appropriate processes and procedures in place for the drawing up of staff rotas;
- Staff rotas are drawn up to reflect workload and breaks;
- Sickness absence is appropriately recorded, monitored and managed in accordance with the All Wales Sickness Management policy.

As part of the review, testing was undertaken within the Internal Medicine and Emergency Medicine Directorates.

3. Associated Risks

The potential risks considered in the review are as follows:

i. Staff rotas are not drawn up in advance.

ii. Unnecessary usage of locums.

iii. Inappropriate shift patterns mean staff do not work contracted hours or do not have appropriate breaks.

iv. Unauthorised or excessive staff absences.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

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

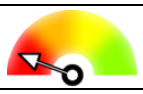
RATING	INDICATOR	DEFINITION
Reasonable		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design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

The arrangements in place for developing rotas ensure that these are developed in advance with sufficient consideration of the required skill mix and that all medical staff work their contracted hours. Usage of locums in both directorates is appropriate and documented with the reason for using them stated. Rotas for staff are appropriate and ensure that Medical staff are working their contracted hours.

Processes for sickness management are in place, however not all are sufficient to ensure compliance with the Sickness Policy. Documentation was not available for some episodes of sickness, and self certification forms were not available for any of the episodes of sickness tested within Internal Medicine.

5. Assurance Summary

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

Assurance Summary					
1	*Rotas are not drawn up in advance*				✓
2	*Unnecessary use of locums.*				✓
3	*Inappropriate shift patterns mean staff do not work contracted hours or do not have appropriate breaks*				✓
4	*Unauthorised or excessive staff absences*		✓		

Design of Systems/Controls

The findings from the review have highlighted 2 issues that are classified as weaknesses in the system control/design for the rotas and sickness process. These are identified in the action plan as (D).

Operation of System/Controls

The findings from the review have highlighted 2 issues that is classified as weaknesses in the operation of the designed system/control for the rotas and sickness process. This is identified in the 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.

Risk 1: Rotas not drawn up in advance

The following areas of good practice were noted:

- Rotas are drawn up in advance and allow junior doctors to view them before beginning rotations.

There were no significant findings under this risk area.

Risk 2: Unnecessary use of locums

The following areas of good practice were noted:

- Reasons for locums are logged with all shifts where locums, both internal or agency, have been worked.

There were no significant findings under this risk area.

Risk 3: Inappropriate shift patterns mean staff do not work contracted hours or do not have appropriate breaks.

The following areas of good practice were noted:

- Appropriate shift patterns are worked by Medical staff to ensure they work their contracted hours.
- Monitoring of rotas is carried out by Medical Workforce to ensure the number of hours worked is compliant with regulations under European Working Time Directive.

There were no significant findings under this risk area.

Risk 4: Unauthorised or excessive staff absences.

The following areas of good practice were noted:

- Information on sickness and the management process is given to all new starters at induction.

The following significant findings were noted:

- No self certification forms were completed for the sickness episodes tested in Internal Medicine;
- No sickness documentation could be located for 7/34 samples of sickness episodes tested;
- Return to work interviews for internal medicine staff are carried out by Directorate Office staff rather than managers;

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

Finding 1: Missing sickness documentation	Risk
Documentation could not be found for all episodes of sickness. Of the sample of 34, documentation could not be located for seven. 5 of these were within the Internal Medicine Directorate with the other 2 within Emergency Medicine. Self-certification forms were not completed for any of the nineteen episodes of sickness sampled within the Internal Medicine Directorate. In addition sickness testing showed that sickness triggers procedures had not been complied with for 2 of the sample. (O)	Unauthorised or excessive staff absences
Recommendation 1	**Priority level**
Management should ensure that the All Wales Sickness Policy is complied with.	**High**
Management Response 1	**Responsible Officer/ Deadline**
Internal Medicine • Junior Doctor hand book contains the Sickness Policy and Process • Sickness SBAR developed within the directorate • Regular reminders to be issued to Juniors around the sickness policy • Sickness tracker to be implemented	Cari Randall, Directorate Manager July 2017 (pre August 2017 rotation)

21.3

Emergency Medicine At the time of the review it was highlighted that information wasn't complete for the 2 Emergency Medicine staff. This was during a time where the secretary who generally arranges sickness meetings was on sick leave due to bereavement. Since that time we have ensured that there is cover if there is sickness and the other two secretaries within the Directorate are now aware of the process. As junior doctor sickness isn't that frequent we hadn't come across this problem before, so it was helpful that it was picked up.	Lorreta Riley, Directorate Manager Complete

Finding 2:	Risk
For fourteen of the sampled sickness episodes within Internal Medicine, Return to Work interviews were carried out over the telephone and therefore do not have a signature on the form to indicate that the staff member agrees with what has been discussed. The interviews are conducted by the Rota Manager and he does record on the forms that the staff members have verbally agreed the content. (D)	Unauthorised or excessive staff absences
Recommendation 2	**Priority level**
Management should ensure that interviews are carried out on a face to face basis wherever possible. If the interview is conducted over the phone then management should consider obtaining alternative forms of confirmation from the member of staff e.g. Email.	**Low**
Management Response 2	**Responsible Officer/ Deadline**
Email confirmation will be obtained for all future return to work interviews that a carried out over the phone.	Cari Randall, Directorate Manager July 2017

21.3

Finding 3: Identifying sickness triggers	Risk
Staff members managing sickness within the Internal Medicine Directorate do not have access to self service ESR. This means the process is currently inefficient and triggers may be missed. (D)	Unauthorised or excessive staff absences
Recommendation 3	**Priority level**
Management should have access to ESR to ensure they are able to monitor sickness of staff under rotation in their department.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
When medicine is live on ESR we will be able to use this function to support sickness management. The monitoring spread sheet referenced in management response 1 will provide additional control until ESR goes live within Medicine.	ESR roll out team August 2017 Cari Randall, Directorate Manager July 2017

21.3

Medicine Clinical Board Medical Rotas & Sickness Management

Cardiff and 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.

Specialist Services Clinical Board
Cardiothoracic Registrars Private Payments

FINAL INTERNAL AUDIT BRIEFING
2016/17

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS Page

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Auditor/s:	M Lewis, I Virgill, J Johns
Distribution:	Jessica Castle, Director of Operations Hywel Pullen, Assistant Director of Finance
Committee:	Audit Committee

ACKNOWLEDGEMENT
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1. Introduction and Background

The review of the payments made to Cardiothoracic Registrars for private work was agreed as an additional internal audit. This was being undertaken due to anomalies in payments identified by the service.

The relevant lead Executive for the assignment was the Medical Director.

Cardiothoracic Services undertake private work with patients being billed by the UHB for use of its facilities and staff, and separate billing in place for consultant time. It was recently identified that registrars have been paid for private work by both the UHB and the Consultant, which may indicate that duplicate payments have been made to them.

A second phase of Internal Audit work was required after feeding back the initial findings to management, where subsequent information was made available.

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 payments to registrars for private work in order to provide assurance to the Health Board.

The purpose of the review was to provide assurance that the governance surrounding payments for private work is appropriate.

The key questions to be answered were:

- When did the duplicate payments commence?
- What individuals have received duplicated payments?
- What is the cost of the duplicated payments?
- What are the underlying reasons for the duplicated payments?

3. Associated Risks

The potential risks considered in the review were as follows:

I. Unnecessary / increased expenditure.

4. Summary Of Key Findings

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

- From discussion with the consultants, they considered that the process has always been that the registrars were paid by them from monies billed to private patients. From about April 2014 this changed with the UHB also paying the registrars. At the time the initial audit work was carried out the full reasons could not be established but it was likely that a lack of communication between the Clinical Director / Directorate Manager and surgeons / registrars, coupled with a lack of any documented procedures led to the error.
- There are no formal procedures and no guidance over the operation and claiming of private patient sessions within the Cardiothoracic Directorate. The claim forms used are the Waiting List Initiative claim forms with "private patient" or "pp" manually written on.
- The audit identified approximately £15,000 of payments, covering 18 registrars, where a payment for private work had been made by the UHB and by the Consultant on a private basis.
- All extra duty payments made to registrars are denoted on payslips as "Private Work" despite the majority relating to WLI sessions. This means there is a lack of clarity over costs of WLI and Private work and a loss of audit trail.
- However, since the original audit field work was undertaken and findings fed back to management, the Clinical Board provided further information and a second phase of work was required, as other staff members, past and current, that were involved in the process had not been originally highlighted.
- The Clinical Board has now highlighted that they had subsequently been informed by the Clinical Director that he decided to make the change to the system as to how the registrars were paid, so all staff undertaking additional activity were paid by the UHB. However there was no physical evidence to substantiate this. As a result the Clinical Board now considered that the payments made by the UHB were appropriate; however they acknowledge that payments may have been made direct to the registrars by the consultants for this activity as well.
- Internal audit then met with the Clinical Director who confirmed that he had made the decision to change the process how these payments were made and had informed the then Directorate Manager of this. However, he did indicate that he had not

communicated this widely across the staff involved in the process and as such they would not have been aware of the change.

- Internal audit then also met with the then Directorate Manager who believes that the details of this process would have been explained to him as part of the handover when he commenced in the role, and he arranged for payments to be made to the registrars through the same process as the other staff involved in the activity. There were however no formal written procedures in place for the process.
- The information provided by the Clinical Director regarding the change to the payment process clearly varied from the understanding of the Consultants whom had made payments directly to the registrars involved in the private patient activity.

As a result of the two phases of audit work, Internal Audit concludes that payments were made twice to a number of registrars due to a breakdown of the governance process within the Directorate as the apparent decision made to change the payment process was not properly communicated to relevant staff involved.

In addition, further weakness in the systems around the absence of procedures, the lack of clarity within the forms being used for the claims and also the fact that the same terminology is used on staff payslips for different types of additional activity payments, contributed to these issues occurring and also the difficulty in identifying that this had occurred.

A series of recommendations have been made below to strengthen the weakness that existed in systems to cover payments to staff for additional activity, to document this fully in a procedure and to inform staff involved that they would have received payments in a private capacity for activity they would have also been paid for by the UHB.

Finding 1	Risk
There are no formal procedures and no guidance over the operation and claiming of private patient sessions within the Cardiothoracic Directorate. The claim forms used are the Waiting List Initiative claim forms with "private patient" or "pp" manually written on. (D)	Unnecessary / increased expenditure.
Recommendation 1	**Priority level**
A formal procedure for the management of private sessions and subsequent claims should be developed and disseminated.	**High**
Management Response 1	**Responsible Officer/ Deadline**
A formal procedure document will be prepared by the Directorate to be followed whenever additional sessions are undertaken, whether these are for private patients, waiting list initiatives or clinical trials. This will include clarity on the rates of pay for each staff group.	Kevin Nicholls, Service Manager / complete
Separate claim forms for additional sessions will be devised for private patients, waiting list initiatives and clinical trials.	Kevin Nicholls, Service Manager / complete
All staff affected will be educated on the procedure and notified of the introduction of separate claim forms.	Peter O'Callaghan, Clinical Director / complete

Finding 2	Risk
The audit identified approximately £15,000 of payments where a payment had been made by the UHB and from consultant on a private basis. The Clinical Board have subsequently informed Internal Audit that the payments made by the UHB are considered to be the appropriate payments. (O)	Unnecessary / increased expenditure.
Recommendation 2	**Priority level**
Management to consider where they believe the correct payment was made by the UHB and then inform the individual members of staff of the circumstances and that they may have also received payment direct from the consultants for private work and this should be discussed with them.	**High**
Management Response 2	**Responsible Officer/ Deadline**
At a meeting held on 27th April with Dr Jonathan Kell, Clinical Board Director, Jessica Castle, Director of Operations, Hywel Pullen, Head of Finance and Jonathan Pritchard, Head of Workforce & OD, additional evidence was provided by Dr Peter O'Callaghan, Clinical Director that he had instructed the previous Directorate Manager, Chris Coslett, that all staff working additional sessions should be paid by the UHB. This led to the change in practice and Dr O'Callaghan acknowledged that neither he nor Chris Coslett had informed the consultants or registrars of this change. The consensus view is therefore that	

21.4

the UHB has paid the staff appropriately and if there is any overpayment this would be on the part of the consultants and is a matter for them to deal with privately as they see fit.	
All consultants undertaking private work will be informed of what has happened and that if they wish to seek to reclaim any overpayments, this will be dealt with as a private matter between the consultant and the registrar.	Indu Deglurkar, Lead Surgeon / complete
A meeting will be held with all registrars informing them of what has happened and confirming that if they receive any payment from consultants going forward, they should take care to ensure this is properly declared. This will also be documented in a letter issued to all registrars.	Peter O'Callaghan, Clinical Director / complete

21.4

Finding 3	Risk
All extra duty payments made to registrars are named as "Private Work" despite the majority relating to WLI sessions. This means there is a lack of clarity over costs of WLI and Private work and a loss of audit trail. Discussion with Payroll indicated that they were never made aware of the differences and so they enter all additional payments as private work. (O)	Unnecessary / increased expenditure.
Recommendation 3	**Priority level**
Payments to staff should be accurately recorded.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
Separate claim forms for additional sessions will be devised for private patients, waiting list initiatives and clinical trials. Shared Services are investigating how sessions can be recorded on payslips aligned to the type of activity noted on the claim form to ensure clarity going forward.	Kevin Nicholls, Service Manager / complete Huw Allaway, Assistant Payroll Manager / September 2017

21.4

21.5

Cardiff and Vale University Health Board

Annual Quality Statement

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Auditor/s:	Kimberley Rowe
Executive sign off:	Ruth Walker, Director of Nursing
Distribution:	Carol Evans, Assistant Director of Nursing, Patient Safety & Quality Alexandra Scott, Patient Safety & Quality Assurance Manager
Committee:	Audit Committee

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

1. Introduction and Background

The review of the Annual Quality Statement (AQS) produced by Cardiff and Vale University Health Board (UHB) has been completed in line with the Internal Audit Plan.

Cardiff & Vale UHB is required to publish an AQS in July 2017 reporting on the 2016/17 year. The AQS is a statement from the Board to the Public and represents a key step forward in meeting the commitment set out in Together for Health.

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

2. Scope and Objectives

The overall objective of the review was to assist Cardiff and Vale UHB with accuracy checking, including the triangulation of data and evidence, before the publication of the AQS.

The scope was limited to assisting the UHB to ensure that the AQS is accurate, complete and consistent with information reported to the Board over the period. In addition consideration was given to compliance with Welsh Government guidance for 2016/17.

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

- The AQS is compliant with Welsh Government Guidance;
- Planned developments and stated challenges from the 2016/17 AQS are appropriately reported within the 2016/17 statement;
- The timetable for the production and publication of the AQS is appropriate;
- There has been appropriate stakeholder engagement in the production and review of the AQS;
- Performance information / data within the AQS that demonstrates 2016/17 achievements and challenges is appropriate and consistent with the auditors knowledge of the Health Board; and
- Performance indicators detailed in the AQS are accurate and can be validated back to source information. This will be achieved through testing a sample of two performance indicators from the report.

3. Associated Risks

The potential risks considered in the review were as follows:

- Failure to follow Welsh Government Guidance;

- The public is not clearly informed of any improvement and challenges experience in the range of services being provided, as well as improvement priorities for the coming year;
- The information detailed in the AQS is incomplete and/or incorrect.

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 Annual Quality Statement 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 UHB has good processes in place to produce an Annual Quality Statement that largely complies with Welsh Government guidance and fairly represents the organisations position and performance in the previous year. Our review has also noted that the linking of the AQS to the UHB's new Quality, Safety and Improvement Framework embeds the process into day-to-day activities rather than being stand alone at the end of the year.

Furthermore the statement is presented in a clear and user friendly format that should be easily understood by its audience.

21.5

5. Assurance Summary

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

Assurance Summary					
1	Failure to follow Welsh Government Guidance				✓
2	The public is not clearly informed of any improvement and challenges experience in the range of services being provided, as well as improvement priorities for the coming year				✓
3	The information detailed in the AQS is incomplete and/or incorrect				✓

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for the Annual Quality Statement.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control for the Annual Quality Statement.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

RISK: Failure to follow Welsh Government Guidance:

The following areas of good practice were noted:

- There is evidence that Welsh Government guidance was utilised in the development of the AQS;
- The AQS includes the main sections as required by the guidance, including:
  - Introduction;
  - Looking Back Over the Past Year;
  - Looking Forward.
- The AQS is separated into sections by quality themes, enabling appropriate reflection of performance and consideration of future priorities;
- The AQS contains a mix of case studies, patient stories and quantitative data. The report also utilises info-graphics to present information clearly to the public;
- The AQS provides signposts to key documents and links to detailed information;
- The AQS is free of 'NHS jargon' and is written so as to be understandable to those with no knowledge of the subject matter.

No significant findings were noted under this risk.

RISK: The public is not clearly informed of any improvement and challenges experience in the range of services being provided, as well as improvement priorities for the coming year;

The following areas of good practice were noted:

- The format for reviewing performance against previous year priorities was consistent between 2015/16 and 2016/17;
- Further developments and challenges overcome within the year have also been explained throughout the narrative of each quality theme;
- The UHB developed an appropriate timetable for compilation, review and reporting of the 2016/17 AQS which was reported to the UHB Quality, Safety and Experience Committee in January 2017;
- The development and review of the AQS were undertaken on a timely basis;

- There was appropriate engagement with a range of internal and external stakeholders in the development and review of the AQS; and
- The UHB has appropriately considered stakeholder feedback in the development of the AQS, one result of this feedback is the AQS being made available in several accessible formats, eg. Braille, Easy Ready and Clear Print.

No significant findings were identified under this risk.

RISK: The information detailed in the AQS is incomplete and/or incorrect.

The following areas of good practice were noted:

- The achievement and challenges stated within the AQS are accurate and relate to 2016/17
- The UHB's three Bold Improvement Goals (BIG 3) have been referenced and addressed throughout the appropriate themes within the AQS.
- Testing carried out on a sample of 2 performance indicators stated within the AQS (Diagnostic procedure waiting times and staff sickness / PADR rates) confirmed that they were both accurately recorded and could be traced to their original source documentation.

No significant findings were identified.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - QSI Framework (Operating effectiveness)	Risk
Instead of including priorities within each of the seven themes for 2017/18, the AQS makes reference to the new UHB Quality, Safety and Improvement (QSI) Framework. This covers the following 6 'aims': • Governance, Leadership and Accountability; • Safe Care; • Effective Care; • Dignified Care; • Timely Care; and • Individual Care. Whilst this demonstrates that the AQS is now embedded in activities throughout the year instead of being a stand-alone end-of-year process, two of the AQS themes are not recorded as having been separately considered (Staying Healthy and Our Staff). There is a concern that there will be difficulty in satisfying the requirements set out by the Welsh Health Circular for reporting under the seven themes in the 2017/18 AQS.	Failure to follow Welsh Government Guidance
Recommendation	**Priority level**
Consideration should be given to how the UHB plans to satisfy the requirements of the Welsh Health Circular in 2017/18 for reporting under the seven key themes.	**Low**

21.5

Management Response	Responsible Officer/ Deadline
The QSI Framework did not include Staying Healthy and Our Staff as domains, as these will be taken forward strategically by the Public Health Framework and the Workforce and Organisational Development Framework. However they will continue to be reported (from a Quality, Safety and Improvement perspective) in the Annual Quality Statement for 2017-2018	Assistant Director Patient Safety and Quality. July 2018.

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

21.6

Cardiff and Vale University Health Board

Charitable Funds

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	C&V-1718-11
Report status:	Final Internal Audit Report
Fieldwork commencement:	4th July 2017
Fieldwork completion:	15th August 2017
Draft report issued:	17th August 2017
Management response received:	24th August 2017
Final report issued:	29th August 2017
Auditor/s:	Murray Gard, Sian George
Executive sign off:	Bob Chadwick – Director of Finance.
Distribution:	Chris Lewis – Deputy Director of Finance. Alun Williams – Financial Services Manager. Lucy Barrett – Fundraising Officer.
Committee:	Audit Committee.

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

1. Introduction and Background

The review of Charitable Funds was completed in line with the 2017/18 Internal Audit plan for Cardiff and Vale University Health Board.

The Cardiff and Vale University Health Board General Purpose Charitable Fund is a registered charity that is governed by the Trust Deed. Under the terms of this deed, the Charitable Fund is administered by the Trustees, the Cardiff and Vale University Health Board as a body corporate.

The fund is an umbrella charity with a number of subsidiary charities registered therein and also managed by the Health Board.

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

2. Scope and Objectives

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

The purpose of the review was to establish if the Health Board has appropriate processes in place to ensure that the Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.

The areas that the review has provided assurance on are:

- All charitable funds income received is appropriate and accounted for correctly (including gift aid);
- All charitable funds expenditure is appropriate, authorised and within the terms of the relevant fund;
- Fundraising appeals are managed appropriately;
- The Charitable/Lottery Funds are used appropriately with bids properly assessed and approved; and
- Funds held in Trust are appropriately monitored, managed and invested.

3. Associated Risks

The potential risks considered in this review are as follows:

- Charitable funds income isn't maximised;
- Charitable funds income may be incorrectly recorded and/or accounted for;
- Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded; and
- Non-compliance with legislation and Charity Commission guidelines.

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 Charitable Funds is **Substantial Assurance**.

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

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

The controls in place to manage the risks associated with charitable funds are of a substantial standard. The review noted good practice within all the areas covered, particularly; strong governance arrangements within the charitable funds committee and also the charitable funds bids panel. Accompanying this was a good standard of record keeping to support the income and expenditure audit trail.

However, the review did identify issues relating to the management of dormant accounts and one instance was identified of inappropriate expenditure. The majority of these issues have been raised within previous years reports.

There were no high priority findings noted within this report.

5. Assurance Summary

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

Assurance Summary					
1	Charitable funds income isn't maximised.				✓
2	Charitable funds income may be incorrectly recorded and/or accounted for.				✓
3	Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded.			✓	
4	Non-compliance with legislation and Charity Commission guidelines.				✓

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

Design of Systems/Controls

The findings from the review have highlighted 0 issues that are classified as weakness in the system control/design for Charitable Funds.

Operation of System/Controls

The findings from the review have highlighted 4 issues that are classified as weakness in the operation of the designed system/control for Charitable Funds.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Risk: Charitable funds income isn't maximised.

We identified the following areas of good practice:

- There are adequate systems in place to capture information that enables the reclamation of gift aid;

- Gift aid is championed by the fund raising department, wherever possible;
- Donation forms have a gift aid section for signature;
- "Thank You" letters are sent on a regular basis and incorporate an additional request for gift aid, if not previously provided;
- A standard schedule is sent to HMRC on a timely basis for reclaiming gift aid;
- Gift aid monies were found to be reapportioned to the correct fund.

We identified no significant findings in relation to this risk.

Risk: Charitable funds income may be incorrectly recorded and/or accounted for.

We identified the following areas of good practice:

- The Health Board has produced a standard donation form;
- All donation forms were completed in compliance with procedures;
- All receipts had been banked in full;
- Donations were verified as allocated to the correct fund;
- In general, appreciation letters were sent in a timely manner, when appropriate to do so.

We identified no significant finding in relation to this risk:

Risk: Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded.

We identified the following areas of good practice:

- The Health Board has produced a *"request for payment from charitable funds"* document, that gives a standard format including details of request, authorisation and payment information;
- All expenditure items reviewed, were appropriately accounted for, with all fund numbers quoted on approval forms matching accounts credited;
- The profit from the staff lottery goes directly to the Make It Better Fund - the general purpose endowment fund for the Health Board;
- The staff lottery had reconciliation controls in place to ensure appropriate membership;
- The fundraising department maintains appropriate records of bid applications and outcomes for the staff lottery;
- There were appropriate processes for assessing and approving of staff lottery funds through the charitable funds bids panel;

We identified two significant findings in relation to this risk:

- From the sample of 20 expenditure items reviewed, there was 1 item identified that may not have been appropriately charged to Charitable Funds. further clarification needs to be undertaken by management to establish the appropriateness of this item.
- Dormant accounts totals had decreased by £0.5 million over the period 2015/16 to 2016/ 17, however, there is still over £1m in dormant funds, with balances up to circa £147,000.

Risk: Non-compliance with legislation and Charity Commission guidelines.

We identified the following areas of good practice:

- Cardiff and Vale has a registered charity with the charity commission - registration number 1056544;
- The charity covers the charitable objectives relating to the NHS services provided by Cardiff and Vale University Health Board;
- The Charitable Funds Committee is a subcommittee of the board with an independent member as chair. It also has executive membership and meetings are held quarterly as per the agreed Terms of Reference;
- The Make It Better Staff Lottery Bid Panel has been established which deals with staff lottery expenditure less than £20,000 and has appropriate membership.
- Cazenove Capital Management (CCM) provides details on the profit/loss of investments in a quarterly report and attends the Charitable Funds Committee meetings on a bi annual basis. This allows the representative to answer questions and give more detailed information about investment options/performance;
- Investments form Cazenove were reviewed and found to be in line with ethical considerations.

We identified no significant finding in relation to this risk:

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**

Finding 1 - Expenditure (Operating effectiveness)	Risk
The audit sampled 20 expenditure items from a range of funds and identified one instance where the item may not have been appropriately charged to Charitable Funds: Professional fees for consultants had been paid via charitable funds.	Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded.
Recommendation 1	**Priority level**
Management will review the appropriateness of this expenditure items and take any action necessary.	Medium
Management Response	**Responsible Officer/ Deadline**
Professional Fees should be paid by the individual members of staff. Clinical Boards to be notified and Financial Control Procedure to be updated.	Head of Financial Services September 2017

21.6

Finding 2 - Dormant Accounts (Operating effectiveness)	Risk
It was noted in the 2015/16 internal audit report on charitable funds, that the monitoring of dormant accounts needed enhancement. Work has been on-going on this issue and has been subject to review by the Charitable Funds Committee. It was also noted during audit fieldwork, that the total dormant accounts have decreased by half a million over the period ending (2015/16 to 2016/17), however, there is still circa £1m in dormant funds and within that, there are accounts with significant balances e.g. £147,000. There were also 8 funds identified, with no designated Director of Operations post; this may potentially be affecting the sign off for expenditure.	Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded.
Recommendation 2	**Priority level**
The Health Board need to further review the monitoring arrangements of dormant accounts to ensure that effective management is in place.	Medium
Management Response	**Responsible Officer/ Deadline**
Finance department to continue working with Clinical Boards to deliver appropriate expenditure plans. The 8 funds are not part of the Clinical Boards and these have now been appropriately assigned.	Completed 2017

21.6

Finding 3 - Attendance (Operating effectiveness)	Risk
The Charitable funds bids panel has delegated authority to consider and approve funding applications from monies held in the Staff Lottery fund. ` It was also noted that there was low attendance from the clinical boards throughout 2016/17 meetings, with no representation over this period from Neurosciences or Dental.	Non-compliance with legislation and Charity Commission guidelines.
Recommendation 3	**Priority level**
Management will ensure that there are wider representation from Clinical Boards staff.	Low
Management Response	**Responsible Officer/ Deadline**
The Fundraising team will continue to engage with the Clinical Boards to ensure appropriate attendance at all meetings.	Simone Joselyn October 2017

21.6

Finding 4 – Policy	Risk
The Health Boards Fundraising Policy was approved by the Board on the 1st July 2014 and gives details of relevant fundraising guidance, activities, support available etc. However, this policy requires review to ensure it is appropriate and in line with current requirements	Non-compliance with legislation and Charity Commission guidelines.
Recommendation 4	**Priority level**
Documentation surrounding the governance of charitable funds will be reviewed for appropriateness and approved via an agreed forum.	Low
Management Response	**Responsible Officer/ Deadline**
Fundraising Policy to be reviewed as per governance arrangements.	Simone Joselyn 2017/18

21.6

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

21.7

Cardiff and Vale University Health Board

Sustainability Reporting

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	C&V-1718-37
Report status:	Final Internal Audit Report
Fieldwork commencement:	15th June 2017
Fieldwork completion:	27th June 2017
Draft report issued:	7th July 2017
Management response received:	4th September 2017
Final report issued:	5th September 2017
Auditor/s:	Kimberley Rowe
Executive sign off:	Abigail Harris, Director of Planning
Distribution:	Geoff Walsh, Assistant Director of Planning
	Jon McGarrigle, Trust Energy Advisor
	Fitzroy Hutchinson, Energy Manager
Committee:	Audit Committee

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

1. Introduction and Background

The review of the Sustainability Reporting process within Cardiff and Vale University Health Board (UHB) has been completed in line with the Internal Audit Plan.

The Government Financial Reporting Manual (FReM) requires that entities falling within the scope of reporting under the Greening Government commitments and which are not exempted by the de minims limit or other exemption under Greening Government (or other successor policy), shall produce a sustainability report to be included within the Management Commentary in accordance with HM Treasury issued Sustainability Reporting in the Public Sector guidance.

Guidance for the completion of Sustainability Reporting is found at https://www.gov.uk/government/collections/public-sector-annual-reports-sustainability-reporting-guidance. The NHS Wales 2016-17 Manual for Accounts provides a recommended structure for NHS Wales bodies Sustainability Reports, including minimum requirements.

Where estimated data is used to prepare the reports, if final data for the period is not available, this should be indicated in the table and a note made to explain the estimate used, eg. final quarter estimated.

Where data is not available and a robust estimate is not possible, an explanatory note must be made in the report to explain what plans are in place to improve data collection.

The relevant lead Executive Director for the assignment is the Director of Capital, Estates and Planning.

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of the management arrangements for the production of the Sustainability Report within the Annual Report. The review established:

- Whether the form and content of the report complies with the requirements of guidance published by the Welsh Government; and
- Whether the information published within the report provides an accurate and representative picture of the quality of services the Health Board provides and the improvements it has committed to undertake.

The audit focused upon the 2016/17 Sustainability Report which will be published within the Annual Report. The scope of the review was limited to the following aspects:

- Arrangements for the preparation, approval and publication of the Sustainability Report including ensuring compliance with relevant guidance;

- Testing of selected indicators to ensure the underpinning data is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.
- This review will draw on the findings of any relevant audit assignments undertaken within the reporting year to prevent any duplication.

3. Associated Risks

The potential risks considered in the review are as follows:

- Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency;
- Reputational risk that published information does not present a fair and balanced picture to stakeholders of the performance in the year; and
- Data quality risk that published information is either incomplete or inaccurate due to information governance controls overall or system controls over reporting information for individual data elements.

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 Sustainability Reporting 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.

21.7

The audit identified that the UHBs Sustainability Report for 2016/17 complies with the required format set out in the Welsh Government guidance. The figures and narrative within the report represent a fair picture of the UHBs position.

The audit notes a considerable improvement in the quality of the draft report provided for audit in comparison to the prior year.

It has also been recognised that the development of data capturing has allowed the Health board to move away from estimating the figures required, to using actuals and therefore enhancing the reliability of the performance data reported.

Whilst the process for preparing the report has advanced, there are some further actions identified that, when implemented, will lead to a more robust procedure.

5. Assurance Summary

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

Assurance Summary					
1	Reputational Risk from non-compliance with WG Guidance			✓	
2	Reputational Risk that published information does not present a fair & balanced picture				✓
3	Published information is either incomplete or inaccurate			✓	

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

Design of Systems/Controls

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

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 Sustainability Reporting.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Risk: Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency

The following areas of good practice were noted:

- The UHB Planning team have established adequate responsibilities and roles for preparing the annual sustainability report.
- It is evident that Annex 5 of the NHS Wales Manual for Accounts 2016-17 has been used to prepare the Sustainability Report instead of just using the prior year report as a template as new reporting requirements have been identified and actioned (eg. Water by office/non-office estate).
- There has been a vast improvement to the prior year with more in-depth narrative provided to support the tables, including considerable actions taken to improve data availability and move away from estimations that were used previously.
- The majority of minimum requirements have been met, with the exception of references being made to where further published sustainability and estate management performance information is published (as per Annex 5, part g).
- The draft submission deadline of 28 June 17 was achieved; however, production of the initial the draft report supplied to audit was delayed.

The following significant findings were noted:

- Whilst the draft submission deadline of 28 June 17 was achieved, the draft report supplied to audit was delayed. Due to the timings of the Health & Safety Group and the Environmental Steering Group and the delay in producing the final draft of the sustainability report, it was unable to be approved by these forums prior to submission to WG. At the time of the audit, the report had also not been approved by the Director of Capital, Estates and Facilities.

RISK: Reputational risk that published information does not present a fair and balance picture to stakeholders of the performance in the year

The following areas of good practice were noted:

- ISO140001 has been awarded across all sites since 2003.
- BSI undertakes six monthly audits of the environmental system in order for them to maintain accreditation.

- There has been increased effort to include more detail to support targets and commitments stated in the report. Where potential future schemes have been listed, they have been supported by on site presentations received.
- The report references key performance indicators and benchmarks where they exist to demonstrate the narrative. This gives the report context and improves the readers' understandability.
- After receiving the required information from contributors, the preparer confirms figures back to source documentation also supplied by the contributors prior to compiling into the report. This is an added step in the process in comparison to the prior year and has prevented the numerous errors that occurred in the draft provided to audit in the prior year.
- The narrative is an accurate reflection of data contained in the report.

No significant findings were identified.

Risk: Data quality risk that published information is either incomplete or inaccurate due to information governance controls overall or system controls over reported information for individual data elements

The following areas of good practice were noted:

- A documented procedure has been written that outlines the process for preparing the sustainability report, however, this needs expanding on as it does not go into the detail required to explain how each figure is compiled from data or where the data is sourced.
- Alongside the draft sustainability report, a folder of supporting information was supplied for audit. This included supporting workbooks for all figures reported, this is a marked improvement to the prior year when it was difficult to support the majority of the figures.
- The use of the Automated Metre Reading (AMR) programme has allowed the UHB to have access to real-time consumption data and therefore the majority of the data is no longer estimated or reliant upon invoices.
- There is a marked improvement on the accuracy of figures included in the Sustainability Report in comparison to the prior year. However, there were still some errors identified in the audit that could have been identified by a more in depth review prior to audit.

The following significant finding was noted:

- Despite the noted improvement in accuracy, there were still some errors identified in the figures included within the initial draft report.

These could have been identified if the initial draft was subject to a more detailed review prior to submission to Internal Audit.

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 - Timetable and Approval (Operating effectiveness)	Risk
Whilst the draft submission deadline of 28 June 17 was achieved, the initial draft report supplied to audit for review was delayed. Due to the timings of the Health & Safety Group and the Environmental Steering Group and the delay in producing the final draft of the sustainability report, it was unable to be approved by these forums prior to submission to WG. At the time of the audit, the report has also not been approved by the Director of Capital, Estates and Facilities.	Reputational Risk from non-compliance with WG Guidance.
Recommendation	**Priority level**
The lead responsible for preparing the Sustainability Report should ensure this is done in a timely manner to ensure there is enough time for the report to be reviewed, audited and approved prior to submission.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
The preparation of future Sustainability reports will have deadlines for data submission by various officers, however it is requested that consideration be given to undertaking the audit process earlier whilst the report is being generated, as this will reduce timescales to generate the final report.	Head of Energy and Performance/Energy Manager January 2018

21.7

Finding 2 – Errors in the report (Operating effectiveness)	Risk

Although it has been noted that there are considerably less errors in the first draft supplied to audit this year in comparison to last, the following errors were still identified:
 	
Greenhouse Gas Emissions Table
• CRC License expenditure was reported as £296,081m instead of £0.3m
• Scope 1 emissions did not agree to cardio tool:
  • reported = 27,643, cardio tool = 27,641
  • the total emissions also affected, reported = 27,804, cardio tool = 27,798
 	
Waste
• Waste costs had not been updated from a prior version and therefore did not agree to supporting information provided.
 	
Water
• The ratio of office to non-office estate had been included the wrong way around
 	
The above errors had been rectified in the final draft of the report.
	Published information is either incomplete or inaccurate.

21.7

Recommendation	Priority level
The lead should ensure that an in-depth review of the report is completed prior to submission to audit. Contributors should also be encouraged to review the report in closer detail when circulated.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
The final report and data was reviewed however future reports will be further scrutinized and the management response provided for Recommendation 1 above will assist this process.	Head of Energy and Performance/Energy Manager April / May 2018

21.7

Finding 3 – Further Published Sustainability Information (Operating Effectiveness)	Risk
Annex 5 of the Manual for Accounts 2016/17 (part g) has the following requirement: *'Reference should also be made to where further sustainability and estate management performance is published, including we references eg. The NHS Estate in Wales reporting'.* No references of this nature have been included.	Reputational Risk from non-compliance with WG Guidance.
Recommendation	**Priority level**
The UHB should ensure references are made to further sources of information as per the guidance provided.	**LOW**
Management Response	**Responsible Officer/ Deadline**
Agreed, references shall be included in future reports where appropriate.	April / May 2018

21.7

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

21.8

Cardiff and Vale University Health Board

Mental Health Sickness Management and Rostering

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Committee:	Audit Committee

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

1. Introduction and Background

The review of the management of sickness absence and rostering within the Mental Health Clinical Board was completed in line with the 2017/18 Internal Audit Plan for Cardiff and Vale University Health Board.

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

All National Health Service organisations rely on a level of temporary nursing staff, in order to maintain service continuity. The inherent nature of providing health services, with the variations in demand, capacity and workforce availability dictate that such expenditure is unavoidable. However, an organisation can influence the demand for temporary nursing staff via a flexible, efficient and robust rostering system.

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

2. Scope and Objectives

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

The purpose of the review was to establish if sickness absence is effectively managed, ward rosters are effectively planned and managed and the use of bank and agency nursing staff is appropriately assessed and utilised.

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

- Sickness absence is appropriately recorded, monitored and managed in accordance with the All Wales Sickness Management Policy;
- Ward rosters are drawn up to reflect the correct establishment and skill mix and they are fair, consistent and ensure that staff members work their contracted hours;
- Appropriate processes and procedures are in place for the booking of bank and agency nursing against demand and usage is appropriate and authorised;
- All bank and agency shifts are effectively verified and authorised prior to payment.

3. Associated Risks

The potential risks considered in the review were as follows:

- Increased sickness absence levels;
- Patient care is compromised due to inappropriate ward staffing levels and / or skill mix; and
- Financial loss due to unnecessary usage and / or incorrect payment of bank and agency nursing.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with sickness management and rostering 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.

The Clinical Board has appropriate processes in place to ensure effective and consistent rostering is undertaken. Guidance has been produced for the Adult Mental Health Directorate and a more comprehensive procedure produced for the Older Adults Mental Health Directorate. It was evident that the rosters are being produced in advance and are forwarded to the Clinical Roster Coordinator along with the Bank requests.

Bank and Agency nurses are appropriately utilised where required and the shifts are verified and approved on the Rosterpro system. Testing did

however identify that timesheets were not always available on the sampled wards to confirm the verification and approval of the hours worked.

Breaks should be taken by Nursing staff for any shifts that are longer than 6 hours. However, it was identified for some of the early and late shifts that staff members are working and being paid for the full 7½ hour shift without taking a break.

The Audit did identify a number of more significant issues with the management of sickness absence within the Mental Health Clinical Board. The All Wales Sickness Policy was not being fully complied with on any of the four sampled wards. There were instances where sickness documentation had not been completed as required and there were delays in carrying out Return to Work interviews. Issues were also identified around the monitoring of sickness triggers, the completion of required interviews and the management of long term sickness.

Whilst we have provided reasonable assurance for the review as a whole, the number and scope of the issues identified in relation to sickness absence mean that, if we had been reviewing this area in isolation, we would have only provided limited assurance.

5. Assurance Summary

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

Assurance Summary					
1	Increased sickness absence levels		✓		
2	Patient care is compromised due to inappropriate ward staffing levels and / or skill mix			✓	
3	Financial loss due to unnecessary usage and / or incorrect payment of bank and agency nursing			✓	

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

Design of Systems/Controls

The findings from the review did not highlight any issues that were classified as weakness in the system control/design for the management of sickness and rostering within the Mental Health Clinical Board.

Operation of System/Controls

The findings from the review have highlighted 5 issues that are classified as weakness in the operation of the designed system/control for the management of sickness and rostering within the Mental Health Clinical Board.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Risk 1: Increased sickness absence levels

The following areas of good practice were noted:

- Staff within the ward areas reviewed were all aware of the All Wales Sickness Policy;
- It was identified from discussions with the selected wards that they have processes in place for reporting and recording sickness absence;
- Audit met with one of the Medical Teams within the Older People Directorate and the staff confirmed that they were aware of the process to follow if an employee was off sick.

The following significant findings were noted:

- Audit was advised by the Pentwyn Medical Team that although they are aware of the All Wales Sickness Absence Policy, it is not always fully complied with.
- Audit selected a sample of 40 nurses from across the 4 wards that had sickness absence to establish if they had been managed appropriately. The following issues were identified which indicate that sickness absence is not being consistently managed in accordance with the All Wales Sickness Management Policy:
  - There was no sickness documentation for one employee;
  - Six instances whereby sickness proformas were not available which record all sickness episodes for each employee;
  - Ten self-certificates were not completed;
  - Seven Return to Work (RTW) forms were not completed;
  - Two RTWs forms had not been signed by the Manager and 1 RTW was not signed by the employee;
  - Three RTWs forms had not been completed on a timely basis;

- Seven employees had hit the triggers but there was no documentation to confirm that meetings had been held;
- One employee had been advanced up the trigger process when they should not have been; and
- One employee was on long term sick but there was no documentation on file to confirm that long term sickness meetings had been held.

Risk 2: Patient care is compromised due to inappropriate ward staffing levels and / or skill mix

The following areas of good practice were noted:

- Both Directorates have appropriate rostering processes in place and these are being consistently applied across the four sampled wards;
- There is a Ward Managers and Deputy Ward Managers Request for Bank and Agency flowchart in place detailing the processes to follow for the Older Peoples Mental Health Directorate;
- There are Guidelines in place titled "Process for requesting extra staff" for the Adult Mental Health Directorate;
- All of the Mental Health ward rosters and requests for Bank and Agency staff are sent to the Clinical Roster Coordinator. This allows one employee to view all the rosters in their entirety and ensure shortfalls in the rotas on the wards are appropriately addressed;
- There are staff establishments for all the wards reviewed;
- There are appropriate shift patterns in place for all the wards reviewed;
- Testing across the 4 wards identified that all staff are working their contracted hours.

The following significant findings were noted:

- Nursing staff on the Cedar, Oak, and Coed y Felin wards are not always taking a minimum 30 minute unpaid break when they work a shift of more than 6 hours. This means that they are not complying with the European Working Time Directives and Health Board policy.

Risk 3: Financial loss due to unnecessary and / or incorrect payment of bank and agency nursing.

The following areas of good practice were noted:

- It was identified that all rotas were drawn up a month in advance for the 4 wards reviewed. Where shortfalls have been identified in the wards, requests to cover these vacant shifts and the off duties are sent to the Clinical Roster Coordinator.

- The requests for bank and agency staff are entered onto Rosterpro and when the shifts are covered this is input onto Rosterpro.
- The Bank and Agency shifts are verified on Rosterpro.

The following significant findings were noted:

- Bank and agency timesheets are not always retained on the wards to confirm that the shits have been appropriately verified and authorised.

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**	**1**	**5**

Finding 1 - Sickness (Operating Effectiveness)	Risk
Audit selected a sample of 10 employees from each of the 4 wards (40 in total), who had sickness absence. These were reviewed to establish if their sickness had been managed in accordance with the All Wales Policy and our findings are recorded below: **Oak Ward** • 2 instances whereby self certs were not completed. • 1 instance whereby RTW form not completed. • 2 instances where RTW form not signed by Manager and 1 of the documentation had been completed by the employee independently. • 1 instance whereby RTW had not been completed within a reasonable timescale. • 2 instances whereby trigger documentation were unavailable for 2 employees. **Cedar Ward** • 4 instances whereby RTW not completed. • 1 RTW not completed within 7 days. • 6 instances whereby self certifications not completed. • 3 instances whereby sickness proformas not fully completed. • 2 instances whereby triggers were not complied with for a 1st formal and informal. **Ash Ward** • 3 instances whereby sickness proformas not fully completed.	Increased sickness absence levels

21.8

• 2 instances whereby self certifications not completed. • 2 instances whereby RTW not completed. • 3 instances whereby triggers were not complied with for a 1st formal and informal. **Coed y Felin** • 1 instance whereby RTW was not completed within 7 days. • 1 instance whereby RTW was not signed by the employee. • There was 1 instance whereby sickness documentation was not available for 1 employee. • There was 1 instance whereby there was no Long Term Sickness Interview documentation for 1 employee. • There was 1 employee whereby they were advanced up the trigger process when they should not have been.	
Recommendation	**Priority level**
Management should ensure that all sickness episodes are managed and documentation is completed in accordance with the Sickness Policy.	**High**
Management Response	**Responsible Officer/ Deadline**
The MHCB has seen significant changes to the inpatient ward management structures within recent months, with several internal secondments into managerial positions. In order to equip the new managers the Practice Development Team have devised a Leadership and Management Skills training programme for the existing and new managers.	Jayne Tottle/Rolling Programme

21.8

This programme covers good practice with regards to staff management. In addition the Operational HR team conduct sickness surgeries with all managers within the MHCB. For the next 9 months these sickness surgeries will focus on management of short term sickness, including a review of staff members' sickness files. This will ensure regular review of how sickness episodes are managed and a documentation review to ensure is completed in accordance with the Sickness Policy	Sarah Lloyd/Joanne Wilson Plan commenced to be reviewed in June 2018

Finding 2 - Staff Breaks (Operating effectiveness)	**Risk**
Audit selected a sample of staff from the 4 wards to ascertain whether they were taking breaks during their shifts as required by the European Working Time Directive. The Health Board's policy is that a 30 minute unpaid break must be taken for any shift over 6 hours. Below are our findings: • Cedar & Oak Wards - From a sample of 16 employees over a 2 month period, 8 did not take the required minimum break. It was noted that there are no unpaid breaks taken during the early or late shifts on these wards with the nurses working and being paid for the full 7½ hours. • Coed y Felin - From a sample of 16 employees over a 2 month period, 5 staff did not take the required minimum break. These staff worked either early or late shifts.	Patient care is compromised. Non-compliance with European Working Time Directive.
Recommendation	**Priority level**
Ward Managers should ensure that recommended breaks are factored in when drawing up staff rotas and times of shifts.	**High**

21.8

Management Response	Responsible Officer/ Deadline
The MHCB have been working alongside staff side colleagues to agree a process and timeframe to enforce changes to shift patterns to facilitate compliance with the EWTD, factoring in an unpaid break. The process was agreed in early September. All staff will receive notification during September 2017, with revised rotas commencing w.c 31/12/2017. MHSOP Directorate will be writing to all staff to confirm the requirement to take an unpaid break during the day shifts. The MHCB recognise that by night, as only one member of qualified staff is rostered per ward, we are currently unable to facilitate an unpaid break. Risk acknowledged on the Directorate and CB risk registers.	Jayne Bell/Mark Doherty January 2018 Mark Doherty October 2017

Finding 3 - Complying with the All Wales Sickness Absence Policy (Operating effectiveness)	Risk
Audit were advised by the Pentwyn Medical Team that although they are aware of the All Wales Sickness Absence Policy, it is not always fully complied with. They stated that the reason the All Wales Sickness Absence Policy is not fully adhered to is due to the low level of sickness within the Team which means that they are not familiar with the detailed requirements of the Policy. There was only one employee who had been recorded as having sickness absence within the Medical Team during the period under review. Audit reviewed the management of that episode and identified that the sickness	Increase sickness absence levels.

proforma was not completed confirming all sickness episodes and the sickness episode was not recorded on ESR. There is a risk that sickness absence within the team is not being appropriately recorded and managed.	
Recommendation	**Priority level**
Management need to ensure that the Medical Team are provided with training on the All Wales Sickness Absence Policy so that they utilise it correctly when there are instances of sickness within their team.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Clinical Directors support local medical managers in the management of sickness absence for SAS doctors. The Clinical Directors manage sickness absence issues for Consultants and trainees. CDs to distribute a guide for all medical colleagues, explaining their responsibilities to report sickness absence, as well as providing clear guidance on whom is responsible for recording of sickness episodes and ensuring documentation is completed in accordance with the Sickness Policy.	Suchitra Sabari/ Sabari Muthukrishnan October 2017

21.8

Finding 4 - Missing agency and bank timesheets (Operating effectiveness)	Risk
Bank and agency time sheets should be retained on the ward. Audit selected a sample of 10 agency and bank shifts from each ward to check if the Nurse in charge had signed the time sheet as confirmation that the shift was worked. Below are our findings: **Coed Y Felin** • 2 instances whereby the Agency forms could not be located at the time of the review. • 1 form for the bank staff had not been signed. **Cedar Ward** • 4 instances whereby the Bank forms could not be located at the time of the review. **Oak Ward** • 4 instances whereby the Bank forms could not be located at the time of the review. **Ash ward** • At the time of the review the 10 bank and agency requests for this ward could not be located and therefore we could not confirm whether they were signed. Audit requested copies of the bank and agency time sheets on a number of occasions but they were not provided in a reasonable timeframe. All the sampled shifts had been appropriately authorised for payment on Rosterpro.	Financial loss due to unnecessary usage and / or incorrect payment or bank and agency nursing.

21.8

Recommendation	Priority level
Nursing staff should be reminded that all bank and agency time sheets should be retained on file. Management to issue reminder to all Nursing staff that all bank and agency shifts worked must be verified.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Reminder sent to ward managers, reiterating the need to retain bank and agency time sheets.	Sarah Lloyd/Joanne Wilson September 2017

Finding 5 - Sickness dates (Operating effectiveness)	Risk
It was evidenced from our testing that there were a number of inconsistencies across all 4 wards with the recording of start and end sickness dates. There were different start and end sickness dates recorded on sickness documentation, ESR and Rosterpro. The majority of differences were only 1 or 2 days which suggests that there is an issue with correctly and consistently recording the dates that sickness ends and the actual dates of return to work.	Increased sickness absence levels.

21.8

Recommendation	Priority level
Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR and Rosterpro and all sickness dates should be the same.	**Low**
Management Response	**Responsible Officer/ Deadline**
This issue will be monitored via the sickness surgeries.	Sarah Lloyd/Joanne Wilson Plan commenced to be reviewed in June 2018

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Quality and Safety Governance Follow-Up

FINAL INTERNAL AUDIT REPORT
2017/2018

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

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Committee:	Audit Committee

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

Please note:

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

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1. EXECUTIVE SUMMARY

The follow up review of Quality & Safety Governance was completed in line with the Internal Audit Plan. The review sought to provide the Health Board with assurance that agreed actions from the previous reviews of each of the Clinical Boards on Quality & Safety Governance have been implemented appropriately.

The initial internal audit reports were finalised between June and September 2016 and highlighted a total of 41 issues which resulted in the following overall assurance ratings:

- Medicine - Reasonable
- Surgery - Reasonable
- Specialist Services (SPS) - Reasonable
- Clinical Diagnostics and Therapeutics (CD&T) - Substantial
- Children & Women (C&W) - Substantial
- Mental Health (MH) - Reasonable
- Primary Community and Intermediate Care (PCIC) – Substantial
- Dental - Reasonable

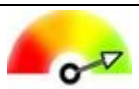
The risks considered in the previous review were as follows:

- Risks are not effectively managed due to a lack of appropriate procedures and/or structures;
- The UHB does not provide an appropriate quality service to users; and
- The UHB is subject to avoidable or repeated incidents or patient harm

Follow up work was undertaken to determine the level of progress that had been made relating to the actions from the agreed management responses.

2. CONCLUSION AND FINDINGS

In summary, progress against the 41 actions contained in the management responses that required implementation was as follows;

Clinical Board / Original Rating	Priority Rating	No of Actions	Fully Actioned	Partially Actioned	Not Actioned	Revised Assurance Rating
Medicine 	**HIGH**	0	0	0	0	
	MEDIUM	4	0	4	0	
	LOW	1	1	0	0	
Surgery 	**HIGH**	0	0	0	0	
	MEDIUM	5	2	2	1	
	LOW	1	0	1	0	
SPS 	**HIGH**	0	0	0	0	
	MEDIUM	5	3	2	0	
	LOW	0	0	0	0	
CD&T 	**HIGH**	0	0	0	0	
	MEDIUM	3	2	1	0	
	LOW	2	2	0	0	
C&W 	**HIGH**	0	0	0	0	
	MEDIUM	3	1	2	0	
	LOW	3	2	0	1	
MH 	**HIGH**	0	0	0	0	
	MEDIUM	4	2	2	0	
	LOW	1	0	0	1	
PCIC 	**HIGH**	0	0	0	0	
	MEDIUM	1	0	1	0	
	LOW	3	0	2	1	
Dental 	**HIGH**	1	0	0	1	
	MEDIUM	4	0	4	0	
	LOW	0	0	0	0	
TOTAL		**41**	**15**	**21**	**5**	

The follow up review concluded that based upon discussions with relevant management and review of the evidence provided, a reasonable level of progress has been made across the Health Board. There are however a number of agreed management actions that need to be further progressed in order to fully address the original control weaknesses identified.

On the basis of this follow up, the level of assurance that could be given as to the effectiveness of the system of internal control in place to manage the risks associated with Quality & Safety Governance has improved overall. The CD&T, Children & Women and PCIC Clinical Boards all remain at Substantial Assurance. The Specialist Services Clinical Board has increased their assurance rating from Reasonable to Substantial Assurance. The Medicine, Surgery, Mental Health and Dental Clinical Boards all remain as Reasonable Assurance.

It should be noted that although there are 21 management actions that were only partially actioned at the time of the review, they all had medium or low priority ratings in the original reports. Whilst some of these actions only require a small amount of additional work to be fully complete, there are others that need more significant development.

The Progress that has been made by each of the Clinical Boards is outlined below:

Medicine

The follow-up review focussed on the quality & safety governance at Clinical Board level and within two of the directorates; Emergency Unit (EU) and Clinical Gerontology (CG), as per the previous audit.

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

- The Medicine Clinical Board are monitoring submissions of directorate Risk Registers and discussing outstanding items at the Formal Clinical Board Meeting. There is clear review of the EU risk register and evidence of discussion at their Quality & Safety Group (Q&S) meetings. The EU are using a standard agenda format as per the clinical board that includes all expected agenda items. There is clear review of the CG risk register and documentation of amendments made, however there is no evidence of discussion at either the Q&S meeting or the Directorate management meetings. CG are not using a standard agenda yet, however, are in the process of preparing one (Finding 1 - Medium – Partially Actioned);
- There is a quarterly trend analysis of reported clinical incidents on the clinical boards Quality, Safety and Experience Committee (QSE) agenda and discussion is captured within the minutes via the Datix top ten trend review. Whilst clinical audit was on the agenda for March, this was not discussed. However, minutes from the June QSE show that the clinical audit plans along with the NICE Q3 were discussed. The Quality dashboard and staff recruitment is evident on the agenda and minutes (Finding 2 - Low – Fully Actioned);
- The Clinical Board QSE Terms of Reference (ToR) dictates that the meeting should be chaired by the Clinical Board Director, Director of Nursing (DoN) or Director of Operations (DoO). It is noted that whilst the meeting was chaired by the DoN in February, both the March and April meetings were chaired by the Deputy DoN. This was to ensure that the meeting went ahead as the DoN and Clinical Board Director were required elsewhere. Minutes of the QSE show good attendance and representation by Acute Medicine, CG, Unscheduled care, Internal Medicine, Dermatology and Rheumatology. However, there is no attendance by Clinical Research as there is currently not a nurse in

post. There is also no evidence of attendance monitoring. (Finding 3 - Medium – Partially Actioned);

- The Clinical Board QSE minutes do not evidence discussion of directorates QSE minutes or Risk Registers. The EU have a Q&S ToR in place, however there is no evidence of this being approved by the Clinical Board. No ToR has been made available by CG. (Finding 4 - Medium – Partially Actioned); and
- The Clinical Board now receive Datix reports that are discussed at the QSE meetings. No monthly newsletter in place to include key messages and learning priorities, however, they are striving to implement this. Whilst staff training & development are on the agenda for each Clinical Board QSE meeting, it is not being discussed as per the minutes. (Finding 5 - Medium – Partially Actioned).

There were no significant issues highlighted through the follow up review.

Surgery

The follow-up review focussed on the quality & safety governance at a Clinical Board level and within two of the directorates: Trauma & Orthopaedics (T&O) and Ophthalmology (Ophth) as per the previous audit.

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

- Both T&O and Ophth follow the Clinical Board Q&S workplan. Risk registers have been produced for both directorates; however there is no evidence of these being reviewed. No risks have been added to the T&O risk register since November 2016 and minutes from the governance meetings do not support review. (Finding 1 - Medium – Partially Actioned);
- ToRs were provided for audit for both T&O and Ophth, however there is no evidence of these in practice; Q&S is included as part of the directorates governance meetings which is not the prescribed format for a Q&S meeting. Ophth maintained attendance logs for these meetings, however, T&O do not. (Finding 3 - Medium – Partially Actioned, Finding 6 - Low – Partially Actioned); and
- Agenda and minutes for the Surgery Clinical Board Q&S Group confirm that the Surgical Board Quality Dashboard and clinical incidents, complaints and claims are a standing item and are discussed. The 2016/17 audit plan has been approved, however they are waiting for the themes for 2017/18. (Finding 4 - Medium – Fully Actioned, Finding 5 - Medium – Fully Actioned).

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

- T&Os Clinical governance meetings do not provide sufficient focus on Q&S, whilst they have a section on Q&S there is no detail around what action points are included. There is no set agenda for the Ophth Q&S. (Finding 2 – Medium – Not Actioned).

Specialist Services

The follow-up review focussed on the quality & safety governance at clinical board level and within two of the directorates; Nephrology & Transplant (N&T) and Cardiothoracic (Cardio) as per the previous audit.

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

- A ToR has been drafted for N&T, however not for Cardio. Neither directorate has detailed agendas for their Q&S group in the standard format, there is no inclusion of incidents, concerns and key risks or evidence of discussion within minutes. (Finding 1 - Medium – Partially Actioned);
- Risk Registers have been provided for both directorates. It cannot be confirmed when these were last reviewed. Neither directorates Q&S agendas have an item to review the Risk register (Finding 2 - Medium – Partially Actioned);
- Incidents and Complaints, HCAI rates and relevant improvement plans are included on the agendas for the Specialist Services Clinical Board QSE meetings and also discussions are supported and evidenced by the minutes. (Finding 3 - Medium – Fully Actioned); and
- The Clinical Board is now using the UHB template for Q&S and therefore using a standard QSE agenda. This includes all issues in the quality framework and therefore covering integration of risk management, risk updates have been provided at each meeting. (Finding 4 - Medium – Fully Actioned, Finding 5 - Medium – Fully Actioned).

There were no significant issues highlighted through the follow up review.

Clinical Diagnostics & Therapeutics

The follow-up review focussed on the quality & safety governance at Clinical Board level and within two of the directorates: Outpatients and Pharmacy as per the previous audit.

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

- The Clinical Board sent out reminders to those members included in the ToR to attend the QSE meetings. (Finding 1 - Medium – Fully Actioned);
- Incidents and concerns have been discussed within the Clinical Board and Directorates QSE meetings as per the minutes. Agendas are consistent using a template and appropriate ToRs have been developed for both the Clinical Board and Directorate QSE meetings. (Finding 2 - Medium – Fully Actioned);
- In the Clinical Board QSE meetings, trends are recognised in incidents, whilst the minutes focus on the number of incidents rather than the causes and severity of the incidents. Actions relating to incidents can be seen logged in the Clinical Board Action plan. Key quality indicators are captured on the QSE scorecard and reported to the group. In Pharmacy, whilst issues raised from errors are discussed, no trends are identified. In Outpatients, no reference is made to trends or themes of incidents which have occurred. (Finding 3 - Medium – Partially Actioned);
- A flow chart has been created at Clinical Board level for the management of risks. It is noted that the Outpatients risk register was seen to be last updated in January 2017. (Finding 4 - Low – Fully Actioned); and
- A scorecard has been developed and used for recording key quality issues, it includes sources of data also for reference. This is included as a standing agenda item at the Clinical Board QSE meeting. (Finding 5 - Low – Fully Actioned).

There were no significant issues highlighted through the follow up review.

Children & Women

The follow-up review focussed on the quality & safety governance at a Clinical Board level and within three of the directorates: Acute Child Health (ACH), Community Child Health (CCH) and Obstetrics & Gynaecology (O&G) as per the previous audit.

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

- At the Children & Women Clinical Board QS&PE meetings, agendas and minutes both demonstrate that staff recruitment is discussed as the Workforce report is shared, however there is no evidence of the quality dashboard being reviewed.

  At the ACH QSE meetings, agenda and minutes both demonstrate that staff recruitment is discussed as staffing levels and recruitment

drive are noted, however there is no evidence of the quality dashboard being reviewed.

At the CCH QS&PE meetings, agenda and minutes show no sign of either staff recruitment or quality dashboard being discussed.

At the O&G Q&S meeting, agendas demonstrate a meeting point on both the dashboard and staff recruitment. Minutes demonstrate that the dashboard is discussed, however, no workforce report update has been provided. (Finding 1 - Medium – Partially Actioned);

- In each of the directorates tested, ACH, CCH and O&G, the risk register is on agendas and evidence of review is documented by the minutes in the respective Q&S meeting; updated risk registers that reflect this were provided for audit. The action log maintained by ACH further demonstrates the update of the risk register. (Finding 2 - Medium – Fully Actioned);
- The directorates Risk Registers are in the format as per the Clinical Board and all risks are adequately transferred. (Finding 3 - Low – Fully Actioned);
- The Clinical Boards ToR dictates membership by directorate lead nurses, the minutes show adequate representation by each of these directorates. The membership in the ACH ToR has not been updated but the minutes show that there has been attendance by key personnel. The CCH ToR was updated in May 17, however a review of the minutes deem attendance to be low. Membership in the O&G ToR has not been updated, this is currently in process. (Finding 4 - Medium – Partially Actioned); and
- The Clinical Board and ACH now produce an action log for each QS&PE meeting which is updated and circulated as part of the papers. There is evidence of an action log embedded within the O&G minutes. (Finding 6 - Low – Fully Actioned).

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

- The ToR has been updated for CCH and submitted to the CB in May 17, however, ACH and O&G have not been updated. (Finding 5 - Low – Not Actioned).

Mental Health

The follow-up review focussed on the quality & safety governance at a Clinical Board level and within two of the directorates: MHSOP & Neuropsychiatry (MHSOP & N) and Adult Mental Health (AMH) as per the previous audit.

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

- The risk register is discussed at each of the Mental Health Clinical Board QS&E meetings. Risks are removed where they have been appropriately mitigated and new risks are considered. Minutes of Directorate QSE groups are presented to the Clinical Board QSE group, as evidenced in the minutes. All risk registers were found to be up to date. Risk assessment forms for the directorates are stored on the MH shared drive. (Finding 1 – Medium – Fully Actioned);
- A MH Performance review dashboard exists, however, there is no supporting evidence to show this has been presented to the Clinical Board QSE meetings. (Finding 3 - Medium – Partially Actioned);
- The Clinical Board did a review of incidents and accompanying incident forms in May, incidents is also a standing agenda item at the QSE meeting. (Finding 4 - Medium - Fully Actioned); and
- The Clinical Board have written a discussion paper on tolerance toward suicide, however, there is no evidence of any discussion, learning priorities or actions. The Quality dashboard is partly implemented but there is no evidence of this being discussed at the QSE meeting. (Finding 5 - Medium– Partially Actioned).

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

- A ToR exists for the Clinical Boards QSE meetings; however this does not depict who is chair. The meetings are not always quorate and attendance is not wholly reflective of membership. (Finding 2 - Low – Not Actioned).

Primary, Community & Intermediate Care

The follow-up review focussed on the quality & safety governance at a Clinical Board level and within the business units as per the previous audit.

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

- In the Clinical Board QSE meeting, staff recruitment has not been on the agenda and was not discussed after January 2017. The quality dashboard has been developed, however, the Q&S officer is new to post and will be populating going forward. Staff recruitment is evident on the agenda for the North & West (N&W) locality and discussion is documented within the minutes. Staff recruitment is evident on the agenda for the South & East (S&E) locality and the Vale locality respectively, however, there is no discussion documented within the minutes. (Finding 1 - Medium – Partially Actioned);
- The N&W updated draft ToR reflects the split between whom the minutes should be shared with and actual attendees. When

comparing this to a sample of minutes, the quorum of a minimum of 5 attendees was met, however attendance was still deemed low. The S&E ToR was provided, review of the minutes deems attendance to be low, however, no role descriptions were provided on the minutes therefore unable to determine whether quorum of 50% was met. No Vale ToR was provided for audit. (Finding 3 - Low – Partially Actioned); and

- Updated ToR for N&W was provided but the ToR for Primary Care is still in development. The S&E ToR is not in the standard format and does not include a review date. No ToR for the Vale was provided for audit. (Finding 4 - Low – Partially Actioned).

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

- The minutes for the Primary Care QS&E group are still notes, this will be changed when the ToR is agreed. (Finding 2 – Low– Not Actioned).

Dental

The follow-up review focussed on the quality & safety governance at a Clinical Board level and within the relevant sub groups as per the previous audit.

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

- The Clinical Board receives minutes from the Community Dental Service (CDS) and other subgroups which it notes and discusses. Vice versa, the CDS received minutes from the Clinical Board group. No supporting evidence has been provided by other subgroups, ie. Dental Hospital. Complaints/concerns are standing agenda items for the CDS group, the minutes support this discussion. (Finding 2 - Medium – Partially Actioned); and
- Both Staffing Levels and 'Top 3 learning areas from review of incidents, complaints and clinical audits' are agenda items for the Dental Clinical Board QSE meetings. However, whilst the minutes note the 'Top 3' report is received, there is no record of discussion of either agenda item. The Clinical Board keep an action log to address key themes raised in their management meetings. (Finding 3 - Medium – Partially Actioned, Finding 4 - Medium – Partially Actioned, Finding 5 - Medium – Partially Actioned);

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

- The Risk Management Group is yet to be set up due to the Dental CB restructure. Whilst all managers are in process of having risk assessment training, no generic risk register template has been fully

rolled out, it is anticipated that all risk registers will be complete by the end of August 17. Whilst the Risk register is an agenda item for the CDS Group, minutes do not support any discussion. No supporting evidence has been provided from any other sub groups. (Finding 1 – High – Not Actioned)

Medical Locums Audit Follow-Up

Cardiff and Vale University Health Board

21.9

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.

August 2017

22

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Consultation on Fees 2018-19

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Consultation on fees 2018-19, incorporating local government and data matching fee scales

Overview

This consultation invites views and comments on the Wales Audit Office's proposals for fee rates and other aspects of the statutory fee regime for audit work.

Following the consultation, the Wales Audit Office will submit a Fee Scheme 2018-19 with its Estimate 2018-19, for consideration by the National Assembly's Finance Committee this autumn. The Fee Scheme is prepared under section 24 of the Public Audit (Wales) Act 2013. The proposals in this consultation are dependent on approval by the National Assembly for Wales of that Estimate and Fee Scheme.

How to respond

Please respond by 22 September 2017.

Response forms can be sent to the following address:

Fee scales consultation
Wales Audit Office
24 Cathedral Road
Cardiff
CF11 9LJ

Or completed electronically and sent by e-mail to info@audit.wales

If you require this publication in an alternative format and/or language please contact us using the details provided above or by telephone on 029 2032 0500.

Publication of responses – confidentiality and data protection

Information provided in response to this consultation may be published or disclosed in accordance with the access to information legislation (chiefly the Freedom of Information Act 2000, but also the Data Protection Act 1998 and the Environmental Information Regulations 2004).

If you want any information you provide to be treated as confidential, it would be helpful if you could explain to us why you regard the information you have provided as confidential.

If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give any assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Wales Audit Office.

Personal data will be processed in accordance with the Data Protection Act. Where such data falls within the scope of a request for information from another person, the provisions of the 1998 and 2000 Acts will need to be considered in the particular circumstances. While no situation can be prejudged, this is likely to mean that information concerning senior officials and public figures is likely to be disclosed while the names and addresses of ordinary members of the public are likely to be withheld.

Contents

Message from the Director of Finance, Wales Audit Office

We recently consulted on a discussion paper covering the complicated fee regime here in Wales; my thanks to all who responded. This consultation document covers how we charge for the work undertaken by the Auditor General for Wales and the Wales Audit Office.

Legislation requires us to consult on the fee scales applicable to our work in local government and on the fees chargeable for the National Fraud Initiative. We go further by consulting on planned fees for all areas of audit work we undertake. We believe this is fairer to our stakeholders and provides for greater transparency when the National Assembly's Finance Committee considers our final Fee Scheme and Estimate (the budget) for the year ahead.

As a reminder, we cannot charge more than the audit work costs us to undertake. Our hourly fee rates are derived from a simple calculation:

- the total costs of the WAO – which are predominantly staff salaries and on-costs – other than the cost of certain functions which are paid for directly from the Welsh Consolidated Fund;
- allocated over the total expected hours of audit work we undertake across the year.

The detail of our running costs is set out in our annual Estimate, which we publish in October every year and which is scrutinised by the National Assembly's Finance Committee. We are now working on finalising our Estimate for 2018-19 and would welcome your views on our proposals around audit fees for the year.

We fully understand the very challenging financial environment in which public services are operating and the pressures upon us, at the Wales Audit Office, to do all we can to minimise the cost of our audit work. Through reviewing our audit approaches, we anticipate being able to deliver a reduction in our fee scales over the next two years for a 'typical' audited body. There is the possibility that our hourly rates may need to increase, by no more than 1%, but this should be considered alongside changes in the skills' mix and number of hours to be charged.

We regularly review our fee rates, and contract out through a competitive procurement exercise 15% of our financial audit work. Increasingly, however, the legislation governing the extent of performance audit work required to be undertaken by UK audit offices has continued to diverge with devolution making direct comparisons difficult. Examples here include the Local Government (Wales) Measure 2009 and Well-being of Future Generations (Wales) Act 2015 (the WFG Act).

For audited bodies in the central government sector, we need to charge fees for the new work we are required to undertake in relation to the WFG Act. We know this is a sensitive matter for the sector; our Engagement Directors will be liaising with relevant bodies on completion of our WFG pilot work in order to estimate what the additional fees may be.

For bodies in the health and local government sectors, we anticipate being able to integrate WFG-related audit work into other areas of our audit work so that additional fees are unlikely to be charged.

The proposals set out in this consultation are dependent on the Finance Committee's consideration of the Estimate. We continue to work hard at containing our costs and we set ambitious savings efficiency targets annually. We also have strategic projects underway that will ensure our fitness for purpose as a cutting edge audit office in the years ahead, seeking to maximise the benefits of data analytics and digital working. You will be able to read more about that in our forthcoming Estimate for 2018-19.

As mentioned, we have delivered on our commitment to consult with audited bodies and other key stakeholders on the complexities of the fee regime governing the Wales Audit Office. That consultation closed on 28 July and our response will be published in the autumn and shared with you and the National Assembly's Finance Committee.

There is much in hand to ensure that the overall cost of public audit in Wales remains transparent, proportionate and justifiable in these challenging times. I encourage you to take this opportunity to let us know your views on the fee proposals set out on the following pages. As demonstrated from previous consultations, your views are carefully considered by the Board and genuinely help to inform its decisions.

Do please contact me directly if you should like to discuss.

Steve O'Donoghue CPFA

Director of Finance
On behalf of the Board and Auditor General for Wales

Consultation

The sections below explain how our fees affect your organisation, according to which sector you form part of.

Consultation with all audited bodies on fee scales for the National Fraud Initiative (data matching)

We invite your views on continuing participation in the National Fraud Initiative (NFI) on a nil-fee basis

1 We are required to consult on and prescribe scales of fees for data matching for mandatory participants in the NFI. The Auditor General conducts the NFI using his statutory data-matching powers under Part 3A of the Public Audit (Wales) Act 2004.

2 The NFI matches data across organisations and systems to help public bodies identify potentially fraudulent or erroneous claims and transactions. The NFI has been a highly effective tool in detecting and preventing fraud and overpayments. Since its commencement in 1996, NFI exercises have resulted in the detection and prevention of more than £30 million of fraud and overpayments in Wales and £1.3 billion across the UK.

3 Since April 2015, the National Assembly has met the costs of running the NFI through payment from the Welsh Consolidated Fund as approved through the Wales Audit Office's Estimate. This is intended to encourage participation of organisations on a voluntary basis and also simplifies arrangements for mandated participants. As required by legislation, the fees for mandatory participants are shown in Exhibit 1.

Exhibit 1: NFI fees

Type of body	Fee 2018-19 £
Unitary authority; police and crime commissioners and chief constables; fire and rescue authorities; NHS trusts; local health boards.	Nil
Voluntary participants	Nil
All participants may also be provided with access to the NFI Application Checker (App Check).	Nil

Consultation on fee scales for work undertaken at local government bodies

4 For local government bodies, the Wales Audit Office is specifically required to consult on and prescribe:

- scales of fees payable in respect of the audit of accounts of local government bodies in Wales; and
- scales of fees in respect of audits, assessments and special inspections carried out under the Local Government (Wales) Measure 2009. We will be designing this work to concurrently discharge the requirements of the WFG Act so as not to increase the overall amount of performance audit work required.

5 These fee scales are provided in Appendix 1. Fee scale minimum, median and maximum figures in the tables are rounded to the nearest £'000. In most cases we have reduced the median figures for 2018-19 through revising our audit approaches.

6 Annual audit work fee scales do not include work that goes beyond the general duty of the Auditor General (under section 17 of the Public Audit (Wales) Act 2004), such as reporting in the public interest, extraordinary audit, special inspections and work in relation to elector challenge and the prevention of unlawful expenditure. Such additional work is charged on an hourly basis. Fee rates apply additionally to work undertaken to certify claims and returns in respect of grants paid or subsidies made to local government bodies.

7 Auditors will use their professional judgement, informed by the Auditor General's Code of Audit Practice, relevant accounting and auditing standards, and guidance issued by the Auditor General to determine where a particular audited body lies on the prescribed fee scale for that type of body. The fees to be charged at individual bodies will depend on each body's circumstances. In order to properly reflect the cost of the audit, and so provide transparency, the fee must be sufficient (but no more than sufficient) to fund the work required taking into account considerations such as the governance environment, risk, financial and performance management arrangements, size, complexity and the body's track record on improvement.

8 Our fee rates for 2018-19 will be confirmed once our Estimate and draft Fee Scheme have been considered by the Finance Committee in the autumn. Initial indications are that the rates could increase, but by less than 1% in cash terms, which is equivalent to a real terms reduction of 5.6% since these rates were last changed in April 2014.

9 However, despite this increase in fee rates, our revised audit approaches mean that we do not anticipate increases in the overall fee charged to audited bodies, unless local circumstances necessitate it. Each body's Engagement Director will discuss with you the skills' mix for your audit and the factors influencing your overall fee.

10 We are planning for access to the National Fraud Initiative (NFI) to continue on a nil-fee basis in 2018-19.

11 Town and community councils in Wales are subject to a limited assurance audit regime. For 2018-19, we will continue to charge for such work on a time basis at our published fee rates.

We would welcome your views on the above.

Consultation on fees for work undertaken in the Health sector

12 Annual audit work includes work undertaken in relation to the audit of accounts, alongside, where applicable, performance audit work.

13 In 2017-18, we have been working with a number of relevant bodies in developing our audit approach under the WFG Act, which places new duties on the Auditor General. We have done this work without charging any additional fee as we secured funding from the Welsh Consolidated Fund via our Estimate to meet the additional costs incurred. In future, we expect to design our 'structured assessment' work so that it concurrently discharges the requirements of this Act so as not to increase the overall amount of work required

14 Our fee rates for 2018-19 will be confirmed once our Estimate and draft Fee Scheme have been considered by the Finance Committee in the autumn. Initial indications are that the rates could increase by less than 1% in cash terms, which is equivalent to a real terms reduction of 5.6% since these rates were last changed in April 2014.

15 However, despite this increase in fee rates, our revised audit approaches mean that we do not anticipate any increases in the overall fee charged to audited bodies, unless local circumstances necessitate it. Each body's Engagement Director will discuss with you the skills mix for your audit and the factors influencing your overall fee.

16 We are planning for access to the NFI to continue on a nil-fee basis in 2018-19.

We would welcome your views on the above.

Consultation with the Welsh Government, Welsh Government Sponsored Bodies and similar bodies, statutory Commissioners and the Assembly Commission

17 Annual audit work is undertaken in relation to the audit of accounts.

18 Our fee rates for 2018-19 will be confirmed once our Estimate and draft Fee Scheme have been considered by the Finance Committee in the autumn. Initial indications are that the rates could increase by less than 1% in cash terms, which is equivalent to a real terms reduction of 5.6% since these rates were last changed in April 2014.

19 However, despite this increase in fee rates, our revised audit approaches mean that we do not anticipate any increases in the overall fee charged to audited bodies, unless local circumstances necessitate it. Each body's Engagement Director will discuss with you the skills mix for your audit and the factors influencing your overall fee.

20 In 2017-18, we have been working with a number of relevant bodies in developing our audit approach under the WFG Act, which places new duties on the Auditor General. We have done this work without charging any additional fee, as we secured funding from the Welsh Consolidated Fund via our Estimate to meet the additional costs incurred.

21 For future years, we will, however, need to charge fees for this additional WFG work. Unlike other sectors, we cannot incorporate the work in to other aspects of our performance audit work, as we do not currently undertake such work for central government bodies. We know the charging of additional fees is a sensitive matter for the sector as you have previously told us that no additional funding is being provided in relation to the Act. Our current Fee Scheme and previous fee consultations have flagged this risk.

22 Our Engagement Directors will be liaising with relevant bodies on completion of our WFG pilot work in order to quantify what the additional fees may amount to. They will also discuss with you the skills mix for your audit and the factors influencing your overall fee.

23 Also, for central government sector bodies, we propose switching to the billing model we use for all other sectors, which is to charge fees in equal instalments over a 12-month period, with a final reconciling adjustment made on completion of the audit assignment. We would welcome your views on this.

24 We are planning for access to the NFI to continue on a nil-fee basis in 2018-19.

25 Advisory support to the central government bodies' Heads of Resources' Group and the Chairs of Audit Committees' Forum will continue to be provided on a nil-fee basis.

We would welcome your views on the above

Fee rates for audit work and fee charging

26 Audited bodies not covered by the statutory requirement for a fee scale have their estimated audit fees calculated in the same way as for those which are covered – that is, through applying published fee rates to the estimated team mix and hours of input required for the audit.

27 The fee rates apply to all audit work that the Wales Audit Office will charge for. In the case of work done under agreements predating 1 April 2014, rates are as agreed.

28 Our fee rates for 2018-19 will be confirmed once our Estimate and draft Fee Scheme have been considered by the Finance Committee in the autumn. Initial indications are that the rates could increase by less than 1% in cash terms, which is equivalent to a real terms reduction of 5.6% since these rates were last changed in April 2014.

29 Exhibit 2 sets out the current fee rates used to calculate our audit fees.

Exhibit 2: Current fee rates for audit staff

Grade	Fee rate since April 2014 (£ per hour)
Engagement director	162
Audit manager	111
Performance audit lead	93
Financial audit team leader	75
Performance auditor	65
Financial auditor	56
Graduate trainee	43

30 Where specialist support, legal, or other professional advice is required, this may be charged to audited bodies in addition to the cost of Wales Audit Office staff.

31 Auditors undertake grant certification work on behalf of the Auditor General, on a per-hour charging basis. The amount of grant certification work undertaken in any year is dependent on the number of schemes subject to audit and the number of audited bodies participating in those schemes. Charges for this work are calculated using the fee rates and time taken.

Fee refunds and excess charges

32 For most bodies we charge fees in equal instalments over a 12-month period, with a final reconciling adjustment made on completion of the audit assignment.

33 On completion of audit assignments, we assess the actual costs incurred in undertaking the assignment against the fee charged. We will let you know, during the audit process, if we experience difficulties which may result in an increased fee. We will refund any excess of fee over cost and, conversely, we may charge additional costs where the fee falls short. We will process refunds and additional charges in a manner which seeks to minimise administrative costs, such as through offsetting against future fees or fees for other aspects of audit activity where permissible under legislation.

Appendix 1

Unitary authorities

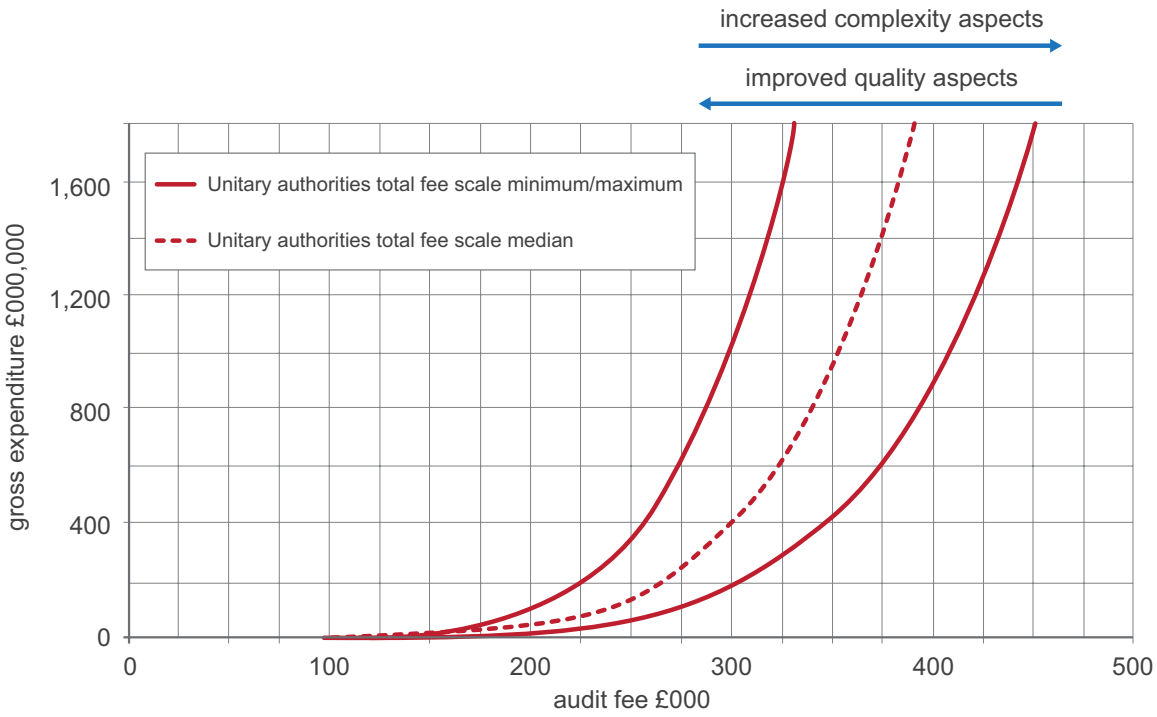
Fee scale for audit of 2017-18 accounts

Gross expenditure £000,000	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
100	117	138	158	139
200	141	166	191	167
300	157	185	212	186
400	169	199	229	201
500	180	211	243	213
600	189	222	255	224
700	197	231	266	233
800	204	240	276	242
900	210	247	284	249
1,000	216	254	292	256
1,100	222	261	300	263
1,200	227	267	307	269

Fee scale for 2018-19 for performance audit work (including improvement audits, assessments and special inspections under the Local Government (Wales) Measure 2009)

All unitary authorities	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
	83	99	115	112

Graphic of total fee scale for unitary authorities



Fire and rescue authorities

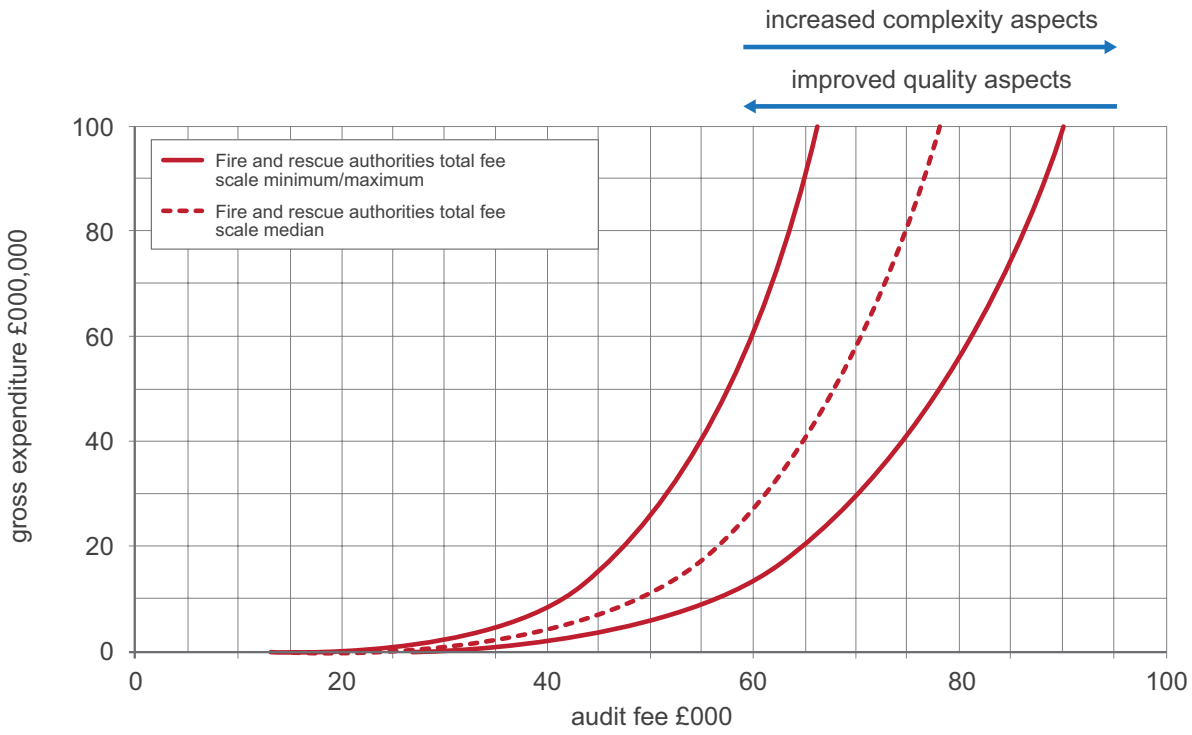
Fee scale for audit of 2017-18 accounts

Gross expenditure £000,000	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
20	34	40	46	41
40	41	49	56	49
60	46	54	62	55
80	50	58	67	59
100	53	62	71	63

Fee scale for 2018-19 for performance audit work (including improvement audits, assessments and special inspections under the Local Government (Wales) Measure 2009)

All fire and rescue authorities	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
	14	16	19	16

Graphic of total fee scale for fire and rescue authorities



National park authorities

Fee scale for audit of 2017-18 accounts

Gross expenditure £000,000	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
2	21	25	29	25
4	26	30	35	30
6	29	34	39	34
8	31	36	42	37
10	33	38	44	39

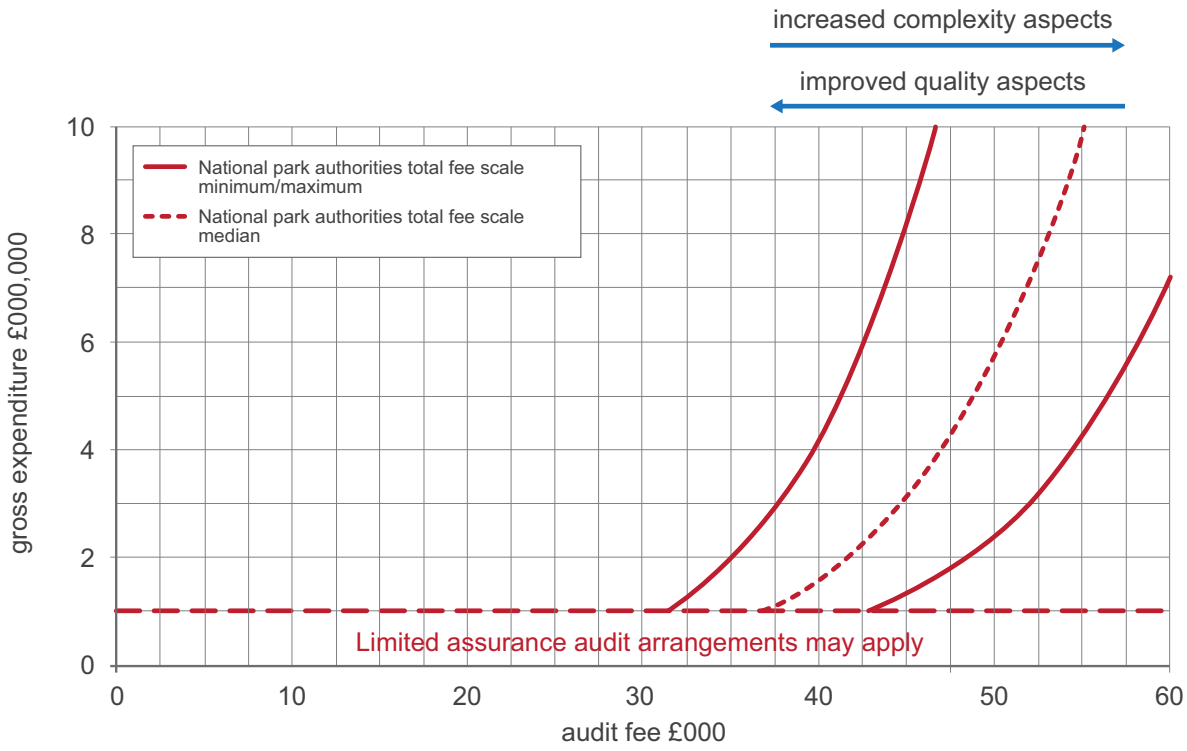
Fee scale for 2018-19 for performance audit work (including improvement audits, assessments and special inspections under the Local Government (Wales) Measure 2009)

All national park authorities	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
	14	17	19	17[1]

1 Actual fee charged to all Parks for 2017-18. This is not expected to change for 2018-19.

22

Graphic of total fee scale for national park authorities



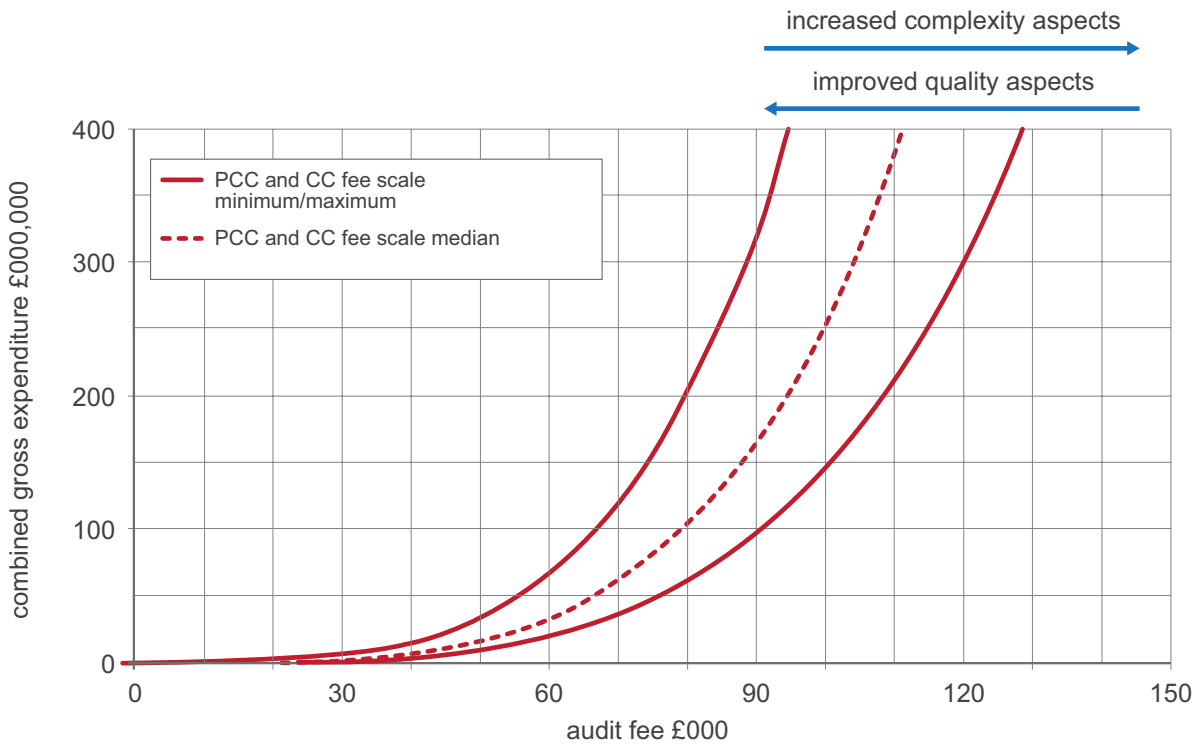
Police and crime commissioners and chief constables

Auditors undertake audits of two statutory bodies in a police area – the Police and Crime Commissioners (PCC) and the Chief Constables (CC). The split of the total fee between the two bodies in a particular police area will be a matter for auditors to determine, based on accounting requirements and the operational arrangements put in place by each of the bodies.

Total fee scale for 2017-18

Combined gross expenditure of PCC and CC £000,000	Combined fee range for PCC and CC £000			Previous year median £000
	Minimum	Median	Maximum	
50	56	66	76	70
100	67	79	91	82
150	74	87	100	91
200	79	94	108	97
250	84	99	114	103
300	88	104	120	107
350	91	108	124	112

Graphic of total fee scale for police and crime commissioners and chief constables



Town and community councils with annual income or expenditure under £2.5 million

Town and community councils in Wales are subject to a limited assurance audit regime. Since 2016-17 we have charged for this work on a time basis rather than the historical basis of a fixed fee according to expenditure/income bands.

The fee rate charges are as set out in Exhibit 2.

In circumstances where the auditor requires further evidence to properly discharge their responsibilities, including following publication of a related public interest report, additional testing will be undertaken to address the auditor's concerns.

It is emphasised that the actual charge made to any particular body will be dependent on the time actually worked on that particular audit. The ranges provided in the table below are for indicative purposes only.

Estimated time charges for audit of 2017-18 accounts of town and community councils

Annual income or expenditure	Indicative baseline charge	Indicative upper range fee
£0 – £5,000	£140	£280
£5,001 – £100,000	£160	£320
£100,001 – £500,000	£200	£380
£500,001 – £2,500,000	£240	£460

Local government pension funds

Fee scale for audit of 2017-18 accounts

All pension funds	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
	33	40	55	40

Fee rates for other work in local government

The audit of other types of local government body, work which goes beyond the general duties of the Auditor General, and grant certification work

Other than those types of bodies for which fee scales have been prescribed, there are a small number of other types of local government body. For audits of these bodies, a zero-based approach to audit planning will still be applied, with resource requirements converted into fees directly based on the costs of delivering the work or by applying the fee rates as set out in Exhibit 2.

For all types of government body to meet their statutory responsibilities, it is sometimes necessary for the Auditor General to carry out work which goes beyond general duties (those set out in section 17 of the Public Audit (Wales) Act 2004). Additional work can include reports in the public interest, extraordinary audit, special inspections and further work in relation to elector challenge and the prevention of unlawful expenditure. Charges for this type of work will reflect the nature of the work required.

Auditors may also undertake grant certification work at local government bodies on behalf of the Auditor General. The amount of grant certification work undertaken in any year is dependent on the number of schemes subject to audit and the number of audited bodies participating in those schemes. Charges for this work are made on a per-hour basis and reflect the size, complexity or any particular issues in respect of the grant in question.

Estimates of the relative proportions of financial audit staff grades to be used for different types of grants work are provided below.

22

Grade of staff	Complex grants staff mix %	All other grants staff mix %
Engagement director	1 to 2	0 to 1
Audit manager	4 to 6	1 to 2
Team leader	18 to 21	12 to 16
Team member/trainee	77 to 71	87 to 81

Complex grants include:

- BEN01 Housing and council tax benefits scheme
- LA01 National non-domestic rates return
- PEN05 Teachers' pensions return

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