AUDIT COMMITTEE

27 February 2018, 9.00am

Corporate Meeting Room, Headquarters, UHW

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AUDIT COMMITTEE

Tuesday, 27 February 2018
9.00am – 11.00am

CORPORATE MEETING ROOM, HQ, UHW
AGENDA

PART 1 – SECTION 1: PRELIMINARIES (Chair)		**(10 mins)**	
1.		Welcome and Introductions	*Oral*
2.		Apologies for Absence	*Oral*
3.		Declarations on Interest	*Oral*
4.		Minutes of the Committee meeting on 5 December 2017	*Chair*
5.		Action log following meeting 5 December 2017	*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 COUNTERFRAUD			
8.	*20 mins*	Internal Audit Position Report and Updates **Assignment** — **Assurance Rating** 1. Specialist Services Patient Care IT Services — Limited 2. Core Financials — Substantial 3. WAO/RKC Action Plan — Substantial 4. Stock Controls Localities Follow-up — Reasonable 5. Waiting List Initiative Follow-up — Reasonable 6. Residences — Reasonable 7. Surgery Clinical Board — Reasonable **Please see part 2 agenda item 20 for full copies of audit reports*	*J Johns*
9.	*10 mins*	To receive the Wales Audit Office Annual Plan 2018	*WAO*
10.		To receive the Wales Audit Office – Committee Update	*WAO*

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11.	*5m*	End of Year Update – Structured Assessment Management Response 2016	*P Welsh*
12.	*5m*	Update on Wales Audit Office – Action Plan of Contractual Relationship with RKC Associates Limited and Its Owner	*P Welsh*
13.	*5m*	To receive Tracking Report on Audit Recommendations	*P Welsh*
14.	*5m*	Post Payment Verification – Approve Annual Plan	*S Lavendar*
SECTION 4: POLICIES AND COMPLIANCE REPORTS			
15.		To receive the Scheme of Delegation Report	*R Chadwick*
SECTION 5: CORPORATE GOVERNANCE			
16.	*5m*	Director of Corporate Governance Report	*P Welsh*
17.		To receive the Corporate Risk Assurance Framework Report	*P Welsh*
SECTION 6: ANNUAL FINANCIAL AND GOVERNANCE STATEMENTS			
18.		Topical Legal and Regulatory Items	*Oral* *P Welsh*
SECTION 7: ITEMS FOR DECISION			
19.		No items to report	
PART 2 – ITEMS FOR INFORMATION			
20.		Internal Audit reports for information **Assignment** — **Assurance Rating** 1. Core Financials — Substantial 2. WAO/RKC Action Plan — Substantial 3. Stock Controls Localities Follow-up — Reasonable 4. Waiting List Initiative Follow-up — Reasonable 5. Residences — Reasonable 6. Surgery Clinical Board — Reasonable	*J Johns*
21.		Safety Notices and Important Documents Management Policy	*P Welsh*
22.		Wales Audit Office – Fee Scheme 2018/19	*P Welsh*

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REVIEW AND FINAL CLOSURE			
23.		Items to be deferred to Board / Committee	*Oral Chair*
24.		To note the date, time and venue of the next Committee meeting: • **Tuesday, 24 April 2018 at 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]

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UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE
HELD ON 5 DECEMBER 2017
IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

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Present:	
John Antoniazzi	Independent Member – Capital, Chair
John Union	Independent Member - Finance
Stuart Egan	Independent Member – Trades Union
In Attendance:	
Abigail Harris	Director of Corporate Governance
Anne Beegan	Wales Audit Office
Carol Evans	Assistant Director of Patient Safety & Quality
Craig Greenstock	Counter Fraud Manager
Ian Virgil	Deputy Head of Internal Audit
James Johns	Head of Internal Audit
Mark Jones	Wales Audit Office
Peter Welsh	Director of Corporate Governance
Robert Chadwick	Director of Finance
Sian Rowlands	Corporate Governance Manager
Simon Cookson	Director of Audit and Assurance
Steve Curry	Chief Operating Officer
Glynis Mulford	**Secretariat**

AC: 16/063 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone present to the meeting. Mr Stuart Egan was thanked for his service to the Health Board and contribution to Audit Committee over the past eight years as Independent Member lead for Unions and wished him well for the future.

AC: 16/064 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 16/065 DECLARATIONS OF INTEREST

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

AC: 16/066 UNCONFIRMED MINUTES OF THE MEETING HELD ON 26 SEPTEMBER 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 26 September 2017.

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AC: 16/067 ACTION LOG FROM MEETING OF 26 SEPTEMBER 2017

The Committee **RECEIVED** the Action Log from the meeting of 26 September 2017 and **NOTED** the following:

AC 17/007: Mental Health Clinical Board Out of Area: Significant investment had been made with three new members of staff. This will be doubled by March and when recruited to full strength the number will increase to 11 which will improve performance to review out of area patients and CHC packages. Since the Internal Audit review a Complex Care and Commissioning Peer Group had been set up. In addition KPI targets have been set within their performance reviews and a trigger had been built into the PARIS system when annual reviews were due. This will be followed up by Internal Audit as part of their routine process. **COMPLETE**

16/093: Internal Audit Position Report and Tracking Report – Medicines Cost Reduction: In regard to the update on the high value issue. The Director of Medicines Management considered there was too much cost associated with putting in a process around this. In terms of wastage this occurred more in the community setting. Issues arose when drugs were no longer needed and patients had returned them to the community pharmacy. They were unable to be reused, recycled or go back into the supply chain as they did not know how the drugs were stored at home. It was considered too costly to put any process in place to track trends and themes; it would also mean a change in contract. In regard to secondary care there was little wastage as there were better processes of redistributing drugs and putting them back in use. It was stated that correspondence had been received and concluded by email that the matter was closed and complete. **COMPLETE**

AC: 17/068 PATIENT SAFETY

Mrs Carol Evans, Assistant Director of Patient Safety and Quality, queried given the HTA report whether Internal Audit would be reviewing HTA processes into next year's programme. In response, the Head of Internal Audit stated that he had a conversation with the Chief Executive and will look at the action plan put in place to see whether any progress had been made against this. Members were informed that the Chief Exec had been allocated sessions within the Internal Audit plan. If considered necessary Internal Audit would be involved with any matters arising in-year and presented to Audit Committee.

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AC: 17/069 INTERNAL AUDIT PROGRESS REPORT

Mr James Johns, Head of Internal Audit presented the above report and explained it gave a range of detail of progress of the plan with any updates and changes and the key issues from the audit work. These included summaries of the Reasonable and Substantial reports and the detail and full versions of the two reports which received Limited Assurance.

The key issues in Section 2 showed four detailed reports of progress against the plan schedule that were shown in Appendix A. These were initially planned to come to the December meeting. It highlighted the status of the work with stages of reporting and reasons for delays in progressing the work to conclusion. It was stated that there had been delays with one report relating to Stock Control and Localities but this was now complete. It was emphasized and reiterated to the Organisation, the importance of supporting Internal Audit work, for having access to relevant staff for information in order to deliver the work to the Committees expectations.

In terms of delivery of plan and key changes, there had been delays and dialogue to changes in the plan with the Health Board. The key issue would be paragraph 4.5 which referenced a piece of work with the Chief Executive. Members were informed there will be regular quarterly items from Internal Audit going to Management Executives.

The Committee:

- **ACKOWLEDGED** and **APPROVED** the piece of work from the Chief Executive
- **CONSIDERED** and **NOTED** the Internal Audit Progress Report

AC: 17/070 INTERNAL AUDIT POSITION REPORT

Cleaning Standards – Limited Assurance: Mr Ian Virgil, Deputy Head of Internal Audit gave an overview of the report. It was explained that the purpose of the audit was to establish if the Health Board (HB) was compliant with arrangements for ensuring it met with national standards in NHS Wales. There were a number of positive areas with clear management, supervisory and staffing arrangements in place for environmental cleanliness. However, the Limited Assurance was the requirement of the HB to carry its own technical audits of cleaning across the HB and to look at standards of cleanliness in areas such as on the wards. A number of weaknesses were identified in the process and the reporting of figures which could mean the HB could not be fully assured that reporting compliance levels were fully accurate.

It had been identified that audits were not being signed off by nursing or ward staff but only the cleaning staff. It was emphasized this was not universal. Other minor weaknesses were indentified relating to consistency across the two sites as there were differences in the way audits were being scored and reported. It was emphasized that there should be consistency to ensure figures are accurate. It was

highlighted that the HB should also be carrying out its own managerial audits to ensure this work was being carried out correctly. The action plan had been discussed with executives.

It was commented and noted:

- It was raised that the recommendations had an ending by March 2018 and suggested a follow up in early May to ensure this work was complete. It was highlighted that the Executive Director of Nurses was reinforcing, through meetings with lead nurses, that there was a requirement for ward staff to sign off the measures and actions.

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Medicine Clinical Board PADRs and Mandatory Training: The Committee was informed the sample testing identified a low level of PADRs identifying 55% completion and those completed were not being signed off neither did it comply with procedure. There was also a low level of compliance with statutory and mandatory training. At the time of review the Medicine Clinical Board had recently moved onto the ESR system and a number of staff was not put under the correct hierarchy. Also noted were the actual processes for monitoring within the directorate and at clinical board level were not receiving accurate information for agreed level of compliance through ESR and LED.

The Chief Operating Officer stated that he had received and accepted the recommendations and had met with the Clinical Board who was taking action and these will be monitored going forward. The departments will have weekly and fortnightly meetings with teams to include a range of other issues. It was assured that the actions will be taken forward and will be monitored through the Executives. There will be performance meetings that will look at all PADRs and be followed-up with Internal Audit. It was emphasized that this was a wider issue as an organisation and will be of particular focus for the Clinical Board. The follow-up report will ensure this will be addressed.

It was commented and noted:

- It was known that the Clinical Board had difficulties as the Medicine Clinical Board was large and dealt with complex patients and was a challenged Clinical Board with a number of issues that needed to be addressed.
- It was stated that there was a very senior management team supporting the Clinical Board Director.
- There were issues with 'running the front door' and it was recognised that the Clinical Board was challenged in a number of areas but had also improved significantly in places. There had been a new Director of Operations and Director of Nursing and there was a need to give time and support for improvements to be made.
- The CEO and executive team review the structure at times and was content with the current arrangements. This was in the executive teams focus and was working very closely with the Clinical Board.

The Committee:

- **CONSIDERED** and **NOTED** the Progress Report Against Plan

AC: 17/071 WALES AUDIT OFFICE REVIEW OF DISCHARGE PLANNING

Mrs Anne Beegan, Wales Audit Office stated that the Review of Discharge Planning was mandatory and was the third assessment on patient flow. The focus of Discharge Planning was in regard to arrangements within the Health Board (HB) to manage discharge planning and in response to the work that had been undertaken with the Wales Audit Office and Health Inspectorate Wales. The findings for the HB were positive in comparison to other HBs. A previous review was undertaken on Delayed Transfers of Care (DToC), which was reflected in the report. Audits were carried out on discharge planning arrangements, policies and pathways to enable the discharge planning process. It was stated that the HB needed to focus on local level of staff awareness and improve training in these areas. The Audit also reviewed the actual discharge planning processes. This was not done in detail but had been looked assessed from a high level. This was not in consistence with other HB as the services are run on a five day per week basis. The final areas reviewed were in regard to performance improvements and how the HB was monitoring its performance against DToC and stated this area was improving.

It was discussed and noted:

- In regard to the RAG rating in the appendix, the NHS Delivery Unit had completed a self assessment. They had undertaken a review on acute and community hospitals and therefore may be a year out of date. In response to the query of how the Health Board had improved, it was stated that the NHS Delivery Unit review had a different focus to the WAO review, which was explained above. The NHS Delivery Unit centred around specific elements of checklists.
- The Director of Corporate Governance stated that Audit Committee receive all WAO reports and this report would go forward to Quality, Safety and Experience Committee to monitor the situation on behalf of Audit Committee to give assurance it is completed. There were four recommendations to progress and the management response was in place. It was highlighted that Recommendation 4 refers to the HB as a Trust.
- In response to whether the HB had made improvements on previous work, it was stated that the work around DToC had identified that there was good partnership arrangements. Although it could not be stated that improvements had been made but in comparison to other HB the arrangements were much better.

ACTION: To forward report to QSE Committee for monitoring purposes

The Committee:

- **NOTED** the report

AC: 17/072 WALES AUDIT OFFICE REVIEW OF GP OUT OF HOURS SERVICES

The Committee **NOTED** the report from Wales Audit Office, who informed members the report was the second review in relation to patient flow. It was stated that it had taken time to receive a management response and explained the process.

The GP Out Of Hours (OOH) was a three pronged approach looking at governance arrangements and where it sits within the HB. The audit looked at the sustainability of services both financial and clinically and focused around what it was like for a patient. In terms of arrangements at the HB, it was identified there was no strategy and was key to focus on GP OOH as a fundamental part of the unscheduled care system. This was the front end service and was vital for GPs to be engaged in the process. There was a need to have an underpinning workforce plan given the pressures in the service. Weaknesses were identified around undertaking Clinical Audit and should be balanced in the system in terms of quality and safety to ensure regular audits are taking place and stated monitoring arrangements were improving. Financially and clinically, the sustainability of the service was fragile and acknowledged this was an all Wales issue. Spending on the service was one of the lowest in Wales. In terms of performance the HB compared well but there were some issues around home visits, appointments and call backs.

It was commented and noted:

- There was robust discussion on receiving management responses in a timely manner and delays will be escalated after a point. It was emphasized that management had accepted all recommendations.
- The Director of Corporate Governance informed that regular reports on Internal Audits were regularly reviewed at Management Executives and would now include Wales Audit Office reports so that executives can be sighted on the status of the reports. Any delays can be brought formally through Management Executive and will do more in terms of supporting staff and linking with individuals and relevant areas to flag up the deadlines. Part of the discussion with Internal Audit was to reinforce the timescales and will put this into the paper for WAO. It was suggested that in the action plan it should read the person's title and not their name.
- The Finance Director considered the expenditure levels in the analysis of Health Boards in Wales to be imprecise when looking at the spread of North Wales and other HBs. This was in regard to looking at outliers as the biggest driver as the model was different.
- An all Wales report was being undertaken as it acknowledged there were issues with royalties and pay rates and issues around the HMRC ruling and what risk could be placed on GPs.
- It was stated that GPs patients in Wales had a 30% higher level than the average in the UK which had an impact on delivery of service and recognised this was not sustainable. It was stated this is part of a bigger picture and looked at the peak times of OOH going to GPs and whether these patients should be going to other services or In Hours.

ACTION: To forward report to QSE Committee for monitoring purposes

AC: 17/073 WALES AUDIT OFFICE REVIEW OF PROGRESS UPDATE – MANAGEMENT OF FOLLOW-UP OUTPATIENTS

The Wales Audit Office informed Members the paper was a progress update specifically in regard to the five recommendations raised previously. This was a mandatory review for the whole of Wales in relation to the management of follow up backlogs. At the time of the report, the number of patients delayed in Cardiff and Vale was more than 50% of the whole of Wales.

The report was RAG rated where progress stood. It was identified that progress was good with one recommendation being implemented and was making progress on the other four. The big task for the Health Board was to ensure they were validating and the Health Board had a number of approaches established to do this. The audit reviewed how patients were managed in terms of clinical risk and identifying risks. It was difficult for HBs to understand what the conditions were and identifying whether patients were coming to harm whilst sitting on the waiting list. Cardiff and Vale were the only HB looking into this area. Whilst there was a focus on high risk conditions it was considered it should be broadened to other specialties. Although This was started as local piece of work but will take out nationally as there was concern of clinical risk with patients sitting on waiting list backlogs. There was further discussion on modernizing the service; change in culture; to have discussions looking at high risk specialties and the work needed around this area.

It was commented and noted:

- It was considered to maintain focus through Quality, Safety and Experience (QSE) Committee in relation to clinical risks to ensure progress continues moving in right direction. The challenge for the HB was the need to take a pragmatic approach for work undertaken on high risks specialties which should go across the board. There was huge focus on outpatients and follow-up through the Transformation process and this is monitored and reported to the Quality, Safety and Experience Committee.
- It was stated that in view of discussions, there was a need to change the focus on papers received at QSE for assurance on action and timescales to be completed. Members were informed that on a weekly basis the Chief Operating Officer presents a tracking report on key targets to Management Executive and this is monitored at a senior level.

ACTION: To forward report to QSE Committee for monitoring purposes

The Committee:

- **NOTED** the report

AC: 17/074 WALES AUDIT OFFICE COLLABORATIVE ARRANGEMENTS FOR MANAGING PUBLIC HEALTH RESOURCES

Mrs Anne Beegan, Wales Audit Office, presented the report for information and stated this was a local piece of work with audit planned with Public Health Wales (PHW). It was useful to bring the report to Audit Committee as there were a few recommendations in terms of collaborative working. The management response had been a collective response and had been reviewed by Board Secretaries to ensure Health Boards had been sighted on the process for monitoring the management response. The report will sit with PHW Audit Committee. Mrs Sharon Hopkins had presented a detailed paper which was discussed and debated and would form part of the response.

The Committee:

- **NOTED** the report

AC: 17/075 WALES AUDIT OFFICE COMMITTEE UPDATE

Mr Mark Jones, Wales Audit Office, stated that the Health Boards Funds for 2016/17 held on Trust go forward to the Trustees Committee at end of January. This should be signed and certified by the statutory deadline being 31 January 2018. The new accounts for 2017/18 had commenced and in October WAO had signed off and certified the three grants the Health Board had acquired.

In regard to the Structured Assessment work a draft report will be issued in January 2018 and aim to take the final report to Board in January 2018; this will be the Wales Audit Office annual governance work. It was explained that there will be a progress update on a local piece of work undertaken regarding a previous review on managing medical equipment, and two thematic pieces of work regarding primary care work and integrated care fund. The primary care had been completed at phase 1 and the second phase will commence in the New Year which will look at HB arrangements. The Integrate Care Fund will be rolled out post Christmas. This was an all Wales piece of work that will review local authorities and focus predominantly at the Regional Partnership Boards. In addition, it will look at Welsh Government and their role in the Integrated Care Fund. National reports for information were included with a summary of good practice events and new events arising over next few weeks.

The Committee:

- **NOTED** the report

AC: 17/076 WALES AUDIT OFFICE – ACTION PLAN OF CONTRACTUAL RELATIONSHIP WITH RKC ASSOCIATES LIMITED AND ITS OWNER

Mr Peter Welsh, Director of Corporate Governance, gave an update on the above report stating this resulted in the CEO and UHB Chair going to a Public Accounts

Committee (PAC). As part of the process an action plan had been developed and went through Board and its Committees and Management Executives. Twenty six actions had been completed and nine were in amber. Actions on an all Wales basis were in amber which was taking longer to implement. The Health Board was feeding our learning into the all Wales discussion and had put longer end dates around these issues and linking with people to keep up momentum. All actions were in line to be completed by the set target date. The Health Board was in dialogue with the WAO and a meeting had been arranged for January 2018. The Public Accounts Committee was being regularly updated. A final report will be submitted to PAC in April 2018 who had been pleased with the comprehensiveness of the action plan and commitment of the HB to put things right. The Health Board was on target for the final action plan to come to the Audit Committee on 27 February and a closure report will be submitted to Board at end of March. This will be followed by an update report to go to the Public Accounts Committee once finalized.

The Committee was assured that gaps had been closed but there was a need to ensure we were continuing the work past the action plan. There was a need to ensure there was good audit records and responding as soon as an issue arises. There was wider discussion on the new processes and it was stated that mechanisms had been strengthened for staff to raise concerns or highlight issues. There had been a review of procedures to recruit Senior Managers which will be updated in the policy once completed. The policy will go forward to Resources and Delivery Committee for sign off which encapsulates very senior management.

The Committee:
- **NOTED** the contents of this report;
- To **MONITOR** the progress of the Action Plan and
- **PROVIDED** the Board with the assurances required.

AC: 17/077 TRACKING REPORT ON AUDIT RECOMMENDATIONS

The Committee **NOTED** the Tracking Report and Mr Peter Welsh, Director of Corporate Governance stated he was working with Internal Audit to develop the report further.

AC: 17/078 CAPITAL ORDERING AUTHORISATION PROTOCOL

Mr Robert Chadwick, Director of Finance stated the policy had been updated with no fundamental changes made. This was the process for capital ordering for IM&T and estates.

The Committee:
- **APPROVED** the protocol which will govern how the UHB places capital orders and **REQUESTED** that the UHBs capital scheme of delegation is updated to include the Executive Director of Therapies, the Head of Capital Planning and the Head of Compliance and Discretionary Capital

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AC: 17/079 DIRECTOR OF CORPORATE GOVERNANCE REPORT

The Director of Corporate Governance highlighted a number of elements from his report:

- ***The Deloittes Financial Governance Review:*** This was being monitored and progress had been made.
  Structured Assessment: Difficulties were encountered last year in losing a number of Independent Members in a short period of time. Two further members will finish their terms of service at the end of December. The Health Board was waiting for new appointments to be ratified by Cabinet Minister.
- ***End of year reporting***: A significant amount of work in regard to the Annual Governance Statement and associated documents had commenced and will be completed within the timescale for Wales Audit Office and Internal Audit to review the documents.
- ***Board / Committee Working:*** In terms of the development of the Board there will be a series of training and development sessions. The CEO had made known the changes to be considered in terms of Board papers received.

The Committee:

- **NOTED** the report

AC: 17/080 UPDATE ON THE CORPORATE RISK ASSURANCE FRAMEWORK

Mr Peter Welsh, Director of Corporate Governance, stated that in summary there had been no significant changes to the current risk register but each committee was receiving their contribution to the CRAF on a regular basis.

In April 2017 it was decided to implement a new vehicle and approach for risks and assurances within the Health Board. The Corporate Governance Manager was in ongoing discussions with Clinical Boards. In the New Year there will be a new method in how risks will be presented, mitigated, described and controlled. Best practice had been looked at and a new template which will be used. The new template and guide will be reviewed by Management Executives in March and the Board Development session will be used for its launch in April. This will be clearly aligned to the strategic objectives of the organisation and reflected in agendas of the Board and Committees to receive assurances.

The procedural guide was almost complete and will go forward to Clinical Boards to see how it will be embedded. The proposal around redefining the risks was to look at risks on the CRAF and recommended for the next committee a report be submitted on Policies that was under the Audit Committees remit. This would be reanalyzed with the new process and what the new target score would be within the new framework. The Framework will be shared with Internal Audit and Wales Audit

Office. The approach was being tested with different Clinical Boards and corporate departments to ensure the framework was fit for purpose.

The Committee:

- **NOTED** the Audit Committee Corporate Risk and Assurance (CRAF) Update Report

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AC: 17/081 LOSSES AND PAYMENTS REPORT

Mr Robert Chadwick, Director of Finance, informed the Committee that regular reports would be brought the Committee to approve losses and special payments with attached appendix.

The Committee:

- **APPROVED** the write off of the losses and special payments outlined in the assessment section shown below:
- **NOTED** the minutes of the 22nd November 2017 meeting of the Losses and Special Payments Panel.

AC: 17/082 REVIEW OF MEETING

An update of the Wales Audit Report was also raised at Board meeting.

AC: 16/082 URGENT BUSINESS

There was no urgent business

AC: 16/083 DATE OF NEXT MEETING

The next Audit Committee meeting is scheduled to take place at 9.00am on **Tuesday, 27 February 2018** in the Corporate Meeting Room, Headquarters, UHW

AUDIT COMMITTEE – ACTION LOG FOLLOWING DECEMBER 2017 MEETING

MINUTE	DATE OF MEETING	SUBJECT	AGREED ACTION	ACTION TO	STATUS	
					OUTSTANDING	DATE FOR COMPLETION
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS						
AC 17/072	5.12.17	Wales Audit Office Review of GP Out of Hours Services	To forward report to QSE Committee for monitoring purposes	QSE Committee	To be discussed at QSE Committee	
AC 17/073	5.12.17	Wales Audit Office Review of Progress Update – Management of Follow-up Outpatients	To forward report to QSE Committee for monitoring purposes	QSE Committee	To be discussed at QSE Committee	
AC 17/071	5.12.17	Wales Audit Office Review of Discharge Planning	To forward report to QSE Committee for monitoring purposes	QSE Committee	Considered at QSE Committee on 13.02.18	
AC 15/008	24.02.15 8.12.15 26.09.17	Business Continuity Planning	Provide a follow up report in September 2015 To discuss with Lead Director the justification of pushing back the review. For the review to take place in the first quarter of 2018/19 and for assurances that improvements were being made.	J Johns J Johns and P Welsh	The follow up has been put back to the 17/18 plan at the request of the Executive Director. The rational for the deferral of the BCP was to do with the progress made since previous audits were undertaken. The Executive Director has taken a paper to the Management Executives in October updating them on BCP actions. IA have subsequently raised where it would be possible to undertake work in Q4 as originally planned.	

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COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)						
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	**COMPLETE**. Update to be provided at December meeting.
AC 16/102	28.02.17	Clinical Audit Programme	Report requested to be submitted to Committee	Secretariat	To be reported at **December 2017** meeting. - **COMPLETE** A detailed report was presented to QSE Committee in February 2017 giving an update of the 2016/17 clinical audit plans and detailing the additional clinical audit activity. The chair of the Audit Committee was satisfied with this and requested that a report be submitted with the proposed clinical audit work for the next year. Subsequently the Clinical Boards have submitted Clinical Audit Plans for 2017/18 and this was presented to QSE committee in September 2017 and an update will be presented to QSE in February 2018.	

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AC 16/076	15.11.16	WAO Progress Against Plan	Resources in Corporate Governance Team to be raised at Board	Chair	Resource allocation being reviewed by Management Executive. No action until outcome is known. To be raised at Governance Coordinating Group	**COMPLETE** CEO is undertaking a review of Executives portfolios.
AC 17/041	26.09.17	Internal Audit Position Report and Tracking Report	To speak to P Welsh in regard to the number of reports being delayed through briefs not being signed off	Chair		**COMPLETE**
AC 17/045	26.09.17	Tracking Report on Audit Recommendations	To highlight to P Welsh for IT to be allocated to the relevant Director who remit was IT	Secretariat	Raised with F Jenkins	**COMPLETE**
AC 17/047	26.09.17	Report on Hospitality Register and Register of Declarations of Interest	To highlight the lack of forms from clinicians To speak to P Welsh around best practice of other Health Boards in relation to submission of forms To report discussion back to P Welsh and S Rowlands	 C Greenstock C Dalton	 Spoken to P Welsh who will be liaising with his peers at both Velindre NHS Trust and NWSSP. A revised policy is being drafted	**COMPLETE** **COMPLETE** **COMPLETE**

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INTERNAL AUDIT	
Audit Committee	**February 2018**

Executive Lead : Director of Corporate Governance
Author : Head of Internal Audit, NWSSP Audit & Assurance Service, UHW 42724
Caring for People, Keeping People Well : n/a
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

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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 **APPROVE** 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. Seven reports have been finalised, two with Substantial Assurance, four with Reasonable Assurance and one report has been issued with a Limited Assurance rating.

Reports that are given substantial or reasonable assurance are summarised in the progress report with the reports given Limited Assurance included in full.

From the reviews finalised from this committee there one report with a Limited Assurance rating. There were also two Limited assurance reports at the previous meeting of the Committee. Further to that from the audits that are at and around draft report stage there are potentially another three Limited assurance reports.

At this stage despite the Limited Assurance reports noted above the UHB is still on course to be issued with a Reasonable Assurance Annual opinion. However if the trend of a growing number of audits with adverse outcomes continues, there is still the possibility that this likely overall opinion rating could reduce. There is still a sufficient volume of audit work to be concluded to impact on the annual opinion.

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

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 a level of assurance given to the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan, as well as an indication over the overall annual opinion.

The report also provides, information regarding the necessary actions required to address control weakness identified and also sets progress with the delivery of the Internal Audit plan.

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Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee February 2018

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Please note:

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

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 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.

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2. ASSIGNMENTS WITH DELAYED DELIVERY

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

All other audits are currently planned to be reported to the February and April Committees as set out in Appendix A.

Audits planned for Audit Committee but not finalised			
Continuing Health Care Follow up –	Draft report	Limited	Not signed off by Executive director as queries of findings in report, with another meeting required for further discussion.
EU -12 Hour target data quality	Work in progress	-------	Fieldwork took longer than planned.
Consultants job planning	Initial draft report	Provisionally limited	Significant delays in receiving key information from one Directorate. Medical Director involved to provide resolution. Information not supplied.
Mortality reviews	Work in progress		Fieldwork took longer than planned.

Model Ward	draft	Reasonable	Key part of field work delayed as information not available to audit. Now awaiting Executive sign off.
Costing	Work in progress		Delay with the delivery of work within audit.
Capital Scheme – Neo Natal	Work in progress	------	Position of capital scheme and reallocation of audit staff.

3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

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

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

FINALISED AUDIT REPORT	ASSURANCE RATING	
Core Financials	Substantial	
WAO/RKC Action Plan		
Stock Control Localities Follow up	Reasonable	
Waiting List Initiative Follow up		
Residences		
Surgery Clinical Board – Anaesthetics Rotas		
Neurosciences IT System Follow up	Limited	

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4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1. Delivery of audit work - From the table in section three above it can be seen that seven audits have been finalised since the Committee met last.

In addition to that, there are numerous audits that have reached draft report stage with several others at the work in progress stage. The audit assignment schedule at Appendix A gives specific details as to the status of the planned work.

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, time to get meetings with key staff through the UHB and subsequently obtaining information. Two reviews have been delayed through the absence of Internal Audit staff. Further detail is given in the audit assignment status schedule at Appendix A.

4.2. Audit Outcomes – From the reviews finalised from this committee there one report with a Limited Assurance rating. There were also two Limited assurance reports at the previous meeting of the Committee. Further to that from the audits that are at and around draft report stage there are potentially another three Limited assurance reports.

At this stage despite the Limited Assurance reports noted above the UHB is still on course to be issued with a Reasonable Assurance Annual opinion. However if the trend of a growing number of audits with adverse outcomes continues, there is still the possibility that this likely overall opinion rating could reduce. There is still a sufficient volume of audit work to be concluded to impact on the annual opinion.

4.3. Plan updates - The UHB have requested that the PCIC Incident reporting review is deferred as the new system is still be implemented and also other issues in the department, and that the Commercial Outlet Audit is deferred as internal work is currently underway enhancing the existing processes. It is asked that the Audit Committee approve the amendments to the plan noted above.

4.4. Follow up reviews - 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.

4.5. **Reporting to the Management Executive –** A report went to the Management Executives meeting in January highlighting progress with the delivery of the Internal Audit plan, key issues and emerging outcomes from audits and it also reinforced the process for the agreement and finalisation of audits.

4.6. **Planning 18/19 –** Planning for the year ahead is well underway, with meetings already held with the majority of the Executive Directors. A meeting has also taken place with the Clinical Board Director of Operations meeting and the Chief Operating Officer and feedback is awaited from that group.

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5. FINAL REPORT SUMMARIES

5.1 Main Financial Systems

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated within the UHB Core Financial Systems is **Substantial Assurance**.

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

The review has identified that the controls in place for the management of the General Ledger and Accounts receivable systems are of a high standard and are being consistently applied in practice.

Appropriate and up to date FCPs are in place for both systems. Access to the general ledger is appropriately controlled with journals and changes to the chart of accounts effectively managed. The controls within the accounts receivable system ensure that invoices are appropriately raised, income is accurately recorded and debts are correctly managed.

The only minor issues identified during the review related to the appropriate completion of the accounts payable reconciliation and the timely authorisation of reconciliations.

5.2 WAO/RKC Action 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 Action plan on WAO Audit of RKC Associates 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 process for monitoring and providing updates on the Action Plan in Response to the WAO Report in respect of C&V UHB's Contractual

Relationships with RKC Associates Ltd and its Owner ('The Action Plan') is well managed by the Corporate Governance team.

The reported level of progress against the planned actions is predominantly an accurate reflection of improvements implemented and the audit only noted a few minor issues. The agreed actions are being effectively implemented, however, it has been identified that in part initial target completion dates were over ambitious and some actions have surpassed the planned timescales; despite this good progress has been made against remaining outstanding actions.

5.3 PCIC Locality Stock Follow up

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	Alternative Action/ no longer Applicable
HIGH	2	1	-	1
MEDIUM	4	3	-	1
LOW	2	2	-	-
TOTAL	**8**	**6**	**-**	**2**

The follow up review concluded that based upon discussions with relevant management and review of the evidence provided, good progress has been made.

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 PCIC Locality Stock has improved to **Reasonable Assurance**.

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

- For each locality the Locality Managers have issued revised stock guidance to all District Nurse Teams. Guidance includes sections on rotating stock and also procedure to be followed for returning unwanted items.
- Management has undertaken a review of all community bases and reinforced to staff the importance of securing stock cupboards.
- Dedicated admin time has been identified within the DN teams to review stock levels and assist with stock ordering. The time is also utilised to ensure stock is rotated so that no stock becomes out of date.

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- Monthly budgeted information is received from Finance. The information is sent to Locality Management as well as individual District Nurse Team Leaders. The financial information is reviewed and discussed at monthly management meetings and 1:1 meetings between management and team leaders in all localities.
- Locality Managers have reviewed storage facilities at all bases to ensure they are fit for purpose and appropriate action has been undertaken such as purchase of new shelving.
- The storage issue at Broad Street Clinic within the Vale Locality has been resolved. The move of one of the DN teams to a new base at Ty Jenner has resulted in both teams now having sufficient and appropriate storage facilities.

It is noted that for two of the findings identified in the original report, a review by management has determined that due to the costs involved of implementation of a stock system that it would not be beneficial to proceed and as such feel it appropriate to manage the small risk associated with this on an ongoing basis.

5.4 Waiting List Initiative Payments Follow up

In summary, progress against the eleven 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	2	1	1	-
MEDIUM	5	5	-	-
LOW	4	3	1	-
TOTAL	**11**	**9**	**2**	**-**

Testing was undertaken within the following Directorates to confirm compliance across the management responses cited;

- T&O Directorate
- Urology Directorate
- Cardiac Surgery
- Ophthalmology Directorate

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, satisfactory progress has been made whereby the majority of recommendations have been fully implemented.

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 WLI Payments has improved to **Reasonable Assurance**.

However, there are two agreed management actions that have been partly implemented and require further progression in order to fully address the original control weaknesses identified.

- The UHB has produced a WLI Payments Policy/Procedure and this has been disseminated to Directorates, but has yet to be finalised and approved by the organisation. Additionally, there are no local Directorate procedures in place for the management of WLI payments as they will work to the UHB Payments Policy/Procedure (Finding 1 – Partially Actioned). Management have provided an updated planned completion date for this action of June 2018.
- Testing identified that whilst Cardiac Surgery make the appropriate checks and accurately record and approve submitted claims, they do not retain copies of the fully authorised WLI Claim Forms as they are sent directly to Payroll. Therefore, at the present time a full audit trail does not currently exist and it is recommended that upon authorisation by the Clinical Board Director of Operations a copy should be taken and provided to Cardiac Surgery management for retention (Finding 10 – Partially Actioned).

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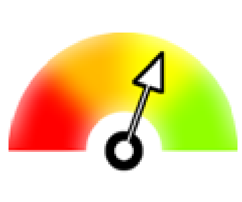
5.5 Management of Residences

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with establishment controls within the Residences is **Reasonable assurance**.

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

The audit review has identified that there are well-established processes in place for the day-to-day administration of residences. Current occupancy levels are high and the collection of rents and other income is effectively managed.

A number of issues were however identified as part of the audit. The

Tenancy agreements currently being used are not fit for purpose and are also not being appropriately approved. The current pricing structure is overly complicated and has not been formalised. It was also noted that the Residences do not currently feature on the Estates and Capital risk register.

5.6 Surgery Clinical Board - Anaesthetics Rota Management

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Anaesthetists Rota Management 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 CLWRota system provides an efficient and effective method for managing, communicating and co-ordinating the Health Board's Anaesthetists rotas. The messaging service enables accurate adjustments to the rotas at short notice which is essential to ensure that planned theatre time does not need to be cancelled. The anaesthetist job plans are built into the CLWRota system which reduces administrative time in completing the anaesthetist rotas. Any changes to the system are in real-time and as such the system is always up to date.

At the time of our review the Health Board did not have Standard operating procedure notes in place for the administration of the CLWRota system. This represents a risk to the effective on-going administration of the CLWRota system in the event of prolonged absence or changes to key personnel.

Assignment Status Schedule Appendix A

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
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.	Planned work for Q4		April
Claims Reimbursement	Director Nursing	Q3/4	Q3	Review re WRP claims standard.	FINAL	Substantial.	Dec
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
Board Working	Corporate Governance	Q2-3	n/a	n/a	Review deferred following discussions with DoF and CEO.	n/a	N/A
WAO Action plan	Corporate Governance			To provide assurance that the actions are	Final	Substantial	Feb

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Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Deloitte action plan	Finance			progressing as planned with evidence available.	WIP		Apr
Regulatory compliance- HTA action plan	COO				WIP		Apr
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. Mgt Exec Team requested for audit to be deferred to 1819. Pre Audit Committee – AC Chair requested doing in Q4. WIP		Apr
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. Now draft report stage. Mgt responses JJ 12/10. Issued as Final.	reasonable	Dec
Wellbeing Objectives	Director of Public Health	Q3/4	Q3	Review process for setting, delivering and monitoring objectives.	Planned to commence Q3. Met DPH. Way forward agreed. Being delivered Q4.		Apr

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Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Continuing Health Care	COO	Q3	Q3	Follow up from previous report.	To commence Q3. Draft issued. Executive Director has requested further discussion as a result of Limited rating.	Limited at draft stage.	Feb
Strategic Planning/IMTP	Director of Planning	Q4	Q4	Review on going delivery and monitoring of the plans.	Planned to commence Q4. Scope Agreed.		April
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.	Final		Feb
Charitable Funds	Director of Finance	Q1-2	Q1-2	Review governance arrangements, including the management of expenditure and donations.	Final Report. – 29/8. 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. MGT now want work deferred. IA recommended that some work may take place dependant on WAO		Apr??

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Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
					structured assessment outcome.		
Costing	Director of Finance	Q3	Q3	Scope as per work agreed at all wales costing group.	Assignment Brief agreed. Work still to be completed.	WIP	Feb
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	Draft issued. Executive Director has requested further discussion as a result of Limited rating.		April
Serious Incidents Management	Nursing	Q2/3	Q2	Review Incident Closures	FINAL	Reasonable	Dec

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Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
Mortality Reviews	Medical	Q1-2	Q3	Review Process and actions taken.	Planning – brief prepared. Start delayed. Medical Director requested end of October for fieldwork commencement. Field work currently underway.	WIP	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.
Information Governance and Security							
IT Strategy	*Director of Therapies*	*Q2*	*Q2/3*	*Strategic MTeD deployment*	*FINAL.*	*Substantial*	*Dec*
IT System	*Director of Therapies*	*Q3/4*	*Q3*	*Welsh Patient Referral System*	*Final*	*Substantial*	*Dec*
Neuroscience IT system follow up	*COO*	*Q2-3*		*Follow up on 16/17 report.*	*FINAL*	*Limited*	*Dec*

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Planned output	**Executive Lead**	**planned timing**	**Revised timing**	**Scope**	**Status/Comments**	**Assurance Rating**	**Audit Com.**
Virtulisation	Director of Therapies	Q3	Q3	Review the security and resilience of the updated virtualised environment.	Draft awaiting response and finalisation.	Reasonable	April
Cyber Security	Director of Therapies	Q2/3	n/a		Review deferred at request of UHB.	n/a	n/a.
DATA quality – EU 12 hour	Public Health			To be added As per CEO request.	Field work substantially complete. Exit meeting to take place.		Feb
Data Quality - RTT	COO				wip		Apr
Data Quality Cancers targets	COO				wip		Apr
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. Draft report 25/10 – Limited. Final*	*Limited*	**Dec**

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Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
					21/11,		
Clinical Board - Surgery	COO	Q1-2		Anaesthetists Rotas (initially to include staff management as well)	Delays in progress. Change of scope, work will now only cover anaesthetists' rotas as per discussions with COO. Delays in obtaining key information and agreement of report. . Finalised February		Feb.
Clinical Board – Mental Health	COO	Q1-2		PADRS and Rotas.	Draft report reasonable assurance. Report still Awaiting mgt. responses and sign off. FINAL		Sept
Clinical Board - C&W	COO	Q2		Medical Staff Study Leave.	Delays with field work and scope reduced as unable to obtain information. Work has now been completed. Draft report prepared for discussion. Now Finalised		Dec
Accommodation/ Residences		Q1-2	Q3	Review arrangements in place for the management of residences.	Final		Feb

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Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
WLI follow up	COO	Q2-3	Q3	Follow up on 16/17 report.	First part of Fieldwork in progress.		Feb
Stock control in localities follow up	COO	Q1	Q2/3	Follow up on 16/17 report.	Fieldwork in progress. Delay with IA. FW complete draft to be prepared. Draft report reasonable 8/11. FINAL		Dec / Now Feb
CD&T Additional Payments follow up	COO	Q2	Q2/3	Follow up on 16/17 work and briefing	WIP w/c 9/10. Draft report and ok from MT on 13/11. Now FINAL	n/a	Dec
PCIC incident management (rolled forward at request by PCIC)	COO	Q3/4	Q3/4	Review process for managing incident that cut across other areas.	Request to defer until 18/19.	--	n/a
Workforce management							
Consultant Job Planning	Medical Director.	Q2-3	Q2-3	Review controls in place to manage key risk areas within the process.	Delays in obtaining key information, potentially limited assurance.	WIP	Feb
Nurse Revalidation	*Nursing*	*Q2-3*	*Q2-3*	*Review controls in place to manage key risk areas within the process.*	*Draft report – responses received 8/11* *Now Final*		*December*
Organisational Values	Director of Workforce	Q3/4	Q3/4	Review controls in place to manage key risk areas	Initial draft reasonable assurance.	WIP	April

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Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
	& OD.			within the process.			
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	Key part of fieldwork delayed as information not available for audit. Draft report awaiting Executive sign off.		February
Cleaning Standards	*Director of Planning*	*Q1-2*	*Q2*	*Review current Service Provision.*	*Now Final. Field work completed. Sept. Awaiting management comments. Comments from GW 13/11 and Exec sign off.*	*Limited*	December
Commercial Outlets	*Director of Planning*	*Q1-2*	*Q4*	Review arrangements for commercial outlets (inc. Aroma and spar UHL)	*Requested that work delayed until 18/19.*	-----	*n/a*
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 credits is	Draft report issued 7/9/17. Final 12/10		December

Planned output	Executive Lead	planned timing	Revised timing	Scope	Status/Comments	Assurance Rating	Audit Com.
				based upon actual usage or informed estimates.			
Neo Natal	Director of Planning	Q2/3		To review key aspects of the schemes	Audit still in progress		Feb.
Rookwood Relocation	Director of Planning	Q2/3		To review key aspects of the schemes	wip		April
Shaping Future Wellbeing Schemes	Director of Planning	Q2/3		To review key aspects of the early part of a scheme.	planning		April

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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.

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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 since the last meeting of the Audit Committee are as follows:

CUHB1617.08 – Patient Access

The report was finalised May 2017 with a rating of **Substantial** assurance. All agreed actions were planned to be implemented by August 2017.

As at 15th January 2018 the progress made against the agreed management actions was confirmed as follows:

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

Completion of all 3 actions is reliant on the production of an updated UHB Patient Access policy.

This has been delayed whilst clarification is sought from Welsh Government around the new waiting list management rules. An updated timescale of June 2018 has been provided for completion of all actions.

CUHB1617.48 – Medicine Clinical Board - Specialling

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

An audit follow up was undertaken in September 2017 and four actions were completed, with a remaining four outstanding. Following a second follow up in January 2018, the progress made against the agreed management actions was confirmed as follows:

Priority Rating	No of agreed management actions	Fully Actioned	Partially Actioned	Not Actioned
HIGH	1	-	1	-
MEDIUM	2	2	-	-
LOW	1	1	-	-
TOTAL	4	**3**	**1**	**0**

Follow ups in progress

In addition to the completed follow-ups detailed above, a further 16 follow-up schedules have been issued to date. Responses are currently being pursued from management for these.

Follow-up Summary Report

Table 1 – Follow-up position

Audit Reference	Audit Title	Rating	Follow Up Status	Date	Actioned	Part Actioned	Not Actioned	Total
CUHB1617.01	Risk Assurance	Reasonable	2nd FU Required	May-18	**-**	**-**	**-**	**1**
CUHB1617.03	Policy Management	Reasonable	Complete	Aug-17	**6**	**0**	**0**	**6**
CUHB1617.06	Public Health Targets - Obesity	Reasonable	2nd FU Required	Mar-18	**-**	**-**	**-**	**2**
CUHB1617.08	Patient Access	Substantial	Complete	Jan-18	**0**	**0**	**3**	**3**
CUHB1617.11	Waiting List Initiatives	Limited	Complete	Feb-18	**9**	**2**	**0**	**11**
CUHB1617.15	Quality Governance - Surgery	Reasonable	In Progress (2.1)	Jan-18	**-**	**-**	**-**	**4**
CUHB1617.16	Quality Governance - Medicine	Reasonable	In Progress (2.1)	Jan-18	**-**	**-**	**-**	**4**
CUHB1617.17	Quality Governance - C&W	Substantial	In Progress (2.1)	Jan-18	**-**	**-**	**-**	**3**
CUHB1617.18	Quality Governance - PCIC	Substantial	In Progress (2.1)	Jan-18	**-**	**-**	**-**	**2**
CUHB1617.19	Quality Governance - Mental Health	Reasonable	In Progress (2.1)	Jan-18	**-**	**-**	**-**	**3**
CUHB1617.20	Quality Governance - CD&T	Substantial	In Progress (2.1)	Jan-18	**-**	**-**	**-**	**1**
CUHB1617.21	Quality Governance – Specialist Serv	Reasonable	In Progress (2.1)	Jan-18	**-**	**-**	**-**	**2**
CUHB1617.22	Quality Governance – Dental	Reasonable	In Progress (2.1)	Jan-18	**-**	**-**	**-**	**5**
CUHB1617.25	Blue Spier IT System	Reasonable	In Progress (1.3)	Aug-17	**-**	**-**	**-**	**6**
CUHB1617.27	Surgery CB Medical Staff Study Leave	Reasonable	In Progress (1.3)	Aug-17	**-**	**-**	**-**	**7**
CUHB1617.28	SPS CB Medical Staff Study Leave	Reasonable	Complete	Sep-17	**7**	**0**	**0**	**7**
CUHB1617.29	Children & Women CB - Staffing	Reasonable	Complete	Aug-17	**3**	**0**	**0**	**3**
CUHB1617.32	CD&T CB - Radiology Treat-In-Turn	Substantial	In Progress (1.2)	Aug-17	**-**	**-**	**-**	**1**
CUHB1617.33	SPS CB - Patientcare IT System	Limited	Complete	Jan-18	**3**	**3**	**2**	**8**
CUHB1617.34	Dental CB - Medicines Management	Reasonable	In Progress (2.1)	Jan-18	**-**	**-**	**-**	**3**
CUHB1617.35	Cardiff Community Resource Team	Substantial	Complete	Sep-17	**5**	**0**	**0**	**5**
CUHB1617.39	Safeguarding Children	Reasonable	In Progress (1.3)	Jan-18	**-**	**-**	**-**	**5**
CUHB1617.40	PCIC CB - Locality Stock	Limited	2nd FU Required	TBC	**-**	**-**	**-**	**2**
CUHB1617.41	Mental Health CB - Info Governance	Reasonable	In Progress (1.2)	Jan-18	**-**	**-**	**-**	**3**
CUHB1617.42	CD&T CB - Information Governance	Substantial	In Progress (1.3)	Jan-18	**-**	**-**	**-**	**3**
CUHB1617.43	Dental CB - Medical Devices	Reasonable	Complete	Sep-17	**5**	**0**	**0**	**5**

8.1

Follow-up Summary Report

Table 1 – Follow-up position

Audit Reference	Audit Title		Follow Up Status	Date	Actioned	Part Actioned	Not Actioned	Total
CUHB1617.44	Estates Timesheets Follow Up	Reasonable	1st FU Required	TBC	-	-	-	**6**
CUHB1617.45	Operational Services Rotas	Reasonable	2nd FU Required	TBC	-	-	-	**3**
CUHB1617.46	Continuing Health Care (CHC)	Limited	In Progress (Full FU)	Nov-17	-	-	-	**8**
CUHB1617.47	Integrated Medium Term Plan (IMTP)	Reasonable	In Progress (1.2)	Jan-18	-	-	-	**8**
CUHB1617.48	Medicine CB - Specialling	Reasonable	Complete (2nd FU)	Jan-18	**3**	**1**	**0**	**4**
CUHB1617.49	Medicine CB - Medical Rotas & Sickness	Reasonable	1st FU Required	TBC	-	-	-	**3**
CUHB1617.51	Theatres Stock Follow Up	Reasonable	1st FU Required	TBC	-	-	-	**4**
CUHB1617.52	Mental Health CB - CHC / OOA Patients	Reasonable	In Progress (1.3)	Aug-17	-	-	-	**4**

The bracketed number within the 'Follow Up Status' column represents the number of follow ups and the stage of the follow up. i.e. 2.2 would indicated this is the second follow up and management responses have been requested twice.

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Follow-up Summary Report

8.1

Audit and Assurance Services
Cardiff and Vale / South Central Team
First Floor, Brecknock House
University Hospital of Wales
Heath Park
Cardiff
CF14 4XW
Contact details: Tel • 02920 742724

Specialist Services Patientcare IT System

INTERNAL AUDIT REPORT 2017/18

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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2. CONCLUSION AND FINDINGS 4

Appendix A Assurance opinion and action plan risk rating

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As 8.2

Review reference: CUHB18.29
Report status: FINAL
Fieldwork commencement: August 2017
Fieldwork completion: November 2017
Draft report issued: November 2017

Final report issued: January 2018
Auditors: Martyn Lewis

Executive sign off: Chief Operating Officer
Distribution:

Committee: Audit Committee

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

Please note:

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

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

1. EXECUTIVE SUMMARY

This follow up review of the Patientcare IT System used within the Neuro Department has been completed in line with the 2017/2018 Internal Audit Plan. The review seeks to provide the Health Board with assurance that agreed actions from the previous review of Patientcare have been implemented appropriately.

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

The risks considered in the previous review was as follows:

I. Inappropriate access to system / data.
II. Inaccurate data held in system.
III. Loss of processing / data.
IV. The UHB is not maximising the benefits from the system.

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

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

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

2. CONCLUSION AND FINDINGS

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

Priority Rating	No of Management Responses to be implemented	Fully Actioned	Partially Actioned	Not Actioned
HIGH	3	1	2	
MEDIUM	4	2	0	2
LOW	1	0	1	-
TOTAL	**8**	**3**	**3**	**2**

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, some progress has been made.

While work has started to develop a contractual basis for the provision and maintenance of the system, this has not been completed and the UHB remains at risk in this respect. As a consequence the system is still using an out of date database with no agreement to update this along with no legal basis for restitution should anything go wrong. Control over leavers has improved however and an outline continuity plan has been developed.

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

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

- The logon process has been enhanced with the use of Nadex being enforced.

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- The Directorate has established a more robust process to ensure that leavers are deactivated.

- Contact has been made with procurement with a view to developing a formal contract / SLA for the management of the system.

- A user group is in the initial stages of being set up.

- A business continuity document relating to Patientcare has been developed for the service

- Contact has been made with the Board Secretary and Head of Corporate Governance in order to gain advice on the ownership of the system.

- A restriction on further developments of the system has been emplaced until an appropriate contractual framework is in place.

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

- At present there is still no formal, contractual agreement for the ongoing maintenance of the system as a whole.

- The underlying database remains the old version of PostgreSQL which contains a number of security weaknesses, including some critical vulnerabilities.

- Although a BCP has been developed for Patientcare, from reviewing this it is a basic document. It notes that any failure would result in service disruption however there is no detail on how this will be mitigated. The document also notes that there would need to be retrospective data entry, but doesn't define how these records will be retained etc.

- There is no process in place for testing the backups.

In order to progress actions and further manage the risks associated with the system the Clinical Board have suggested additional actions with a proposed action date of April 2018:

- Further liaising with the Head of Corporate Governance in order to finalise the UHB opinion on ownership of the system;

- Formally contacting the company requesting that the database be updated and a contractual agreement reached;

- Liaising with IM&T in order to formally risk assess the system and including on the Directorate / Clinical Board risk register.

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Patientcare IT System

Cardiff & Vale University Health Board

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

8.2

Archwilydd Cyffredinol Cymru
Auditor General for Wales

2018 Audit Plan – **Cardiff and Vale University Health Board**

Audit year: 2017-18

Date issued: February 2018

Document reference: **391A2018-19**

9

This document has been prepared for the internal use of Cardiff and Vale University Health Board as part of work performed/to be performed in accordance with statutory functions.

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

This document was prepared by Anne Beegan, Dave Thomas, John Herniman and Mark Jones on behalf of the Auditor General for Wales.

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2018 Audit Plan

Summary

1 As your external auditor, my objective is to carry out an audit which discharges my statutory duties as Auditor General and fulfils my obligations under the Code of Audit Practice, namely to:

- examine and certify whether your financial statements are 'true and fair' and lay them before the National Assembly together with any report that I make on them;
- satisfy myself that the expenditure and income reported in your financial statements have been incurred or received lawfully and in accordance with the authorities which govern them; and
- assess whether you have made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

2 The purpose of this plan is to set out my proposed work, when it will be undertaken, how much it will cost and who will undertake it. I can confirm that there have been no limitations imposed on me in planning the scope of this audit.

3 My responsibilities, along with those of management and those charged with governance, are set out in Appendix 1.

Financial audit

4 It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on their 'truth and fairness' and the regularity of the expenditure and income within them.

5 The audit work we undertake to fulfil our responsibilities responds to our assessment of risks. This understanding allows us to develop an audit approach, which focuses on addressing specific risks whilst providing assurance for the financial statements as a whole. Our audit approach consists of three phases as set out in Exhibit 1.

Exhibit 1: my financial audit approach

Planning: Enquiry, observation and inspection to understand the entity and its internal controls in order to identify and assess risks

→

Execution: Testing of controls, transactions, balances and disclosures in response to those risks

→

Concluding and reporting: Evaluation of evidence obtained to conclude and report appropriately

6 The risks of material misstatement which I consider to be significant, and which therefore require special audit consideration, are set out in Appendix 2 along with the work I intend to undertake to address them.

7 I do not seek to obtain absolute assurance on the truth, fairness and regularity of the financial statements and related notes, but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the financial statements being misled. The levels at which I judge such misstatements to be material will be reported to the Audit Committee and Board prior to completion of the audit.

8 For reporting purposes, we will treat any misstatements below a 'trivial' level (set at 5% of materiality as not requiring consideration by those charged with governance and therefore we will not report them.

9 My fees are based on the following assumptions:

- information provided to support the financial statements is timely, to the quality expected and has been subject to quality assurance review;
- appropriate accommodation and facilities are provided to enable my audit team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accountable Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete and management has responded to issues that may have affected the financial statements.

10 I also undertake the audit of:

- the annual financial statements of the Health Board's charitable funds; and
- annual grant claims for specified areas of Health Board expenditure.

11 My audit fee for this work is included in Exhibit 3.

Performance audit

12 It is my responsibility to satisfy myself that the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance work each year.

13 I set out in this section, the programme of performance audit work to be undertaken at the Health Board. The content of the programme is informed by an ongoing analysis of the risks and challenges facing NHS Wales as a whole, as well as consideration of issues and risks that are specific to the Health Board. I have also taken account of the work programme of Healthcare Inspectorate Wales (HIW)[1] [2].

14 The topics I plan to examine as part of my 2018 performance audit work are summarised in Exhibit 2.

9

Exhibit 2: contents of my 2018 performance audit work programme

Theme	Approach/key areas of focus
NHS Structured Assessment	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. My structured assessment work in recent years has included comparative assessments of aspects of governance, which have presented challenges to most NHS bodies. I intend to continue to pursue this approach in 2018 and I will engage with NHS bodies during the early part of the year to identify which areas of comparative analysis would be most useful.

[1] An operational protocol between HIW and the Auditor General sets out how the two organisations will work together. March 2015

[2] Wales Audit Office, **Working Together to Provide Assurance describes the collective arrangements the AGW and HIW make use of to review governance arrangements in the NHS**, November 2016

Theme	Approach/key areas of focus
All Wales Thematic Reviews	**Orthopaedic Services: Follow up** As part of my commitment to assess the progress made in areas I have previously reviewed, I plan to examine the progress made in orthopaedic services since my 2015 all-Wales review. My work will assess whether my recommendations and areas I identified for improvement have been effectively responded to and to determine whether health boards are developing arrangements to help manage the demand on, and supply of, orthopaedic services. **Clinical Coding: Follow up** I plan to examine the progress made in responding to the recommendations that I set out in my 2014 review of clinical coding arrangements across health boards and Velindre NHS Trust. This review will assess the extent to which there have been improvements in raising the profile of clinical coding, the timeliness and quality of clinical coding data, and the quality of the medical records, which are the predominant source of the coding process.
Locally focused work	I will also undertake thematic performance audit work that reflects issues specific to the Health Board. 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/other committee.
Implementing previous audit recommendations	The examination of governance arrangements I undertake as part of my structured assessment work, includes a review of the arrangements that the Health Board has in place to track progress against my previous audit recommendations. This allows my team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables me to more explicitly measure the impact my work is having.

15 The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with the Health Board, are set out in Appendix 3.

Fee, audit team and timetable

Fee

16 Your estimated fee for 2018 is set out in Exhibit 3. This figure represents a 1.2% decrease compared to the fee set out in the 2017 annual audit plan.

Exhibit 3: audit fee

Audit area	Proposed fee for 2018 (£)[3]	Actual fee for 2017 (£)
Financial statements work	260,000	265,000
Performance audit work:		
• Structured Assessment	74,007	71,751
• All-Wales thematic reviews[4]	63,669	64,713
• Local projects	17,976	19,188
Performance audit work total	155,652	155,652
Total fee	415,652	420,652

17 Planning will be ongoing and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance.

18 Further information on my fee scales and fee setting can be found on our website.

Audit team

19 The main members of my local audit team, together with their contact details, are summarised in Exhibit 4.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
John Herniman	Engagement Lead – Financial Audit*	02920 320566	john.herniman@audit.wales
Dave Thomas	Engagement Lead – Performance Audit	02920 320604	dave.thomas@audit.wales
Mark Jones	Financial Audit Manager	07748 181679	mark.jones@audit.wales
Anne Beegan	Performance Audit Manager	07879 848666	anne.beegan@audit.wales
Dave Burridge	Financial Audit Team Leader	07798 503066	dave.burridge@audit.wales

[3] The fees shown in this document are exclusive of VAT, which is no longer charged to you.

[4] As detailed in the respective audit plans.

Name	Role	Contact number	E-mail address
John Llewellyn	Financial Audit team leader	07973 699076	John.llewellyn@audit.wales

* and the Engagement Director for the Health Board.

20 I can confirm that my team members are all independent of the Health Board and your officers. In addition, I am not aware of any potential conflicts of interest that I need to bring to your attention.

Timetable

21 I will provide reports, or other outputs as agreed, to the Health Board covering the areas of work identified in this document. My key milestones are set out in Exhibit 5.

Exhibit 5: timetable

Planned output	Work undertaken	Report finalised
2018 Audit Plan	December 2017 to January 2018	February 2018
Financial statements work: • Audit of Financial Statements Report • Opinion on Financial Statements • Financial Statements Memorandum	February to June 2018	June 2018
Performance work: • Structured Assessment • Orthopaedic Services follow up • Clinical Coding follow up • Local project work	Timescales for individual projects will be discussed with the Health Board and detailed within the specific project briefings produced for each study.	
Annual Audit Report for 2018	November to December 2018	December 2018
2019 Audit Plan	December 2018 to January 2019	February 2019

9

Future developments to my audit work

Well-being of Future Generations (Wales) Act 2015

22 The Well-being of Future Generations (Wales) Act 2015 (the Act) became law in April 2016. The Act requires me to report every five years to the National Assembly on how public bodies apply the sustainability principles. During 2017 and the early part of 2018, I have undertaken my first work relating to the Act. This has sought to understand how public bodies are beginning to respond to the Act, to identify and disseminate emerging practice and to help inform the focus of future audit work. The findings will take the form of a Year One Commentary, and will be shared at a national event in May 2018.

23 I plan to undertake further specific work at individual NHS bodies during 2019 that will inform the report I must prepare for the National Assembly by May 2020. My 2019 audit plan for the Health Board will provide more detail on this work. In the meantime, I will use my wider programme of work to continue to build up a picture of how public bodies are applying the sustainable development principle.

24 The work I plan to undertake to discharge my requirements under the Act will be integrated into my existing statutory programme of work, which means that there will be no increase in audit fee arising from my work on the Well Being of Future Generations.

Other

25 Details of other future developments including forthcoming changes to key accounting standards, the Wales Audit Office's Good Practice Exchange seminars, and the new General Data Protection Regulation, are set out in Appendix 4.

Appendix 1

Respective responsibilities

My powers and duty to undertake your financial audit are set out in the Public Audit (Wales) Act 2004. It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on:

- their 'truth and fairness', providing assurance that they:
  - are free from material misstatement, whether caused by fraud or error;
  - comply with the statutory and other applicable requirements; and
  - comply with all relevant requirements for accounting presentation and disclosure.
- whether the remuneration report is properly prepared.
- the regularity of the expenditure and income.
- the consistency of other information presented with the financial statements.

It must also state by exception if the Annual Governance Statement does not comply with requirements, if proper accounting records have not been kept, if disclosures required for remuneration and other transactions have not been made or if I have not received all the information and explanations I require.

In addition, I may place a substantive report on the financial statements if I wish to make additional observations on any matters within them.

My powers to undertake performance audit work at the Health Board are set out in the Government of Wales Acts 1998 and 2006 and this work also discharges my duty under the Public Audit (Wales) Act 2004 to satisfy myself that the body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

My audit work does not relieve management and those charged with governance of their responsibilities which include:

- the preparation of the financial statements and annual report in accordance with applicable accounting standards and guidance;
- the keeping of proper accounting records;
- ensuring the regularity of financial transactions; and
- securing value for money in the use of resources.

Appendix 2

Significant financial audit risks

Exhibit 6: key financial audit risks

Significant audit risk	Proposed audit response
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA[5] 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
Under the NHS Finance (Wales) Act 2014, health boards ceased to have annual resource limits with effect from 1 April 2014. They instead moved to a rolling three-year resource limit, with the first three-year period running to 31 March 2017. To date the Health Board has not exceeded its capital resource limits. However, with regard to revenue, for the three years to 31 March 2017 the Health Board had a three-year revenue deficit of £50.5 million (I therefore qualified my regularity opinion on the Health Board's 2016-17 financial statements). For 2017-18, the Health Board expects to exceed its annual revenue resource allocation by £30.9 million; which would mean an increased cumulative deficit of £60.1 million and for the three years to 31 March 2018.	My audit team will continue to monitor the Health Board's financial position for 2017-18, and for the cumulative three-year position to 31 March 2018. This review would also take into account the impact of any relevant uncorrected misstatements over those three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2017-18 financial statements. I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.
The Health Board has not yet submitted its Integrated Medium Term Plan (IMTP) to the Welsh Government for 2017-18 and has therefore failed to meet its statutory requirement.	My audit team will ensure that appropriate disclosure is made in the financial statements. If an approved IMTP is not in place, I would expect to place a substantive report on the financial statements.

[5] International Standards on Auditing

Significant audit risk	Proposed audit response
The five yearly valuation of all land and buildings has taken place during 2017-18, with all assets revalued at 1 April 2017. Previous revaluations had seen NHS bodies revalue their land and buildings on a different basis. For example, they may have been valued on either a site, block, or individual building's basis). For the 2017-18 revaluation exercise all revaluations must be at a building level, which could result in material movements in the value of assets. There is the risk of material misstatement arising from these complex accounting transactions.	My audit team will review the methodology used to revalue land and buildings assets and audit the resulting revaluations and accounting entries.
I audit some of the disclosures in the Remuneration Report, such as the remuneration of senior officers and independent members, to a lower materiality due to their sensitivity. In 2016-17 there were numerous changes to the Health Board's senior positions, which led to material misstatements that had to be corrected. In 2017-18 there have been further changes to senior positions, which again increase the risk of misstatement.	We will review all entries in the Remuneration Report and ensure that all known changes (for example from our review of the minutes of the Board and the Remuneration Committee) have been accurately and completely recorded in the Remuneration Report.
The Welsh Government is required to approve all Health Board contracts that exceed £1 million. In previous years, for some contracts, the Health Board failed to seek Welsh Government approval, which it had then sought retrospectively. Contracts awarded without the required Welsh Government approval may give rise to irregular expenditure, which if material (individually or collectively) would affect my regularity opinion.	I will review the procurement department's log of contracts and obtain evidence of Welsh Government approval for those that exceed £1 million.

9

Appendix 3

Performance audit work in last year's audit plan still in progress

Exhibit 7: 2017 performance audit work still in progress

Performance audit project	Status	Comment
Follow-up review of medical equipment	Draft report	Report being finalised. Final report planned for February 2018.
Primary Care Services	Set up	Draft report planned for Summer 2018.
Integrated Care Fund	Scoping	Fieldwork due to commence in March 2018. A single national report planned for November 2018.

Appendix 4

Other future developments

Forthcoming key changes to the International Financial Reporting Standards (IFRS)

Exhibit 8: changes to IFRS standards

Standard	Effective date	Further details
IFRS 9 Financial instruments	2018-19	IFRS 9 financial instruments will replace IAS 39 and includes a new principles-based approach for the classification and measurement of financial assets. It also introduces a new impairment methodology for financial assets based on an expected losses rather than incurred losses. This will result in earlier and timelier recognition of expected credit losses. The accounting requirements for financial liabilities are almost all carried forward unchanged from IAS 39.
IFRS 15 Revenue from contracts with customers	2018-19	IFRS 15 revenue from contracts with customers introduces a principles-based five-step model for recognising revenue arising from contracts with customers. It is based on a core principle requiring revenue recognition to depict the transfer of promised goods or services to the customer in an amount that reflects the consideration the body expects to be entitled to, in exchange for those goods or services. It will also require more extensive disclosures than are currently required.
IFRS 16 Leases	2019-20	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.

Future changes to UK GAAP (relevant to the charitable funds' financial statements)

Following the introduction of the new UK GAAP accounting regime in 2015-16, and the replacement of the Financial Reporting Standard for Smaller Entities (FRSSE) by Section 1A of FRS 102 in 2016-17, there will be no substantive changes to FRS 102 until 2019-20. Any changes made then are expected to be limited in nature.

More significant amendments are expected from 2022-23, reflecting recent changes in the IFRSs, including accounting for financial instrument and leases.

Good Practice Exchange

The Wales Audit Office's GPX helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face-to-face and resources shared on line. The main areas of work are regarding financial management, public-sector staff and governance. Further information, including details of forthcoming GPX events and outputs from past seminars.

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General Data Protection Regulation (GDPR)

The GDPR is a new data protection law for the whole of the EU applicable from 25 May 2018, which has the intention of harmonising and updating data protection laws. The UK Government has introduced the Data Protection Bill, which will incorporate the GDPR into UK law and replace the 1998 Data Protection Act, and which it intends will also come into force on 25 May 2018.

The GDPR introduces new requirements for personal data processing, including an accountability principle, which will require more detailed records of the processing of personal data, evidence of compliance with the data protection principles and the technical and organisational security measures taken to protect the data. We are updating our own policies, processes and documentation with a view to meeting these requirements and expect that the bodies we audit will be taking similar steps. Key areas of additional work include the use of more detailed fair processing notices, more privacy impact assessments and more extensive record keeping in relation to processing activities.

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Auditor General for Wales

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

Date issued: February 2018

Document reference: CVACU2018

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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		
In late January we certified the Health Board's 2016-17 Funds Held on Trust Account, meeting the Charity Commission's deadline of 31 January. In December we commenced our planning of the Health Board's 2017-18 financial audits. This work is covered in our 2018 Audit Plan, which the Audit Committee will consider at its meeting on 27 February 2018.		

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
Structured Assessment (2017)	Savings approaches are helping to curtail the growing financial deficit, but while operational arrangements are largely robust, there are weaknesses in governance arrangements and informatics are not yet effectively supporting services. • The Health Board now has effective arrangements in place to support the planning and monitoring of savings, but is facing an increased deficit position for the three-year period ending March 2018 • Operational arrangements are generally effective but there are weaknesses in Board oversight and assurance, and it is unlikely that the new data protection regulations will be met in time • Workforce and estates are increasingly supporting the goals of the Health Board, though informatics is struggling to keep pace	Awaiting final comments from Health Board	Peter Welsh	February 2018	Being developed

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Work currently underway

Exhibit 3: Work currently underway

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Local project (2017)	This work will examine the progress made by the health board in relation to our recommendations raised in relation to our previous work of medical equipment.	Report being drafted	Fiona Jenkins	April 2018
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.	Terms of reference issued for Phase 2	Steve Curry	~~April 2018~~ Amended to September 2018 as work now not due to commence until February
Thematic review – integrated care fund (2017)	This work will focus on the Integrated Care Fund (ICF) which is available to health boards and local authorities to develop integrated services. The exact focus of this work is still to be confirmed but is likely to examine whether the fund is being use to the best effect. The work will examine both a national and regional perspective and is likely to result in a single national report.	Terms of reference due to be issued in March	TBC	~~April 2018~~ Amended to September 2018

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Other Auditor General studies

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

Exhibit 4: Auditor General Reports published since last audit committee

Product	Summary
Informatics systems in NHS January 2018	We reviewed the arrangements for delivering national informatics services. We focused on whether NHS Wales is well placed to achieve the intended benefits from investment in updated clinical informatics systems. For the purposes of this study, we include the Welsh Government's Department of Health and Social Services as part of NHS Wales. We focussed in particular on the arrangements within NWIS to deliver national systems. We looked at six specific systems in more detail as indicators of the wider approach to informatics. This work included looking at health boards' engagement with the delivery of national systems. Overall, we found that although the vision for an electronic patient record is clear and key elements are being put in place, there have been significant delays in delivery. While there have been some important developments during the period of our review, there are still some key weaknesses in arrangements to support and oversee delivery and to ensure the systems deliver the intended benefits. The NHS has recently identified that significant additional funding will be required to deliver the vision, but further work is required on the detailed plans and to confirm the funding arrangements.
District Nursing Services in Wales December 2017	We have produced a checklist with the aim of supporting NHS board members to seek assurance on how local district nursing resources are managed and the progress made to address our local audit recommendations

Good Practice Exchange

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

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

Exhibit 5: Good Practice Exchange

Recent and forthcoming events
Recent events
Using alternative delivery models to deliver public services – December 2017 (past) This seminar shared examples of how public services are integrating with housing organisations to deliver more preventative services in a different way.
The role of scrutiny in relation to the WFG Act – January 2018 (past) In partnership with the WLGA, Welsh Government, Welsh NHS Confederation, the Office of the Future Generations Commissioner and Good Practice Wales we held a free event with the aim of considering Governance under the Well-being of Future Generations Act.
Forthcoming events
I'm a patient get me out of here – 14 March 2018, and 22 March 2018 This seminar will share examples of how public services are collaborating to deliver a hospital discharge service, which provides better outcomes for individuals.
How you manage risks around organisational change, service transformation and innovation – 15 March 2018 We are holding a free seminar on how public services can use well-managed risk taking to respond effectively to the major challenges they face and the requirements of the Wellbeing of Future Generations Act.

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

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

Management response

Report title: Structured Assessment 2016 – Cardiff & Vale University Health Board

Completion date: February 2017

Document reference: 706A2016

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
R1	Strengthen financial reporting arrangements by including additional information within the financial report to the Board and the new Finance Committee relating to:							
	a) A dashboard summarising performance against key performance indicators; and	Greater clarity for Board members on financial performance when considering the Health Board's financial position.	Yes	Yes	Noted - Currently the dashboard for finance is in the Board Performance Report presented to the Board. This will be reviewed and included in the Finance Report which will facilitate the dashboard being sighted at the Finance Committee also.	April 2017 (2017/2018)	Director of Finance	Finance Committee

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
					Included with Finance Report to the Finance Committee and Board since April 2017 and has been present all year. This action has been followed up by the Finance Committee as part of the WAO review of Financial Reporting at its November 2017 meeting this completed action was noted	November 2017 **COMPLETE**		
	b) The issues and detail of actions being taken to manage budget overspend and deliver necessary savings by clinical area.	Greater clarity for Board members on the issues affecting the financial position and the actions being taken.	Yes	Yes	Details of overspends are included in the Finance Report to the Board, but not the recovery actions. A summary of actions will be included for 2017/18 and a summary of delivery against the CRP programme for clinical boards/departments. It is not planned to take to the Board more detailed recovery measures but to the Finance Committee. The report for the Finance Committee has yet to be designed but under consideration for introduction for 2017/2018 and will include financial performance of clinical board/departments, CRP performance and recovery plans.	April 2017	Director of Finance	

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
					The key concerns and actions being taken to mitigate risks are not included in the Finance Report that goes to the Finance Committee and the Board. This action has been followed up by the Finance Committee as part of the WAO review of Financial Reporting at its November 2017 meeting and this completed action was noted.	November 2017 **COMPLETE**		
R2	Ensure cost reduction plans are adequately supported prior to the start of the financial year.	Realistic cost reduction plans are developed ahead of the financial year which enables the Health Board to provide a robust financial plan for the year ahead.	Yes	Yes	Primary budget holders have been instructed to identify opportunities for CRP using local knowledge, benchmarking and transformation of services. In addition to populating the red CRP pipeline an additional document has been requested to provide assurance of opportunities available prior to the start of the financial year 2017/18. In addition the “Turning the Curve” exercise will provide wider opportunities available to the UHB beyond the annual CRP target. For 2017/18 the UHB and each Clinical	31.03.17	Director of Finance (With support from all primary budget holders)	Finance Committee

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
					Board has a fully identified savings plan that is sufficient to deliver the targets set. This is reported to the Finance Committee and the Board within the monthly Finance Report.	November 2017 **COMPLETE**		
R3	When developing the 2017-18 three-year plan, ensure that there is: a) clear connectivity between the medium term plan and its longer term strategy, as well as its other strategic plans and requirements such as the Health & Social Care Wellbeing Act and Future Well Being Generations Act; and	The three-year plan provides a comprehensive understanding on how the Health Board will deliver its longer term strategy alongside its other strategic requirements.	Yes	Yes	The IMTP/annual plan will be set out in a way that aligns the 1/3 year actions with the strategic objectives of Shaping Our Future Wellbeing. The IMTP/annual plan will also confirm the actions being taken to deliver the requirements of the SSWB Act and WBFG Act- although in relation to the former, there is also an implementation plan approved and overseen by the Regional Partnership Board. The IMTP will not duplicate all of the detail.	March 30th 2017	Director of Strategy & Planning	People, Planning and Performance and Strategy and Engagement Committee

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
					The IMTP for 17/18 was developed in a way that demonstrated alignment with the 'Shaping Our Future Wellbeing'. The plan sets out how the UHB is applying the Wellbeing Future Generations (WBFG) Act and summarising the work that the Regional Partnership Board (RPB) drives forward in relation to implementation of the Social Services & Wellbeing Act (SSWB) Act. This approach has been further strengthened in the development of the 2018/19–2020/21 IMTP.	22 January 2018		
	b) a clear understanding of the benefits expected from the actions and priorities set out in its plan.	The intended outcomes and benefits of the plan are clearly set out and understood.			The IMTP/annual plan will set out the expected outcomes and measure for the actions detailed within it.	30 March 2017	Director of Strategy & Planning	
R4	Establish the new Strategic Planning Committee as a matter of urgency to ensure that sufficient time is allocated to scrutinise the	Scrutiny of the Health Board's plan in more detail than that current allowed within the Board agenda.	Yes	TBC	The Board will confirm new arrangements for Committees by the end of March 2017. Subject to their approval new arrangement will be implemented for April 2017.	May 2017	Director of Corporate Governance	Strategy and Engagement Committee

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
	development of the 2017-18 three-year plan.							
R5	Strengthen progress reporting on delivery against plan by including aspects identified in our comparative review of progress reports and ensure that this is considered on a regular basis by the Strategic Planning Committee in line with the new requirements of the NHS Planning Framework for 2017-20.	Regular scrutiny of delivery against plan in line with the requirements of the NHS Planning Framework for 2017-20.		TBC	Reporting against the IMTP/annual plan to be reviewed and most effective mechanism for ensuring comprehensive report will be provided to the Board and Strategic Planning Committee (if the Board supports the establishment of the Committee) The Board/Strategy & Engagement Committee has received quarterly reports detailing the actions taken against the key programme of work being taken forward. The Board Performance Report has been reviewed to ensure closer alignment with reporting against the key deliverable targets.	June 2017 22nd Jan 2018	Director of Strategy & Planning	Strategy and Engagement Committee
R6	Undertake an evaluation of planning capacity to provide assurance to the Board that the Health Board has sufficient planning capacity	Assurance that the Health Board has sufficient planning capacity to support the development of plans	Yes	Yes	Planning/PMO/Service change capacity requirements will be considered as part of the development of management arrangements required to support the transformation programme.	June 2017	Interim Chief Executive Officer	Strategy and Engagement Committee

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
	and capability within the organisation. This evaluation should also include its change management capacity to minimise the continuous need for the Health Board to commission external support.	and the associated change required to implement the plans.						
R7	Review the way objectives are defined in the Corporate Risk Assurance Framework to facilitate the ability to identify what success looks like and what needs to be done to achieve these objectives, ensuring that these are further aligned with those set out in the ten year plan.	A CRAF that sets out what success looks like, what needs to be done, and what assurances are needed to achieve the Health Boards strategic objectives.	Yes	Yes	The Board Development full day session on 27th April 2017 has been dedicated to review the CRAF and explore new approach to risk management for the Health Board. The outcome of the day will be reported to the Audit Committee on the 23rd April 2017 with recommendations. Throughout 2017/18, the Corporate Risk and Assurance Framework has been reviewed with regular updates to Audit Committee and the Board. A revised risk management process has been trialled in three committees risk register. The new system, aligned to strategic objectives will be implemented in April 2018	May 2017 **COMPLETE**	Director of Corporate Governance	Audit Committee and Board

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
R8	Ensure compliance with all requirements of the Welsh Health Circular (reference WHC/2016/22) on transparent public reporting. Specifically, the Health Board should ensure that the following are easily accessible via the Health Board's website: • citizen engagement plan; • complaint/concerns raising policy; and • flexible visiting times policy.	The Health Board will be compliant with the Welsh Health Circular.	Yes	Yes	A review of the Boards website will be undertaken to ensure compliance with the issues raised plus compliance with our policies	June	Director of Corporate Governance	Quality, Safety and Experience Committee
R9	As a matter of urgency, ensure that all independent member vacancies are filled and that post holders are in post to support quorate running of committees.	Scrutiny and challenge is provided by a full establishment of independent members and the risk of attendance at committee meetings not being quorate is minimised.	Yes	Yes	All current vacancies now filled with 1 additional Associate Board Member. To note Planning in conjunction with Welsh Government has already commenced for recruitment of 3 Independent vacancies for October 2017	January 2017 **COMPLETE**	Director of Corporate Governance	

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
R10	Establish the new 'Resources and Delivery' Committee as a matter of urgency to ensure that robust scrutiny is given to the Health Board's performance.	Regular scrutiny of the Health Board's performance in more detail than that current allowed within the Board agenda.	Yes	Yes	Same as recommendation 7	May 2017 **COMPLETE**	Director of Corporate Governance	
R11	Ensure that relevant performance information is made available to the new 'Resources and Delivery' Committee, including the sharing of the clinical board performance reviews, to enable it to focus its attention on the areas of performance which need the greatest scrutiny.	The focus of scrutiny and challenge is on areas that require the greatest attention.	Yes	Yes	This will be a standard agenda item for the Committee and summary/dashboard updates will be provided on a quarterly basis.	August 2017 Summary presented 5.11.17 and 30.01.18	Chief Operating Officer	Resource and Delivery Committee
R12	Undertake a further evaluation of the corporate governance capacity to ensure that the Health Board has sufficient governance capacity and capability within the organisation to provide	Assurance that the Health Board has sufficient capacity to ensure that all required assurances are in place.	Yes	Yes	Discussions have commenced with the Interim Chief Executive and Director of Corporate Governance to agree a plan to address the recommendations. The outcome of this will be shared with the Governance Co-ordinating Group (Chair and Independent Members) at their	**COMPLETE** May 2017	Director of Corporate Governance	Audit Committee

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Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
	the necessary assurances to the Board. The views of independent members on what assurances are needed should be sought as part of this evaluation.				meeting in May 2017 In addition, the role of Director of Corporate Governance has been reviewed to facilitate and focus on governance rather than corporate issues. This in in line with the Welsh Government White Paper published in 2017. The department also obtained services of a national graduate trainee for 2017/18.	December 2017 October 2017		
R13	Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee on the extent to which both performance and financial audit recommendations have been completed, and ensure that	Effective arrangements are in place to ensure that external audit recommendations are implemented and have the required impact			Paper presented to the Management Executive meeting on 20th March 2017 IM&T sub committee receive a report of all IT related audits and actions, as well as update of outstanding actions at every meeting. IM&T and IG sub Committees merged together. Standing item is all IM&T/IG related audits are added to a tracked which is updated and discussed	March 2017 **COMPLETE** 5/12/16 22/01/18	Director of Finance Director of Therapies and Health Sciences	Audit Committee

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
	all action plans are monitored through to completion by the relevant committees of the Board.				at every meeting Nutrition and Catering committee receive a report on all audits – including WAO audits with updates on actions, at every meeting. This is also reported to the QSE committee – with a tracker updated in between meetings Learning disabilities HIW audit actions and progress reported to QSE committee and UHB Learning Disabilities Group. A tracker is held and updated between meetings. HIW eye care AMD audit actions and progress reported to Cardiff and vale UHB Eye Healthcare Group and QSE Committee These will be ongoing until all actions complete	14/12/16 13/12/16 22/01/18 13/12/16 10/2/17 22/01/18 21/2/17 22/01/18		

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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:** 27 February 2018

Executive Lead: Chief Executive
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk
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

ASSURANCE is provided by:

- The progression of the Action Plan provided
- Ongoing monitoring by this Committee
- Internal Audit review

RECOMMENDATION

The Committee is asked to:

- **NOTE** the contents of this report
- **MONITOR** the progress of the Action Plan
- **PROVIDE** the Board with the assurances required

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SITUATION

Further to the critical report of the Auditor General for Wales dated July 2017 relating to the UHB's contractual relationships with RKC Associates Ltd and its Owner, the UHB developed a comprehensive action plan to make the necessary further improvements to ensure no similar incidents of this kind occur in the future.

BACKGROUND

This report follows that provided to the Committee on 5 December 2017, and contains the updated version of the Action Plan.

CARING FOR PEOPLE
KEEPING PEOPLE WELL

Following the attendance of the Chair and Chief Executive at the Public Accounts Committee (PAC) in September 2017, an update on the implementation of the Action Plan is due to be provided to the PAC in April 2018.

ASSESSMENT AND ASSURANCE

The Action Plan reflects the progress that has been made since the last report to the Committee.

The Governance Department met with Wales Audit Office on 20 January 2018 and it was acknowledged that good progress has been made, whilst being mindful that improving the culture completely within the Health Board will be a longer term goal, but is essential if we are to avoid similar incidents occurring in the future.

Internal Audit has also reviewed the progress made against the Action Plan and provided a finding of Substantial assurance. Three recommendations for improvement are made which are accepted and responded to as part of this report.

Of the 26 actions contained within the Action Plan, only 6 now remain outstanding. The updates provided in the Action Plan provide assurance that good progress is being made in relation to these outstanding actions.

Two actions have been amended as partially complete acknowledging that even though the reviews have been completed, approval of an updated policy and development of a scrutiny checklist will fully complete these actions and provide robust assurance.

Full closure of the Action Plan was intended for March 2018, it is clear that the following 3 actions will not be concluded by this stage:

- Full implementation of the no purchase order no payment system – the initial target set was overambitious given the size of the organization;
- Development of an internal protocol providing a system for senior leaders to raise concerns – following recent discussions between Corporate Governance, the UHB Chair and Nurse Director, and taking account of the observations of the PAC regarding culture, it is considered that more work is required around this and the re-launch of the Procedure for NHS Staff to Raise Concerns. A Working Group has therefore recently been established to include Corporate Governance, Corporate Nursing, and WOD to take this forward.
- Circulation of a bulletin to the UHB Board and throughout the UHB reinforcing the Nolan principles of Good Governance – finalization of this communication will form part of the Working Group's agenda.

Therefore it is proposed that a final closure report come back to the Committee, following completion of the last action in June 2018.

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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.

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.

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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.

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Conclusion 1 Action Plan	Lead	Completion	Update	Status
Training 1. Provide training for all Board members on the law, rules and regulations relating to employment and procurement at the August Board Development Day.	Director of Corporate Governance	Aug 2017	**Complete** Training delivered on 31/08/17.	
2. Cascade the training provided at Clinical Board senior management teams and throughout the organisation to Directorate Management level.	Executive and Clinical Board Directors	Oct 2017	**Complete** Discussed at ME on 04/09/17 & cascaded.	
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	Aug 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	Sep 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	Sep 2017	**Complete** Approved by ME on 25/09/17	
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	Oct 2017	**Complete**	
7. Implement a no purchase order, no payment system to prevent the processing of manual payments.	Head of Procurement	June 2018 (original date set was Mar 2018)	Roll out has taken place in the Executive Team, UHB “no purchase order no payment” Group meets monthly & feeds into the National Group. Full implementation now expected	

			by June 2018.	
8. Develop and cascade process guidance for off-payroll working.	Head of Procurement	Aug 2017	**Complete** Approved by ME on 14/08/17, taken to HSMB on 17/08/17 for cascading by Clinical Board Directors.	

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.

We are committed to utilising temporary employment contracts rather than consultancy contracts wherever possible.

Conclusion 2 Action Plan	Lead	Completion	Update	Status
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	Sep 2017	**Complete** All training complete, refresher sessions will continue.	
2. Obtain quality management accreditation for the Procurement Department in respect of its tendering processes.	Head of Procurement	Mar 2018 (original date set was Nov 2017)	Audit has now been arranged for 15/02/18.	
3. Develop a Procurement flowchart for use by Board and Senior Managers.	Head of Procurement	Oct 2017	**Complete** Flowchart considered by ME on 11/12/17 & agreed that Executives will cascade through Management Structures.	
Audit 4. Enhance existing audit processes within the Procurement Department to verify compliance with contract procedure.	Head of Procurement	Sep 2017	**Complete** Forward programme for audit planned & training of Clinical Boards & departments to continue.	
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	Nov 2017 (original date set was Sep 2017)	**Complete** Specific audit included in 2018 plan, to look at overall progress of action plan &	

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			review in detail a sample of actions.	
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	Sep 2017	**Complete** Standing agenda item with first report received at Audit Committee on 26/09/17.	
7. Review the Terms of Reference for the Remuneration and Terms of Service Committee to include a requirement to report any Executive level secondments and Consultancy appointments for approval to this Committee.	Director of Corporate Governance	Jan 2018 (original date set was Oct 2017)	**Complete** Review approved by Board on 30/11/17. Amendment made to note at the next meeting of the Remuneration and Terms of Service Committee.	
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 to recruit due to small numbers of applicants with the relevant skills and experience. 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				

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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.

Conclusion 3 Action Plan	Lead	Completion	Update	Status
Review 1. Review the procedures used to recruit Executive Directors and other Senior Managers.	Assistant Director of Workforce and Organisational Development	May 2018 (target date set Jul 2017)	**Partially Complete** Process revised & now to be reflected in the updated Recruitment and Selection Policy & Procedure which is due for approval in May 2018.	
2. Review the quality of information and its presentation to the Remuneration and Terms of Service Committee.	Chair and Director of Corporate Governance	Mar 2018 (target date set Sep 2017)	**Partially Complete** New process introduced in January 2018 whereby all papers are assured by Chair & Director of Corporate Governance prior to publication. Checklist being formulated to support this scrutiny.	
Process				

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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	Aug 2017	**Complete** Process revised & now to be reflected in the updated Recruitment and Selection Policy & Procedure.	
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	Aug 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	Oct 2017	**Complete** Included in the programme for the October Board Development Day.	
Additional Improvements				
Action Plan	**Lead**	**Completion**	**Update**	**Status**
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	Jan 2018 (target date set Oct 2017)	**Complete** All Wales Procedure adopted at January meeting of Resource & Delivery Committee, Working Group established to re-launch Procedure, agree underlying process & improve culture.	
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	Apr 2018 (target date set Oct 2017)	This will be developed by the above Working Group.	
Governance and Accountability Framework 3. Revise the UHB Governance and Accountability Framework to reflect	Director of	Mar 2018	Model Standing Financial	

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any amendments by the Directors of Finance All Wales Group to the Standing Financial Instructions and Standing Orders.	Corporate Governance		Instructions and Standing Orders being developed on an All Wales basis.	
4. Review and revise the UHB's Scheme of Delegation.	Director of Finance	Feb 2018 (target date set Oct 2017)	Review to be presented to Audit Committee on 27/02/18.	
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	Apr 2018 (target date set Oct 2017)	Draft prepared, final version delayed to ensure content aligns with product of Working Group.	
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	Oct 2017	**Complete** Reports at Board, ME, HSMB, LPF. Continued dialogue with Senior Trade Union / Staff Side representatives, CEO communication placed on intranet and internet. Action plan monitored by Audit Committee.	

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Wales Audit Office Tracking Report December 2017

Date of Report	Title of Review	Summary of Findings / Recommendations (as reported to Audit Committee	Excutive Lead	Management Response to Date	Status (Ongoing / Completed)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Jan 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 Therapies and Health Science and IT	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) 28/09/17 - There were 14 recommendations within this report – 12 of which have been completed entirely, the remaining two (these were bother investment dependant) have partially been completed with a target date to be completed December 2017.	On-going	Strategy and Engagement John Antoniazzi Information Governance & Technology sub-Committee - Eileen Brandreth	28/01/2014 - initial report 26/02/2015 - (PPP) Follow-up Report See below for update. IGSC 23.03.16 Presented to IT&GSC Oct 17
01 Feb 2015	Orthopaedics (2012)	Orthopaedic services are generally coping with demand, which is consistently low, but MRI waits are long, the inpatient pathway needs to be improved to make better use of resources and although outcomes are generally positive, revision rates and missed follow-up appointments are some of the highest in Wales - Investment in primary care services is increasing and there is a consistently lower rate of GP referrals, although the impact of the Clinical Musculoskeletal Assessment and Treatment Service (CMATS) is unclear. - Outpatient and physiotherapy services are generally meeting demand, although a reduction in did not attend rates for outpatient appointments and the availability of direct access to physiotherapy could further improve waiting times. Access to MRI for GP referred patients is problematic. - More timely pre-operative assessment, increased day surgery rates, maximised bed occupancy and a reduction in prosthetic costs could improve the use of inpatient resources; and - Patients generally have positive outcomes with the exception of revision rates, which are some of the highest in Wales and not all patients are followed-up. WAO informed of upcoming follow-up review for next financial year 2018/19	Chief Operating Officer	Report received and action plan approved by PPP Committee in July 2015. Interim report received in January 2016 and a full report in 12 months February 2017) R&D 7.11.17 - A revised model of care was being piloted in CMATS and indicated a significant impact on outpatient demand. Substantial work had been undertaken to reduce the waiting list. This remained challenging as there were pockets with significant demand but was confident this would continue to improve which had been reflected in the RTT position over the last few quarters. In regard to prosthesis costs; the service with NWSSP had negotiated the lowest cost of knee replacement in Wales. The Planned Care Programme had been rolled out to spinal surgery and achieved an 84% response rate for this year. This had allowed only 5-6% of patients to require follow-up stating clinical outcomes were better than the UK average.	On-going	Resource and Delivery - Charles Janczewski	21/07/2015 (PPP) 18.01.16 (PPP) R&D 7.11.117
01 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 Governnance andTechnology sub-Committee - Eileen Brandreth	10/11/2015 IM&T 7.03.16 IM&T 10.06.16 IGSC 18.12.16
01 Jun 2015	Medicines Management (2014)	The work reviewed medicines management arrangements in the acute sector to assess scope for making improvements in relation to the quality and efficiency of services. The review concluded that there are strengths in the way the Health Board managed medicines but there were also issues associated with the strategic approach, storage facilities, transfer of medicines information and performance monitoring. - There was clear executive leadership, regular financial monitoring and improved clinical engagement but there was scope to raise pharmacy's profile, clarify accountabilities and strengthen the strategy. - Pharmacy staff costs per bed day were lower than the Welsh average and workload pressures were similar to the rest of Wales. There was scope to dedicate more resource to training and improve access to the pharmacy team outside normal hours. - Pharmacy facilities largely comply with key requirements although there were risks associated with storage of medicines, monitoring the temperature of ward fridges and infrequent audit of injectable medicine preparation on the ward. - There were some strengths to medicines management processes but there were risks related to information transfer between primary and secondary care, timeliness of reconciliations, non-medical prescribing and supporting patients to take their medicines properly. - There is scope to improve performance reporting, mixed evidence about the effectiveness of learning processes and a need to understand more about the root causes of the pharmacy team's safety interventions.	Medical Director	Report agreed and action plan developed. Action plan presented to and agreed by the PPP Committee in January 2016. Whilst the Committee did not agree when a follow-up would be received it will be added to the workplan for February 2017 by which time most actions will have been completed. Report to be presented to Committee, 7 November 2017 7.11.17 - The Nurse Executive Director was pleased to see there was improvement and progress being made. This was endorsed by the Chair in light of looking at the action plan. It was agreed for further assurance that recommendations were being acted on, a report would be brought back to the Committee on an annual basis for an update on progress but would be monitored through the Medicines Management Group.	On-going	Resource and Delivery - Charles Janczewski	18.01.16 (PPP) R&D 7.11.17
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	Resource and Delivery - Charles Janczewski	10/11/2015 & 15/03/16 (PPP) 12.07.16 (PPP) 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 Governnance andTechnology sub-Committee - Eileen Brandreth	02.05.16 (PPP)

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Date of Report	Title of Review	Summary of Findings / Recommendations (as reported to Audit Committee	Excutive Lead	Management Response to Date	Status (Ongoing / Completed)	Assurance Committee & Chair	Date Reported to Assurance Committee
26 Jan 2016	Review of Operating Theatres (Jan 2016)	1) The theatre improvement project is driving change through a clear focus on improving processes and performance management to improve efficiency 2) Theatre utilisation and productivity have improved but the Health Board has not clearly demonstrated that its investment has led to cashable financial savings. 3) Problems with staff engagement and workforce capacity mean there are risks to maintaining momentum 4) The focus on utilisation has not been matched by a strong enough focus on quality, although staff have positive views about surgical safety.	Chief Operating Officer	To be considered by the PPP Committee in May 2015 To report to PPP Committee January 2017 meeting. 10.01.17 - The report from WAO was responded to and an action plan developed, 86% of which was now green. This prompted the Theatre Strategy work and out of this five workstreams had been created. 16.05.17 - • Theatres had received £860k of replacement equipment but faced a backlog of £3m. • The metrics were looked at in relation to the utilization of theatres. This provided visibility to what was happening across the patch. They were able to predict what would happen with the ability to track all categories. • There were issues with a few of the theatres. These were currently addressed and a plan was in place. • An theatre estates plan was being developed to refurbish the wards at UHW and UHL. 7.11.17 - THEATRE UTILISATION • In order to strengthen areas key strategies were put in place such as; a workforce plan to improve staffing levels; to strengthen governance and accountability with the clinicians; to look at systems reviewing whole pathways around the surgical stream• The position has increased to 78-79% utilisation with a stretch target of 83% being the national standard. Bookings have reached 86% compliance; this was an 8% improvement. Improvements in CAVOC had shown 92% of theatre utilization. Work had commenced with the Children's Hospital predominantly to do with the use of theatres for elective and emergency surgery. There has also been improved trajectory for day units on both the UHL and UHW sites.	On-going	Resource and Delivery - Charles Janczewski	02.05.16 (PPP) 12.07.16 (PPP) 10.01.17 (PPP) 16.05.17 PPP 7.11.17 - R&D
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 - John Antoniazzi	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	Resource and Delivery - Charles Janczewski	Audit 28.02.17
01 Nov 2016	Review Delayed Transfers of Care	1) Discharge Planning Audit - address the findings from the Delivery Units discharge planning audit either by: developing an action plan; or incorporating actions into existing service improvement action plans. 2) Imtermediate Care Fund (ICF) - Explore ways of mainstreaming services funded through the ICFG to ensure services remain resilient	Chief Operating Officer	Draft being prepared. To go forward to next QSE meeting in April 2017. Asked when it was anticipated that progress would be seen (the UHB had the third highest number of delayed transfers of care) in Wales, it was noted that Mrs Alice Casey was taking the lead on length of stay through the transformation work and this would be reported to the UHB Board through the Transformation Board.	Complete	Resource and Delivery - Charles Janczewski	Audit 28.02.17 18.04.17 - QSE
01 Jan 2017	Review of Estates	1) To ensure thte estates service is represented at board level, priortise recruiting an independent board member for estates. 2) Create a central log of estates related issues and actions resulting from Clinical Board meetings. 3) Develop a fully costed Estates Management Strategy. 4) Develop a zero based estates budget that makes provision for likely revenue costs arising from changes to the Health Board estate, such as new buildings. 5) Introduce a system to inspect a percentage of repairs each month. 6) Strengthen performance management by: extending the performance dashboard to include Key Performance Indicators (KPIs) for the other serices covered by the Service Board; and making greater use of the data captured through the Backtraq repairs maintenance system. 7) To ensure repairs are correctly priortised: run Backtraq refresher training for helpdesk staff; and review questions on call handlers' script	Director of Strategic Planning	1) An Independent Member with responsibility for Capital & Estates has been appointed. 2) This can be achieved by our Backtraq Maintenance System. All actions can be logged on this system. 3) Estate Strategy ready for launch, also Modernisation programme near completion. 4) Exec Teams to consider options. 5) Full KPI pack for Estates in place and being measured. 6) KPI's completed and communicated each month. Content covers all of Service Board responsibilities. 7) Refreshers completed and Backtraq has multi levels dedicated for prioritisation. Teams manage all tasks by priority on a daily basis. Levels 1 to 5. (Immediate to Planned Work within 28 days).	Ongoing	Strategy and Engagement John Antoniazzi	Audit 28.02.17 Audit 5.12.17
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 - John Antoniazzi	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 - John Antoniazzi	28.02.17 30.03.17 - Board

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

Wales Audit Office Tracking Report December 2017

Date of Report	Title of Review	Summary of Findings / Recommendations (as reported to Audit Committee	Excutive Lead	Management Response to Date	Status (Ongoing / Completed)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Oct 2017	Collaborative Arrangements for Managing Local Public Health Resources	R1 Collaborative arrangements for managing local public health resources do not work as effectively as they should do. The Wales Audit Office recognises, in part, that the problems identified in this report relate to matters that are the responsibilities of Welsh Government, Health Boards and Public Health Wales. R2 Continued working with Health Boards through the DsPH to agree the public health priorities that need to be delivered collectively, including identifying individual contributions to delivery and agreeing how outcomes will be measured collectively and monitored and reported locally and nationally. R3 Developing effective arrangements to demonstrate that PHW is securing value for money from the specialist public health resources allocated to LPHTs. R4 Clarifying the roles and responsibilities of the Trust's national and local teams in relation to developing and delivering health improvement programmes. R5 Progressing work to develop reliable methods for allocating specialist public health resources to LPHTs and other stakeholders that covers the breadth of public health practice including healthcare public health. R6 Agreeing appropriate mechanisms for communicating and sharing information between the Trust and LPHTs. R7 Agreeing a mechanism whereby workforce planning discussions take place on a more formal basis between the Trust and DsPH R8 Clarifying the requirements for career progression for staff working within LPHTs, including whether a post-graduate degree in public health is a pre-requisite R9 Clarifying expectations for staff working within LPHTs about voluntary registration with the UK Public Health Register and whether it is, or should be, a requirement to undertake particular roles.	Director of Public Health	Presented to Audit 5.12.17	Ongoing		

Cardiff & Vale University Health Board

Post Payment Verification Progress Report

For the period: 1st April 2017 to 31st December 2017

Cardiff & Vale University Health Board

Issued: February 2018
Prepared by: Mr Scott Lavender (PPV Location Manager)

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

1. Introduction

This report has been prepared for the 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:

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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
18	16	2	18	0

During the period 1st April 2017 to 31st December 2017, the PPV team has visited 18 GMS contractors as per the visit plan agreed with Cardiff & Vale UHB. The PPV team have recovered £13,189.05 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 8.35% 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
23	20	3	23	0

During the period 1st April 2017 to 31st December 2017, the PPV team have visited 23 GOS contractors as per the visit plan agreed with Cardiff & Vale UHB. The PPV team have recovered £5,030.80 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 3.82% 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
28	27	1	28	0

During the period 1st April 2017 to 31st December 2017, the PPV team has visited 28 GPS contractors as per the visit plan agreed with Cardiff & Vale UHB. The PPV team have recovered £1,041.90 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 1.91% 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 are currently working with the UHB to organise a training event for GOS contractors to outline expectations to staff and in the long term help with error rates and recoveries decreasing.

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

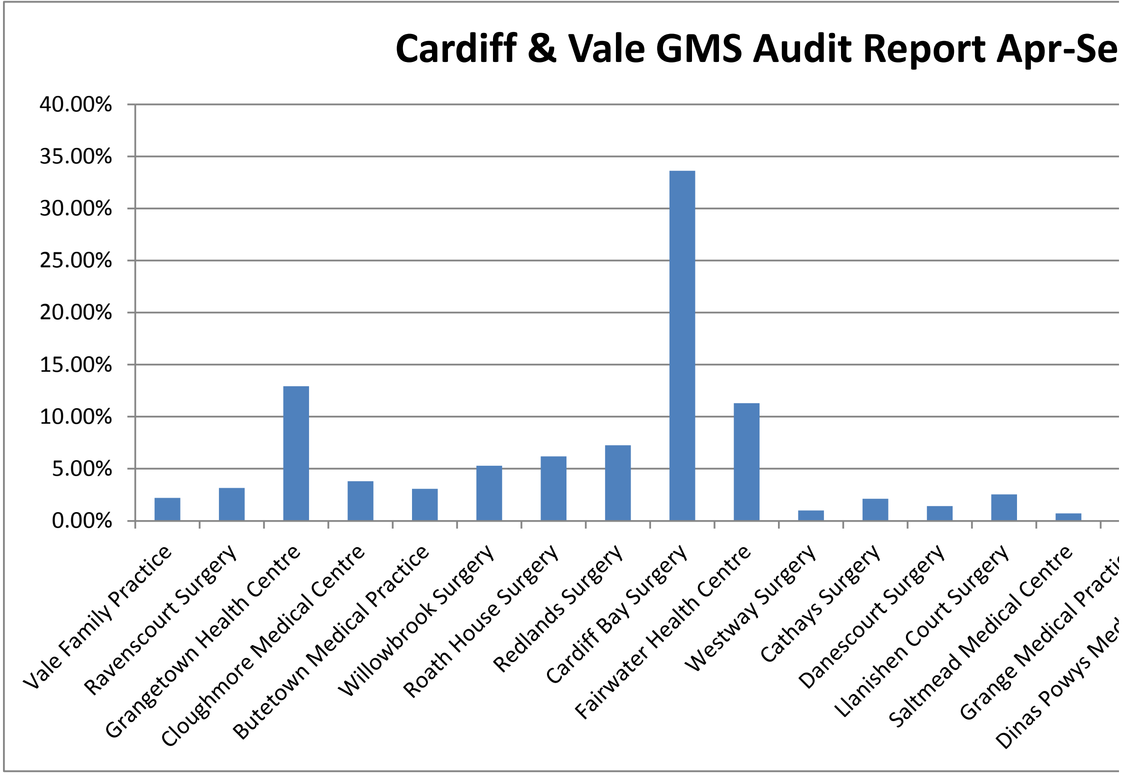
Completed GMS visits

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	10/4/2017	10/4/2017	10/4/2017	259	8	0.00%	3.09%	£308.10
Willowbrook Surgery	W97069	Routine	7/5/2017	7/27/2017	10/5/2017	10/6/2017	10/6/2017	227	12	5.29%	5.29%	£379.60
Roath House Surgery	W97034	Routine	7/13/2017	7/21/2017	11/15/2017	11/15/2017	11/16/2017	242	4	1.65%	6.20%	£308.30
Redlands Surgery	W97003	Routine	7/31/2017	8/7/2017	9/12/2017	9/12/2017	9/22/2017	193	14	4.15%	7.25%	£1,117.64

Cardiff Bay Surgery	W97044	Routine	8/3/2017	8/4/2017	9/26/2017	9/26/2017	9/27/2017	116	39	0.86%	33.62%	£1,019.54
Fairwater Health Centre	W97047	Revisit	8/15/2017	8/21/2017	10/6/2017	11/8/2017	11/16/2017	912	103	0.22%	11.29%	£3,311.90
Westway Surgery	W97017	Routine	8/31/2017	9/1/2017	10/23/2017	11/8/2017	11/16/2017	303	3	0.00%	0.99%	£264.30
Cathays Surgery	W97009	Routine	9/19/2017	9/25/2017	10/20/2017	10/21/2017	10/24/2017	188	4	7.45%	2.13%	£170.96
Danescourt Surgery	W97036	Routine	9/25/2017	10/5/2017	11/2/2017	11/8/2017	11/17/2017	212	3	2.83%	1.42%	£101.47
Llanishen Court Surgery	W97013	Routine	10/23/2017	10/24/2017	11/21/2017	11/21/2017	11/21/2017	276	7	2.90%	2.54%	£662.45
Saltmead Medical Centre	W97029	Routine	11/16/2017	12/1/2017	1/31/2018	1/31/2018	2/1/2018	143	1	5.59%	0.73%	£30.35
Grange Medical Practice	W97061	Routine	11/20/2017	12/1/2017	1/2/2018	1/2/2018	1/2/2018	339	73	5.60%	21.53%	£3,523.68
Dinas Powys Medical Centre	W97055	Routine	12/5/2017	2/1/2018								
Albert Road Surgery	W97057	Revisit	12/18/2017									
Cardiff & Vale UHB average								**4,277**	**357**		**8.35%**	**£13,189.05**

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
3 x Near patient testing, 1 x Anti-coagulation Monitoring, 2 x Minor surgery, 2 x Homeless
2 x Near Patient Testing, 1 x Anti-coagulation Monitoring, 1 x Contraceptive Services, 6 x Administration of Gonadorelins, 1 x Flu, 1 x Minor Surgery
2 x Contraceptive Services, 1 x Minor Surgery, 1 x Nursing Homes
5 x Near Patient Testing, 6 x Minor surgery, 3 x NOAC

3 x Minor Surgery, 2 x Flu (£783.70 claimed as SLW and should have been INR)
10 x Minor Surgery, 31 x Administration of Gonadorelins, 63 x Near Patient Testing
3 x Minor Surgery
1 x Flu, 1 x Pertussis, 1 x Substance misuse, 1 x Nursing Homes
2 x Near Patient Testing, 1 x Anti-coagulation Monitoring
2 x Minor Surgery, 2 x Administration of Gonadorelins, 3 x Learning Difficulties
1 x Non-UK registrants
3 x Anti-coagulation monitoring, 56 x Minor Surgery, 2 x Administration of Gonadorelins, 1 x Flu, 2 x MMR, 2 x Pertussis, 7 x Non-UK Registrants



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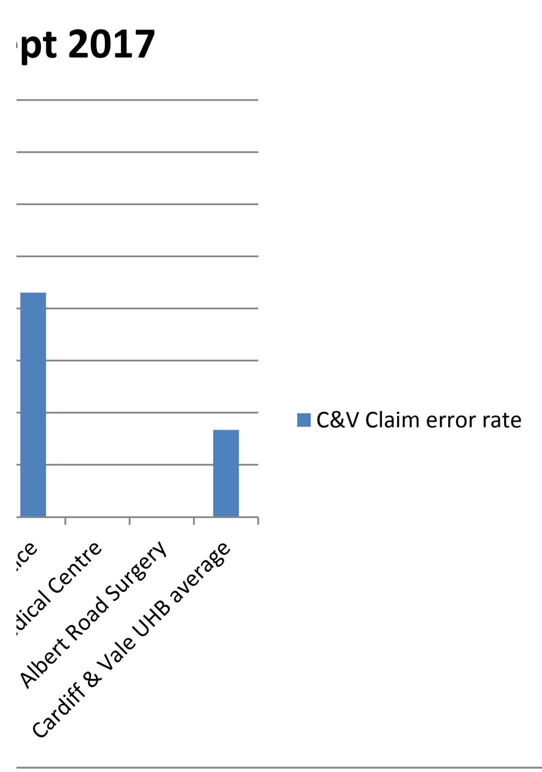

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Practice Name	Practice Code	Visit Status	Visit Date	Date initial report sent to contractor	Date final report sent to HB	Report agreed by HB (DOF)	File closed by PPV
Specsavers Barry	418	Routine	4/3/2017	4/11/2017	5/2/2017	5/10/2017	5/10/2017
City Road 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	8/31/2018	9/1/2017
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	9/6/2017	10/19/2017	10/19/2017	10/19/2017
Costco Leckwith Rd	573	Routine	8/29/2017	8/30/2017	10/13/2017	10/13/2017	10/16/2017
Pearce & Bowler	515	Routine	8/30/2017	8/31/2017	10/10/2017	11/8/2017	11/16/2017
S Greenberg Llandaff	326	Routine	9/6/2017	9/7/2017	10/20/2017	10/21/2017	10/24/2017
Direct Eyecare	504	Routine	9/12/2017	9/15/2017	9/22/2017	10/9/2017	10/9/2017
Radyr Eyecare	472	Revisit	9/21/2017	9/22/2017	11/22/2017		
Optimise Opticians	468	Routine	10/2/2017	10/3/2017	10/9/2017	10/9/2017	10/9/2017
Chris Williams	401	Routine	10/5/2017	10/13/2017	11/13/2017	11/13/2017	11/13/2017
Parish Opticians	343	Routine	11/8/2017	11/8/2017	11/16/2017	11/8/2017	11/17/2017
R N Roberts	349	Revisit	11/15/2017	11/15/2017	12/22/2017	1/22/2018	1/23/2018
Nina Davies	448	Routine	11/17/2017	11/28/2017	1/8/2018	1/25/2018	1/26/2018
R E Lloyd Cowbridge	336	Revisit	11/21/2017	12/22/2017	2/13/2018		
Asda Opticians Coryton	424	Routine	12/6/2017	12/8/2017	1/30/2018		
Cardiff & Vale UHB average							

14.1

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	8	28.00%	8.00%	£233.90	6 x EHEW, 1 x GOS 4
100	1	9.00%	1.00%	-£10.20	Adjustment of £10.20 in practice favour
59	4	84.75%	6.78%	£360.60	4 x GOS 3
100	2	14.00%	2.00%	£120.00	2 x EHEW
100	8	13.00%	8.00%	£320.00	8 x EHEW
100	4	19.00%	4.00%	£227.80	5 x EHEW, 1 x GOS 3, 2 x GOS 4
100	0	2.00%	1.00%	£20.00	1 x EHEW
100	1	12.00%	1.00%	£40.00	1 x EHEW
100	0	57.00%	0.00%	£0.00	All claims verified
100	0	0.00%	0.00%	£0.00	All claims verified
				£1,229.80	
100	1	16.00%	1.00%	£8.80	1 x GOS 3
2,459	**94**		**3.82%**	**£5,030.80**	

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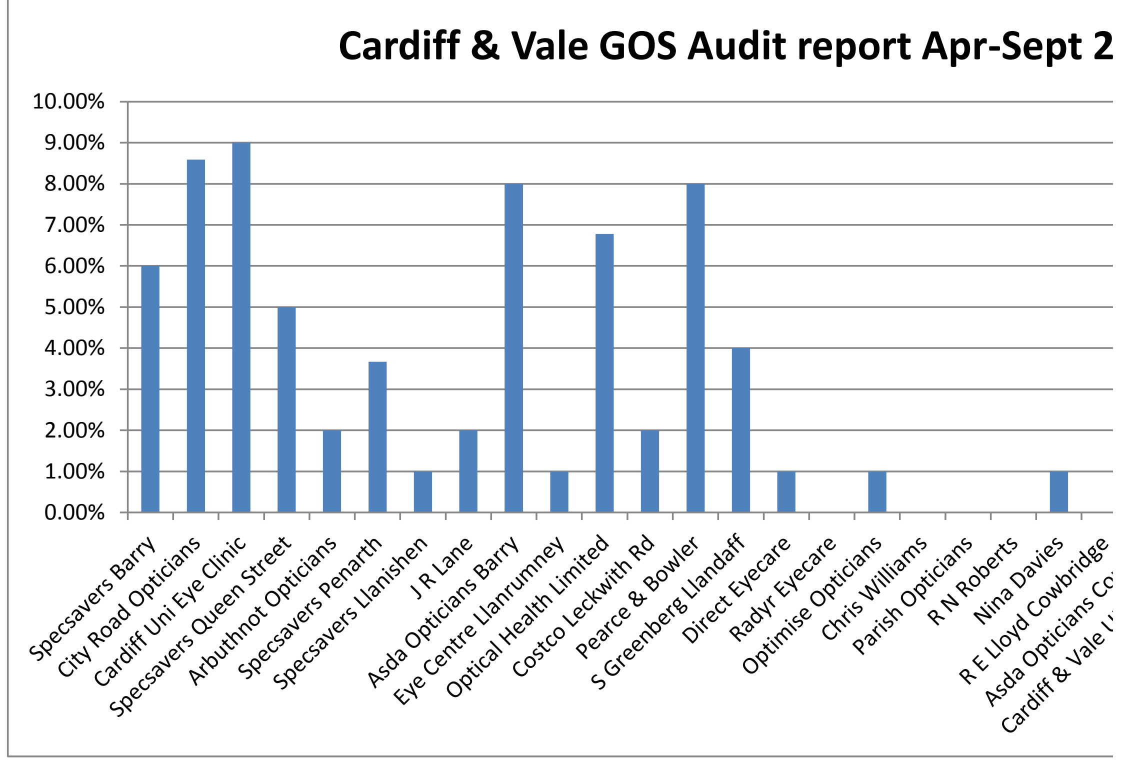

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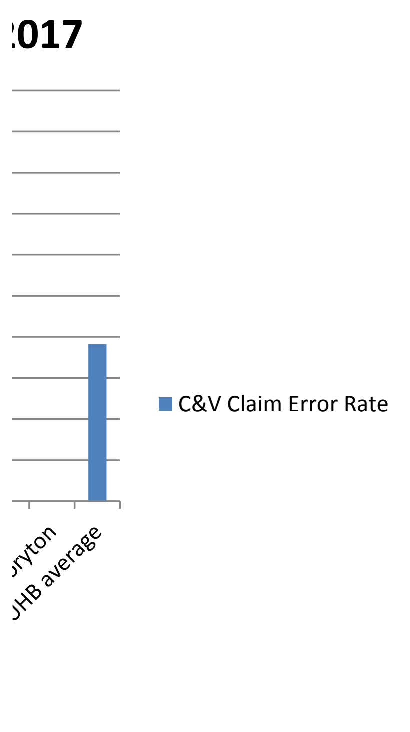

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Cardiff & Vale University Health Board
GOS PPV Progress Report: 2017/18

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)	File closed by PPV	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Mayberry Pharmacy Penarth	602422C	Routine	4/12/2017	4/13/2017	5/24/2017	6/6/2017	6/15/2017	73	1	4.11%	1.37%	£28.00	1 x MUR
Boots UK Ltd Penarth	602816L	Routine	4/12/2017	4/13/2017	5/10/2017	5/11/2017	5/12/2017	100	0	28.75%	0.00%	£0.00	All claims verified
Lloyds Pharmacy Rhiwbina	602807B	Routine	4/25/2017	4/26/2017	6/15/2017	6/16/2017	6/19/2017	100	8	18.75%	21.25%	£187.88	5 x MUR, 3 x Flu
Well Pharmacy Rhiwbina	602853H	Routine	4/25/2017	4/28/2017	5/19/2017	6/6/2017	7/3/2017	100	0	6.25%	0.00%	£0.00	All claims verified
Asda Pharmacy Coryton	602806F	Routine	5/3/2017	5/9/2017	6/15/2017	6/15/2017	6/15/2017	88	0	11.36%	0.00%	£0.00	All claims verified
Lloyds Pharmacy Park Rd	602807C	Routine	5/3/2017	5/9/2017	6/14/2017	6/15/2017	6/15/2017	100	0	16.25%	0.00%	£0.00	All claims verified
Central Pharmacy	602004B	Routine	5/8/2017	5/10/2017	7/3/2017	7/11/2017	7/11/2017	100	0	54.54%	0.00%	£0.00	All claims verified
Boots UK Ltd Albany Rd	602816H	Routine	5/8/2017	5/9/2017	6/20/2017	6/29/2017	7/3/2017	99	2	6.27%	46.65%	£43.95	1 x MUR, 1 x Flu
Boots UK Ltd Cowbridge Rd	602816J	Routine	6/16/2017	6/22/2017	7/21/2017	7/25/2017	8/9/2017	100	15	22.50%	56.25%	£298.23	5 x MUR, 10 x Flu
Well Pharmacy Bute St	602855M	Routine	6/16/2017	6/20/2017	7/18/2017	7/25/2017	8/11/2017	100	5	20.00%	5.00%	£103.88	2 x MUR, 3 x Flu
Boots UK Ltd Cardiff Bay	602818G	Routine	6/21/2017	6/29/2017	8/11/2017	8/31/2017	8/31/2017	100	0	4.00%	0.00%	£0.00	All claims verified
Tesco Stores Ltd Culverhouse Cross	602870D	Routine	6/21/2017	6/30/2017	8/24/2017	8/24/2017	8/30/2017	92	0	28.26%	0.00%	£0.00	All claims verified
Clifton Pharmacy	602139B	Routine	7/4/2017	7/5/2017	7/17/2017	7/25/2017	7/26/2017	100	0	55.00%	0.00%	£0.00	All claims verified
Well Pharmacy Upper Clifton St	602856L	Routine	7/4/2017	7/7/2017	7/28/2017	8/18/2017	9/4/2017	100	0	13.00%	0.00%	£0.00	All claims verified
M W Phillips Splott Rd	602545L	Routine	8/22/2017	9/4/2017	10/19/2017	10/19/2017	10/19/2017	63	2	3.18%	3.18%	£56.00	2 x MUR
Boots Uk Ltd Queens St	602816M	Routine	8/22/2017	8/29/2017	10/5/2017	10/6/2017	10/6/2017	100	0	17.00%	0.00%	£0.00	All claims verified
Sylvia Williams Chemist Cowbridge	602755C	Routine	9/4/2017	9/6/2017	9/25/2017	10/13/2017	10/16/2017	100	0	4.00%	0.00%	£0.00	All claims verified
Lloyds Pharmacy Stirling Rd	602807E	Routine	9/4/2017	9/5/2017	10/13/2017	10/13/2017	10/13/2017	68	0	13.24%	0.00%	£0.00	All claims verified
Lloyds Pharmacy Merthyr Rd	602807K	Routine	9/8/2017	9/14/2017	10/6/2017	11/13/2017	11/16/2017	100	2	53.00%	2.00%	£56.00	2 x MUR
Tesco Stores Ltd Western Avenue	602870M	Routine	9/8/2017	9/13/2017	10/23/2017	10/23/2017	10/25/2017	88	0	20.45%	0.00%	£0.00	All claims verified
TH & L Jones Dinas Powys	602381B	Routine	9/18/2017	9/21/2017	10/4/2017	10/4/2017	10/4/2017	11	0	27.27%	0.00%	£0.00	All claims verified
Lloyds Pharmacy Court Road	602808G	Routine	9/18/2017	9/21/2017	10/2/2017	10/13/2017	10/13/2017	93	2	38.61%	2.14%	£56.00	2 x MUR
G S Bhogal Pharmacy	602030A	Routine	10/10/2017	10/11/2017	10/25/2017	11/8/2017	11/9/2017	80	0	10.00%	0.00%	£0.00	All claims verified
Lloyds Pharmacy	602807J	Routine	10/10/2017	10/11/2017	11/9/2017	10/26/2017	10/30/2017	100	3	57.00%	3.00%	£84.00	3 x MUR
Boots UK Ltd Holton Road	602816I	Routine	11/3/2017	11/7/2017	12/4/2017	12/4/2017	12/6/2017	81	1	14.81%	1.23%	£15.96	1 x Flu
Lloyds Pharmacy Holton Road	602805E	Routine	11/3/2017	11/7/2017	12/7/2017	1/31/2018	2/2/2018	83	4	21.69%	4.82%	£112.00	4 x MUR
Washington Pharmacy	602123A	Routine	12/1/2017	12/7/2017	1/18/2018								
Pearns Pharmacy Penarth	602514C	Routine	12/1/2017	12/4/2017	12/21/2017	1/22/2018	1/23/2018	37	0	24.32%	0.00%	£0.00	All claims verified
Cardiff & Vale UHB average								2,356	45		1.91%	£1,041.90	

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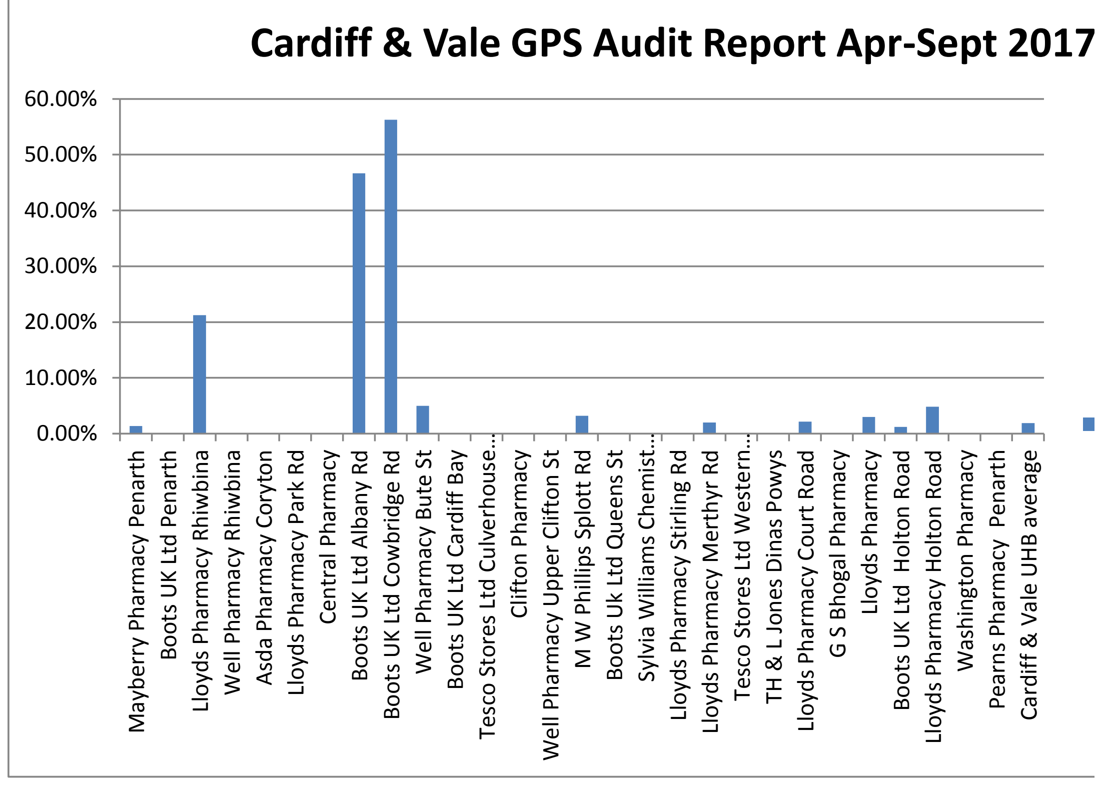

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REVIEW OF THE UHB'S SCHEME OF DELEGATION	
Name of Meeting : Audit Committee Meeting	**Date:** 27th February 2018

Executive Lead : Executive Director of Finance
Author : Deputy Director of Finance 02920 743555
Caring for People, Keeping People Well: This report strengthens financial governance which supports the values of the UHB.
Financial impact: Increased financial controls.
Quality, Safety, Patient Experience impact: Not applicable
Health and Care Standard Number: Governance, leadership and accountability Standard 7.1 Workforce
CRAF Reference Number: 8 and 9
Equality Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The review of the Scheme of Delegation and proposed amendment.

RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the assessment made on the current Scheme of Delegation;
- **APPROVE** the proposed addition for off-payroll working;
- **REQUEST** that the Scheme of Delegation is updated to include this addition;
- **ENDORSE** the completion and closure of this action within the UHB action plan on the Contractual Relationship with RKC Associates.

SITUATION

As part of the audit of the UHB Financial Accounts, the Wales Audit Office became aware of payments made to RKC Associates for HR consultancy work that took place between December 2014 and March 2016. The owner was subsequently appointed on a 1 year fixed term contract as Director of Workforce and Organisational Development in 2016. The Wales Audit Office then decided to undertake a review of the procurement process and management of the contract and issued their report on the matter in July 2017. Part of the UHB action plan in response to this report was to review and revise the UHB's Scheme of Delegation.

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BACKGROUND

The WAO audit report identified a number of serious issues relating to the consultancy contracts. These included:

- The UHB failing to comply with its own procurement procedures when it awarded the consultancy contracts in November 2014 and June 2015;
- The award of the consultancy contracts breached public procurement rules;
- The UHB failed to undertake due diligence checks of RKC Associates;
- The UHB was in breach of its own Standing Financial Instructions.

The concluded that the way in which the UHB procured and managed the HR consultancy contract awarded to RKC Associates fell well short of the standard that the public have the right to expect.

In addition, the process followed by the UHB that led to the appointment of the Director of Workforce and Organisational Development was fundamentally compromised, lacked transparency and was poorly documented.

ASSESSMENT AND ASSURANCE

This WAO audit report was presented to the Board at its July 2017 meeting. An action plan to respond to the key finding was approved and it was agreed that the Audit Committee would monitor progress of actions and provide the Board with the assurances required.

The comprehensive action plan developed to make the necessary further improvements required included the review and revision of the Scheme of Delegation.

The Scheme of Delegation is a live document and gets updated as required when changes are made to formal control processes e.g. recent changes to Capital Ordering Authorisation that was approved by the Audit Committee. The current Scheme of Delegation has been reviewed specifically in the context of the weaknesses identified and key findings of the WAO audit report.

With the exception of one issue, the review of the Scheme of Delegation has not revealed any weaknesses and it is deemed to be appropriate to support good governance in the organization. The one exception however is that the process that has been put in place regarding procurement of off-payroll working does not feature in the Scheme of Delegation. This process and supporting guidance was put in place in August 2017 as per a separate action in response to the WAO audit Report on RKC Associates. Best practice would now be to incorporate this within the Scheme of Delegation, especially due to the significant failures identified in the WAO report.

The following addition is therefore proposed within the Finance and Procurement section of the current Scheme of Delegation:

Area	Delegated Matter	Delegated to
Off-payroll working (as per procurement process guidance)	Completion of service specification and check on employment status which is to be forwarded to the Head of Procurement	Clinical Board Director / Clinical Board Director of Operations / Executive Director (support provided by Finance and Workforce)
	Procurement process undertaken ensuring suppliers are aware of the employment status.	Head of Procurement
	Clinical Board Director / Clinical Board Director of Operations / Executive Director to be notified of the contract award including reaffirming the employment status of the engagement.	Head of Procurement
	If status is deemed to be employed, completion of IR35 off-payroll enrolment	Clinical Board Director / Clinical Board Director of Operations / Executive Director

REPORT OF THE DIRECTOR OF CORPORATE GOVERNANCE	
Name of Meeting : Audit Committee	**Date of Meeting:** 27 February 2018

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance
Caring for People, Keeping People Well : This paper supports our Value and Behaviors 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 Committee is asked to:

- **NOTE** the paper

SITUATION

Following discussion with the Chair of the Audit Committee, it has been agreed that we introduce a Report from the Director of Corporate Governance at each meeting of the Audit Committee. This is the third report presented to 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.

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The report from the Director of Corporate Governance in this section is now 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" and the role of the Board Secretary:

The following issues are brought to the attention of the Committee:

1. Wales Audit Office Report on the Contractual Relationship with RKC Associates Ltd and its Owner.

This is a standing item on the agenda and very good progress on implementing the action plan should be noted. An update on the completion of the Action Plan is scheduled for April 2018.

2. Independent Members Vacancies on the Board

The following appointment by the Cabinet Secretary has now been confirmed:
- Dawn Ward, Independent Member (Trade Union)

3. End of Year Reporting

Work has already commenced on the above with particular reference to the Annual Governance Statement. This ensures sufficient time is scheduled for

discussion with the Wales Audit Office. Below is the proposed timetable for the production of the Accountability Report (incorporating the Annual Governance Statement, Remuneration Report & Financial Statements).

27 April 2018	Unaudited Accounts	Welsh Government & WAO
3 May 2018	Draft Accountability Report	Welsh Government & WAO
22 May 2018	Draft Accountability Report	Audit Committee Workshop
31 May 2018 am **pm**	Final Accountability Report (containing Financial Statements)	Special Audit Committee Board
1 June 2018	Final Accountability Report (Also AQS)	Welsh Government
26th July 2018	Accountability Report as part of Annual Report (Also AQS)	AGM
31 July 2018	Annual report (to include Performance Report)	

4. Board / Committee Working

A review of the above was discussed at Board Development Day in February 2018. This is very important for effective Board / Committee working and give the number of changes in Membership of the Board in 2017.

5. Parliamentary Review

The Parliamentary Review of Health and Social Care in Wales was recently published on 16 January 2018. This was a high level report and the overriding issue was around implementation and pace. Importance was placed on the Health and Care Strategy and a consultation will be held over the summer months. The Health Board will be considering the report and ensuring that its recommendations and delivery are reported to the Board and Committees. Further information is available on the links below.

http://gov.wales/newsroom/health-and-social-services/2018/care/?lang=en

http://gov.wales/topics/health/nhswales/review/?lang=en

6. Standards of Behaviour Policy

Work is currently being undertaken and progression is being made on the Standards of Behaviour Policy. This will be presented to the Audit Committee in April 2018. The policy will include hospitality and gifts.

7. Special Adviser to the Board

Members were informed at the January Board meeting that the above post is currently being advertised with interviews taking place in March. This will be an Adviser to the Board in relation to Strategy and Transformation who will bring to the role national and international experience and knowledge of service improvement and science.

8. Car Parking – Management Contract

Final specification are now out to tender with the shortlisted companies. It is anticipated that a recommendation to award the contract will be presented to the Board at its meeting in March.

9. Strategy and Delivery Committee

Following discussions with the Chairs, Chief Executive and Lead Executive Directors, the Resource and Delivery Committee and Strategy and Engagement Committee have now been stood down and replaced with the above. This new Committee will focus on the UHB 10 year plan and its delivery through IMTP. The first meeting of the Committee will take place on 13 March 2018.

CORPORATE RISK AND ASSURANCE FRAMEWORK (CRAF) WRITTEN CONTROL DOCUMENTS UPDATE REPORT	
Name of Meeting: Audit Committee	**Date of Meeting:** 27 February 2018

Executive Lead: Director of Corporate Governance
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk Graduate Management Trainee hattie.cox@wales.nhs.uk
Caring for People, Keeping People Well: This report supports the UHB's strategic objective to "Reduce harm, waste and variation sustainably making best use of the resources available to us"
Financial impact: Out of date controlled written documents and failure to adhere to in date controlled written documents can result in regulatory fines and litigation costs.
Quality, Safety, Patient Experience impact: It can also lead to the provision of care that is contrary to accepted best practice.
Health and Care Standard Number: Governance & Accountability, standard 2.1and many of the other themes.
CRAF Reference Number: 8.2.3 (existing CRAF reference)
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by the audit results of UHB written controlled documents.

REASONABLE ASSURANCE is provided by:

- The assessment and proposed update of the risk as it currently sits on the CRAF
- The work being undertaken to reduce the number of out of date control documents
- The proposed actions to increase Corporate oversight of the process in the future to ensure that the number of out of date control documents does not return to its current level, and that immediate action is taken to minimize risk if a control document does lapse

The Audit Committee is asked to:

- **NOTE** the updated risk assessment
- **CONSIDER** the appropriateness of the target score and proposed further actions to reduce this risk

SITUATION

At the last meeting on 5th December 2017 it was agreed that the Committee would receive a report on risk reference 8.2.3 around relevant up to date policies (control documents) which is an extreme risk assigned to the Committee. The risk is a Corporate level risk and is also recorded in

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

Specialist Services Clinical Board's risk register. It had an overall risk score of 20.

BACKGROUND

The review of the overall risk management process, including the CRAF continues. This report forms part of that review, and sets out the analysis and evaluation of the CRAF risk surrounding written control documents in the suggested new format.

ASSESSMENT AND ASSURANCE

Control documents are an essential component of the organization. They ensure compliance with laws and regulations, give guidance for decision making and streamline internal processes. All control documents must be properly implemented and monitored.

In August 2016 policy management was reviewed by Internal Audit. Overall, the management of policies was considered reasonable but the audit did identify, "a key issue relating to the number of out of date policies available on the UHB intranet which may put the UHB at risk of inappropriate processes being followed".

In November 2016 an audit of the UHB's written control documents was undertaken to assess how many were out of date and how long documents were past their review date. The audit was repeated earlier this month to assess the extent to which the situation had changed in light of steps taken in response to the Internal Audit findings. The results can be seen in the table below:

Written Control Documents	Nov 2016	Feb 2018
Total Number	**402**	**428**
In date	**214 (53%)**	**256 (60%)**
Out of date	**188 (47%)**	**172 (40%)**
Up to 2 years	90 (48%)	57 (33%)
2 – 4 years	22 (12%)	51 (30%)
4 – 6 years	23 (12%)	8 (5%)
6 – 8 years	22 (12%)	20 (12%)
8 – 10 years	16 (9%)	20 (12%)
Over 10 years	15 (8%)	16 (9%)

There has been a slight improvement in that the proportion of documents that are in date has risen since November 2016 by 7%. It must be noted, however, that the number of documents that are out of date has only reduced

by 16 in 14 months. It is clear that more action is needed to further reduce this number.

The Corporate Governance Department maintains the Register of Written Control Documents and therefore this risk sits with the Director of Corporate Governance. It should be noted however that responsibility for the updating of control documents sits with the Executive Leads that have ownership of them.

This is how the risk is currently captured on the CRAF.

8.2.3 **Principal Risk** Comply with relevant, up to date and accessible policies, procedures and other control documents								
Exec Lead	**Corp**	**Spec**	**Total**	**Controls**	**Assurance How does the Board know?**	**Gaps**	**Further Action**	**Lead Committee**
DoG	20	8.1.10 (12)	20	Up to date Policy in use within the UHB A generic EHIA was developed and approved for "Admin-type" Policies in Dec 2016. Staff training and awareness Intranet and internet access arrangements Information regarding review of database presented to Exec Leads Exec for their advice and oversight regarding theiron-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.	Revised Policy and Procedure approved at Board on 30.11.17. Committees review of out of date policies at least annually. Minutes received by Board Internal Audit of Policy Management undertaken in Aug 2016 provided reasonable assurance (2015/16) Satellite Dialysis Units - KPIs, All Wales KPIs being developed by Renal Network	40% of documents have exceeded their review date (in Feb 2018) Some shortfalls in internal processes and full implementation of policy Satellite Dialysis Units - differing practices	Refresh list of out of date documents and provide information to Exec Leads. Satellite Dialysis Units - Working group consisting of Directorate and satellite unit staff to develop protocols that all can implement. Renal Unit are considering KPIs but being developed on All Wales basis	Audit

As part of the review of the CRAF currently underway we are trying to ensure that risks are captured more accurately and clearly set out targeted actions to reduce the risk and achieve our target score. The Corporate Governance Department has carried out an updated risk assessment to achieve this which is captured below. This assesses the risk currently at a score of 16 and sets a target risk score of 12 to be achieved by February 2019. The Department will keep the risk under review, with the aim of even further reducing the level of risk to the organization.

As seen in the CRAF extract above, Specialist Services Clinical Board also has a risk around written control documents. The Corporate Governance Department is currently linking with them to clarify this risk. When this information is available it will further inform the overall risk assessment and determine the new CRAF entry.

Strategic Objective:
To reduce harm, waste and variation sustainably making best use of the resources available to us

Risk
If we do not address the number of expired written control documents in circulation then there may be reliance on documents that contain outdated information potentially resulting in harm, variation and non-compliance with accepted standards

	Service Interruption	Financial	Statutory Duty / Inspections	**Safety**	Adverse Publicity/ Reputation	Quality/Complaints/Audit
Main Risk Impact	1 Negligible	3 Moderate	3 Moderate	**4** Major	3 Moderate	3 Moderate

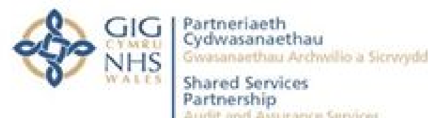
	Impact	**Likelihood**	**Score**	**Date**
Initial Risk Score	5	4	20	March 2014
Current Risk Score	4	4	16	February 2018
Target Risk Score	4	3	12	February 2019

Current Controls
- Up to date policy for the management of written control documents
- Central Register of Written Control Documents
- Alerts issued 6 months before documents expire
- Lead Executives regularly advised regarding their out of date documents

Further Actions	**Status**	**Progress**	**Lead**	**Completion**
Issue alert to control document authors 12 months before expiry with a further reminder at 6 months		Alerts issued at 6 months, to be extended to 12	Head of Governance	May 2018
Implement system to assess and respond to risk of lapsed control documents so that users are clear about document status		Communication prepared to send to document authors	Head of Governance	May 2018
Establish with Executive Leads that documents lapsed > 6 years can be removed		Lists compiled	Head of Governance	June 2018
Check documents available on intranet against central Register		Audit underway	Head of Governance	May 2018
Audit how areas access UHB control documents & check systems around managing area specific control documents		Contacting areas & formulating audit questions	Head of Governance	January 2019
Focused meetings with Executive Leads around stalled documents & to prioritize updating of highest risk documents		Meetings underway	Head of Governance	June 2018
Reinforce process/deadlines to Secretariats for approving Committees		Checklist drafted	Head of Governance	March 2018
Review tools available to assist areas in updating documents & how we provide updates on new/expired/removed documents		Not yet commenced	Head of Governance	July 2018

Suggested Key Performance Indicators

	Baseline (Nov '16)	**Current** (Feb '18)	**Target** (Feb '19)
• Number of in date written Control Documents	52%	59%	85%



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

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Cardiff and Vale University Health Board

UHB Core Financial Systems

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Opinion and key findings

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

Review reference: C&V-1718-10

Report status: Final Internal Audit Report
Fieldwork commencement: 14th November 2017
Fieldwork completion: 2nd February 2018
Draft report issued: 12th February 2018
Management response received: 12th February 2018
Final report issued: 13th February 2018

Auditor/s: Ian Virgill, Kimberley Rowe, Ross Hughes

Executive sign off: Bob Chadwick, Director of Finance

Distribution: Chris Lewis, Deputy Director of Finance

Richard Hurton, Assistant Finance Director

Alun Williams, Financial Services 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.

Disclaimer notice - Please note:

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

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

1. Introduction and Background

The review of the Core Financial Systems was completed in line with the 2017/18 Internal Audit plan for Cardiff and Vale University Health Board (UHB).

Given the high level of assurance that has been provided for the Core Financial reviews in previous years, this year's review focused on the General Ledger (GL) and Accounts Receivable (AR) systems. Other key areas of the financial systems will then be covered on a cyclical basis over future years.

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

2. Scope and Objectives

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

The purpose of the review was to establish if the Health Board has appropriate processes in place to ensure the effective management of the GL and AR systems.

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

General Ledger

- The Financial Control Procedure (FCP) is appropriate and up to date;
- Access to the financial system is appropriately administered;
- Relevant monthly reconciliations are appropriately completed and reviewed;
- Journals posted to the GL are appropriately authorised and supported with appropriate evidence; and
- Changes to the coding structure of the GL are appropriately administered.

Accounts Receivable

- The FCP is appropriate and up to date;
- There are appropriate, regular reconciliations between the GL and the debtor system;
- Income due is appropriately identified and invoices are accurately and promptly raised;
- Receipts are accounted for properly, promptly and in full;
- Outstanding debt is appropriately monitored and followed up; and
- Debt write-off is managed appropriately.

3. Associated Risks

The potential risks considered in this review were as follows:

- Incorrect date may be held on the GL; and
- Income due to the Health Board may not be received or properly accounted for.

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 within the UHB Core Financial Systems 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 review has identified that the controls in place for the management of the General Ledger and Accounts receivable systems are of a high standard and are being consistently applied in practice.

Appropriate and up to date FCPs are in place for both systems. Access to the general ledger is appropriately controlled with journals and changes to the chart of accounts effectively managed. The controls within the accounts receivable system ensure that invoices are appropriately raised, income is accurately recorded and debts are correctly managed.

The only minor issues identified during the review related to the appropriate completion of the accounts payable reconciliation and the timely authorisation of reconciliations.

5. Assurance Summary

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

Assurance Summary					
1	Incorrect Data may be held on the General Ledger				✓
2	Income due to the Health Board may not be Received or Properly Accounted for				✓

** 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 UHB Core Financial Systems.

Operation of System/Controls

The findings from the review have highlighted 1 issue that is classified as weakness in the operation of the designed system/control for UHB Core Financial Systems.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Incorrect data may be held on the General Ledger:

The following areas of good practice were identified:

- A financial Control Procedure is in place and all procedural guidance documents are up to date and reflect the current processes;
- Robust access controls are in place for the Cardiff and Vale Oracle system and appropriate processes are in place to ensure that users have their access removed after leaving the Health Board;
- All reconciliations sampled had been signed off as authorised;
- The sampled suspense accounts all had a nil balance for the 3 months sampled;
- All journals sampled were supported with backing documentation on request; and

- All of the sampled coding structure changes were made on a timely basis with a clear audit trail of the change.

The following significant findings were identified:

- The monthly reconciliation of accounts payable to the general ledger is not fully reconciled due to the exclusion of the 'SCAN' cost centre code.
- Reconciliations are not always authorised within an appropriate timescale following completion of the reconciliation.

Risk: Income due to the HB may not be received or properly accounted for.

The following good practice was identified:

- An up to date Financial Control Process Document is in place;
- All procedure guidance is up to date and reflects the current processes;
- A reconciliation between the General Ledger and Debtors system was appropriately completed and signed off as authorised for the 3 months reviewed;
- All sampled invoices had information that matched the transaction register and auto-invoice batch it was raised from;
- All sampled invoices were raised on a timely basis and against the correct financial code;
- All receipts sampled were accurately recorded to the correct invoice on the general ledger on a timely basis;
- All outstanding debts sampled had correctly followed the dunning process, with Oracle showing that reminder letters have been issued on a timely basis;
- All debts outstanding after the second reminder letter was issued were referred onto CCI with the exception of two debts due appropriate mitigating circumstances; and
- The sampled written off bad debts had all followed the correct Dunning Process, were subject to appropriate approval and were processed in a timely basis following request.

There were no significant findings 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**	**1**	**0**	**1**

Finding - ISS.1 - Reconciliation (Operating effectiveness)	**Risk**
A sample of 15 balance sheet codes (Five from months five, six and seven) were selected in total to ascertain if a sample of reconciliations had been completed. From the areas selected the following findings were made: • 3 of the 15 reconciliations sampled (all Accounts payable) did not reconcile due to the exclusion of the 'SCAN' cost centre code, this was written onto the reconciliation after the Trial Balance was completed. • 1 of the 3 accounts payables reconciliations was still not reconciled after the inclusion of the SCAN cost centre (month seven) with the outstanding value classed as unexplained. • 3 of the 15 reconciliations sampled were signed off over a month after the month end and are therefore classed as not signed off in a timely manner.	Incorrect data may be held on the general ledger
Recommendation	**Priority level**
Management should look to include the SCAN cost code into the original reconciliation calculation to ensure the reconciliation matches the figurers held within the Oracle financial ledger. Also that all monies are accounted for with no unexplained amounts outstanding. Management should ensure that all reconciliations are prepared and approved within a timely manner.	**Medium**

20.1

Management Response	Responsible Officer/ Deadline
The UHB will speak to NWSSP colleagues about the need to incorporate the reconciliation of the AP SCAN code into their monthly procedures. Up to this point the UHB has been picking the work up retrospectively in order to ensure that a full reconciliation is complete. While the unexplained amount is not significant (£53), the recommendation will be passed onto NWSSP colleagues to ensure future compliance. The UHB agrees with and accepts the recommendation in respect of ensuring that reconciliations are signed off on a timely basis.	Richard Hurton / March 31st 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.

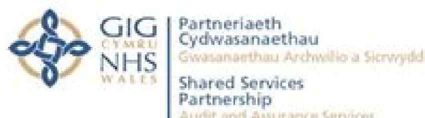
No assurance - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk**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



Action plan on WAO Audit of RKC Associates

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

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2. Scope and Objectives 3
3. Associated Risks 3

Opinion and key findings

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6. Summary of Audit Findings 5
7. Summary of Recommendations 6

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

Review reference:	C&V-1718-42
Report status:	Final Internal Audit Report
Fieldwork commencement:	January 2018
Fieldwork completion:	February 2018
Draft report issued:	14th February 2018
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Auditor/s:	Ian Virgill, Deputy Head of Internal Audit; Kimberley Rowe, Principal Internal Auditor
Executive sign off:	Peter Welsh, Director of Governance
Distribution:	Peter Welsh, Director of Governance Sian Rowlands, Head of Corporate Governance
Committee:	Audit Committee

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

Disclaimer notice - Please note:

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

1. Introduction and Background

Our review of the progress made against the Action Plan prepared to address issues raised in the Wales Audit Office (WAO) report on the contractual relationships with RKC Associates Limited and is owner was completed in line with the 2017/18 Internal Audit plan for Cardiff and Vale University Health Board (the UHB).

The UHB developed a comprehensive action plan following the WAO audit of the UHBs contractual relationships with RKC Associates Ltd and its Owner. This action plan has been developed to ensure necessary further improvements are made to avoid similar incidents occurring in the future.

The action plan was presented to the Board at its July 2017 meeting. It was subsequently presented to the Public Accounts Committee in September 2017 and a further update on implementation is required in April 2018.

Progression of the action plan is reported and monitored by the Audit Committee.

The relevant lead Executive Director for the review is the Director of Corporate Governance.

2. Scope and Objectives

The objective of our review was to evaluate and determine the adequacy of the systems and controls in place for reporting progression against the agreed actions, in order to provide assurance the Health Board's Audit Committee that risks material to the achievement of the systems objectives are managed appropriately.

The main purpose of our review was to establish if the reported improvements being made by the Health Board are occurring as stated to enable completion and closure of the agreed actions.

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

- The UHB has appropriate processes in pace to monitor and report on the progress towards the implementation of agreed actions;
- The reported level of progress against the planned actions is an accurate reflection of improvements implemented; and
- The agreed actions are being effectively implemented in line with planned timescales.

3. Associated Risks

The potential risks considered in this review are as follows:

- Identified actions may not be effectively implemented

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Action plan on WAO Audit of RKC Associates 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 process for monitoring and providing updates on the Action Plan in Response to the WAO Report in respect of C&V UHB's Contractual Relationships with RKC Associates Ltd and its Owner ('The Action Plan') is well managed by the Corporate Governance team.

The reported level of progress against the planned actions is predominantly an accurate reflection of improvements implemented and the audit only noted a few minor issues. The agreed actions are being effectively implemented, however, it has been identified that in part initial target completion dates were over ambitious and some actions have surpassed the planned timescales; despite this good progress has been made against remaining outstanding actions.

5. Assurance Summary

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

Assurance Summary					
1	Identified Actions may not be Effectively Implemented				✓

** 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 Action plan on WAO Audit of RKC Associates.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weakness in the operation of the designed system/control for Action plan on WAO Audit of RKC Associates.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

RISK: Identified actions may not be effectively implemented

The following areas of good practice have been noted:

- The Action Plan and its subsequent update report is kept as a live document and managed appropriately by the Head of Corporate Governance with frequent progress reports provided to Audit Committee;
- Audit conducted testing of a sample of eight actions with a status of 'complete', there was sufficient evidence to provide assurance that seven of these actions were reasonably complete and the progress update provided to audit committee is an accurate reflection of improvements implemented. Details of the one action deemed partially complete can be found in Appendix A of this report;
- Five of these actions were completed within the timescale initially indicated, with three surpassing this date.
- Audit conducted testing of a sample of four actions with a status of 'non/partially complete' and are satisfied that the commentary provided in update report was a reasonable reflection of actions undertaken.

- All of the planned completion dates of uncompleted actions have surpassed and were therefore not achieved, however, testing has concluded that three of these actions will be complete in time for closure of the action plan in March 2018.

The following significant issue was identified:

- Whilst progress has been made to implement the new 'No PO No Pay' Policy (Conclusion 1, Action 7), full implementation of this is not anticipated until summer of 2018 and therefore will not be complete in time for full closure of the Action Plan by March 2018.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding 1 - Deadlines for Non-Complete Actions (Operating effectiveness)	Risk
All of the planned completion dates of the four uncompleted actions tested have surpassed and were therefore not achieved, however, testing has concluded that three of these actions will be complete in time for closure of the action plan in March 2018. Whilst progress has been made to implement the new 'No PO No Pay' Policy (Conclusion 1, Action 7), full implementation of this is not anticipated until summer of 2018 and therefore will not be complete in time for full closure of the Action Plan by March 2018.	Identified actions may not be effectively implemented
Recommendation	**Priority level**
Action timescales should be reasonably considered and further updates to the audit committee should include achievable updated target completion dates.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accepted. We will continue to emphasise the importance of realistic timescales when assisting in the development of action plans. Action Update report for the February Audit Committee will contain this information.	Director of Corporate Governance February 2018

20.2

Finding - 2 - Complete Actions not fully supported (Operating effectiveness)	Risk
Testing of a sample of eight actions with a status of 'complete' was conducted to ensure there was sufficient evidence to provide assurance that actions were reasonably complete and the progress update provided to audit committee is an accurate reflection of improvements implemented. Conclusion 3, Action 1 was deemed to only be partially complete: • It is evident from the draft 'Employment Policies Sub Group' minutes that the Recruitment and Selection Policy has been discussed, particularly the executive recruitment processes as a result of the WAO report and the policy will cover all staff. However, this policy is still in draft and going through consultation, it is due to be approved by the EPSG in March 2018 with the intention of approval by the Resource and Delivery Committee in May 2018. Whilst the procedures have been 'reviewed' no changes will be formally made until May therefore this action is not fully complete.	Identified actions may not be effectively implemented
Recommendation	**Priority level**
Further updates to the audit committee should include Conclusion 3, Action 1 as not fully complete and commentary updated to reflect outstanding approval of the Recruitment and Selection policy by the Resource and Delivery Committee.	**Low**

20.2

Management Response	Responsible Officer/ Deadline
Accepted. Action Update report for the February Audit Committee will contain this information.	Director of Corporate Governance February 2018

Finding 3 - Complete Actions passed target date (Operating effectiveness)	Risk
Five of the eight 'complete' actions tested were completed within the timescale initially indicated, with three surpassing this date: • Conclusion 2 - Action 5 (Planned for Sept 17, completed Nov 17) • Conclusion 2 - Action 7 (Planned Oct 17, Completed Jan 18) • Conclusion 3 - Action 1 (Planned July 17, Not yet complete) The action plan was not updated to indicate that the actions had not been completed within the original planned timescales.	Identified actions may not be effectively implemented
Recommendation	**Priority level**
Action timescales should be reasonably considered and realistic and achievable target completion dates should be set. Where initial planned completion dates are not achieved then updated planned dates should be recorded on the action plan.	**Low**

20.2

Management Response	Responsible Officer/ Deadline
Accepted. We will continue to emphasise the importance of realistic timescales when assisting in the development of action plans. Action Updated action plan for the February Audit Committee, subsequent Board and Public Accounts Committee will contain this information.	Director of Corporate Governance February 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.

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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.

Primary, Community & Intermediate Care Clinical Board Locality Stock 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

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2.	CONCLUSION AND FINDINGS	4

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

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Review reference:	CUHB_1718_30
Report status:	Draft
Fieldwork commencement:	August 2017
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Draft report issued:	November 2017
Management response received:	29th November 2017
Final report issued:	1st December 2017
Auditor/s:	Jayne Gibbon

Executive sign off :	Steve Curry, Chief Operating Officer
Distribution:	Sue Morgan, Director of Operations
Committee:	Audit Committee

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

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1. EXECUTIVE SUMMARY

This follow up review of the stock management within locality premises operated by the Primary, Community & Intermediate Care (PCIC) Clinical Board has been completed in line with the Internal Audit Plan. The review seeks to provide the Health Board with assurance that agreed actions from the previous review of the PCIC Locality Stock Audit report issued in February 2017, had been implemented appropriately.

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

The risks considered in the previous review were as follows:

i. Stock is lost / damaged / stolen

ii. Too much stock is held resulting in unnecessary cost or wastage

iii. Insufficient stock causes delays to patient treatment

iv. Management is not aware of stock position.

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 recommendation is accepted. The Clinical Board is keen to have the same level of bar coding in primary and community care services as there is in the acute sector. (Finding 1, High Priority)
- Radyr, Lansdowne and Broad Street had previously undertaken work on better stock control processes and will be restarting this work soon. (Finding 1, High Priority)
- A group is being established to look at common themes / difficulties with the procurement process and also the feasibility of having bar code scanners across sites. The majority of stock is already on the system of bar coding and with District Nurse Admin posts being appointed to, the teams now have the staff resource to manage this. (Finding 1, High Priority)
- Stores / Procurement have been contacted requesting detail on provision of hand held bar code scanners. (Finding 1, High Priority)
- Management will develop guidance for staff. (Finding 2, High Priority)
- In house/team guidance will be provided to all DN teams on agreeing baseline levels of standard stock. It is noted that currently

teams carry out stock control by rule of thumb based on local knowledge of their teams/population needs. It was also noted that some Oracle orders only allow orders in larger that needed quantities. Suggestions from DN team leads have included a reporting system to go to teams monthly in order to see where they could utilise stock before ordering.(Finding 2, High Priority)

- Standing orders to be reviewed in relation to surplus stock held. (Finding 2, High Priority)
- Management will remind staff of the importance of securing stock cupboards. (Finding 3, Medium Priority)
- The space constraints currently experienced in Broad Street will be resolved when the teams relocate to Ty Jenner in January 2017. (Finding 3, Medium Priority)
- Lansdowne has locked rooms with coded door entry system and Radyr has locked door. Neither area is accessible to public. (Finding 3, Medium Priority)
- Other Community bases to be reviewed to consider identified recommendations. (Finding 3, Medium Priority)
- Stock rotation guidance will be added to the general stock control guidance developed for Recommendation 1. (Finding 4, Medium Priority)
- Guidance has been issued for returning Repose products to JES but will be circulated again. (Finding 4, Medium Priority)
- Medication should be returned to pharmacy by patients and should not be stored in bases. Guidance will be re-issued to staff. (Finding 4, Medium Priority)
- Staff are reminded at team meetings to review stock and bring forward older stock on shelving. As mentioned previously reporting system between DN teams may help reduce waste. (Finding 4, Medium Priority)
- It's proposed that DN admin role has specific time allocated to review stock balances and set up re-ordering systems. (Finding 4, Medium Priority)
- Dressing products are currently ordered via ONPOS and the value of each item and the total order value are listed when staff are placing these orders. (Finding 5, Medium Priority)
- The total spend each month on stock is listed on the monthly financial report from the finance team. This report is sent to each DN sister and senior nurse for sign off. Budget reports are explained and reviewed with the DN team leaders by their Senior

Nurses on a monthly basis. It has been discussed that drilling down into subjective line expenditure needs to take place and procurement reports generated from Oracle are to be discussed. Non stock orders are approved by management team. This information will be shared and discussed going forward. (Finding 5, Medium Priority)

- The introduction of a bar coding system as per recommendation 1 will address this recommendation. The provision of a bar code service would help manage the maintenance of sufficient stock levels. Currently CSSD attend clinical areas in secondary care to scan stock levels for wards and this service would be of benefit to all DN teams. However, it is doubtful whether this service would be offered across community sites but the allocation of scanners to the DN admin support, if possible, would greatly improve the situation. (Finding 6, Medium Priority)
- The management team in the Vale are looking at opportunities to improve the locations where teams are based to ensure they are fit for purpose. Barry DN team are moving to Ty Jenner in January 2017 which will free up space in Broad Street clinic. (Finding 7, Low Priority)
- Stock in Radyr and Lansdowne is kept in locked rooms with fire detection. Other community bases to be reviewed in line with recommendation. (Finding 7, Low Priority)
- New shelving system for Broad Street Clinic is being sourced. Shelving in place in both Radyr and Lansdowne and stock is put away on delivery in a timely fashion by nursing and admin team. (Finding 8, Low 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	Alternative Action/ no longer Applicable
HIGH	2	1	-	1
MEDIUM	4	3	-	1
LOW	2	2	-	-
TOTAL	**8**	**6**	**-**	**2**

The follow up review concluded that based upon discussions with relevant management and review of the evidence provided, good progress has been made.

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 PCIC Locality Stock has improved to **Reasonable Assurance**.

Following feedback on the findings from the original audit the individual localities undertook a number of actions to address many of the findings.

The management of the North Locality undertook their own audit of the DN teams in July 2017. The aim of the audit was to ensure that all stock was suitably stored, in date and where surplus stock was identified arrangements were made with Procurement to return the items. Going forward these audits will continue to take place on a periodic basis.

The Vale Locality also reviewed the storage facilities at all DN bases and reminders issued to staff regarding securing store cupboards at all times.

The South East locality held an internal meeting to discuss the findings of the original report and to agree on implementing the agreed management actions. The Locality also set up a Task and Finish Group to review stock at all the DN bases. Initial focus was on high cost stock. A proforma was developed that detailed, stock item, expiry date and cost and value of the stock. Each DN base was then visited and the proforma completed so that Management were able to understand the value of the stock held at each DN base. The group also reviewed the security arrangements for each of the DN bases.

All localities have taken action to remind staff on steps to take when ordering to avoid surplus staff and also to ensure that stock is rotated to avoid stock becoming out of date. Dedicated time has been allocated to staff within DN teams to address these issues.

It is also noted that the North West Locality has set up a spreadsheet that can be used to list surplus stock that is no longer required and in date, that could be used by another locality. The spreadsheet is located on the shared drive and can be accessed by all localities. The aim is that all localities view and update this spreadsheet before placing any orders and thus reducing wastage.

It is noted that for two of the findings identified in the original report, a review by management has determined that due to the costs involved of implementation of a stock system that it would not be beneficial to

proceed and as such feel it appropriate to manage the small risk associated with this on an ongoing basis.

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

- For each locality the Locality Managers have issued revised stock guidance to all District Nurse Teams. Guidance includes sections on rotating stock and also procedure to be followed for returning unwanted items.
- Management has undertaken a review of all community bases and reinforced to staff the importance of securing stock cupboards.
- Dedicated admin time has been identified within the DN teams to review stock levels and assist with stock ordering. The time is also utilised to ensure stock is rotated so that no stock becomes out of date.
- Monthly budgeted information is received from Finance. The information is sent to Locality Management as well as individual District Nurse Team Leaders. The financial information is reviewed and discussed at monthly management meetings and 1: 1 meetings between management and team leaders in all localities.
- Locality Managers have reviewed storage facilities at all bases to ensure they are fit for purpose and appropriate action has been undertaken such as purchase of new shelving.
- The storage issue at Broad Street Clinic within the Vale Locality has been resolved. The move of one of the DN teams to a new base at Ty Jenner has resulted in both teams now having sufficient and appropriate storage facilities.

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*

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WLI Payments 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

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1. EXECUTIVE SUMMARY 2
2. CONCLUSION AND FINDINGS 4

Appendix A Assurance opinion and action plan risk rating

Review reference:	CUHB1718.28
Report status:	Final
Fieldwork commencement:	13th November 2017
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Auditors: Ian Virgill, Stuart Bodman, Alexandra Wicks

Executive sign off : Steve Curry, Chief Operating Officer

Distribution: Steve Curry, Chief Operating Officer

Mike Bond, Director of Operations, Surgery Clinical Board

Paula Goode, Director of Operations, Specialist Services Clinical Board

Caroline Bird, Assistant Chief Operating Officer

Committee: Audit Committee

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1. EXECUTIVE SUMMARY

The follow-up review of Waiting List Initiative (WLI) Payments was completed in line with the Internal Audit Plan.

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

The original WLI Payments Internal Audit report was finalised in May 2017 and highlighted a total of 11 issues which resulted in an overall assurance rating of Limited Assurance.

The risk considered in the previous review was as follows:

- Unnecessary / inappropriate expenditure.

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

- Whilst there is a UHB wide protocol for the payment of staff undertaking additional sessions, circulated July 2013, it is acknowledged that this needs updating and developed into a UHB wide policy for approval and circulation. The UHB policy will cover planning, justification and authorisation of claims and, therefore, should negate the need for local procedures at a Directorate level (Finding 1 – High Priority);
- Payments to non-consultant staff will be paid in line with their working contract (Finding 2 – High Priority);
- All directorates will be reminded of the authorisation hierarchy and the need to ensure claims are appropriately authorised and in line with the revised UHB wide policy (Finding 3 – Medium Priority);
- Specialist Clinical Board - Each Friday the theatre schedule for the following week is circulated to the Directorate and Clinical Board, clearly identifying where additional sessions are planned due to vacancies or consultant leave. In addition, the Directorate have now established a database of planned additional sessions against which claim forms are cross referenced.
  Surgery Clinical Board - Each Directorate will maintain appropriate records of planned additional sessions. As part of RTT monitoring agreed additional paid activity will be monitored against agreed spend (Finding 4 – Medium Priority);
- The Cardiac Surgery Directorate have now established a database of planned WLI sessions against which claim forms are cross referenced

to ensure there is no duplication of claims before they are submitted to the Director of Operations for authorisation (Finding 5 – Medium Priority);

- Specialist Clinical Board -The Cardiac Surgery Directorate has now established a database of planned WLI sessions against which claim forms are cross referenced. The Service Manager will check all claims against patient activity recorded on TheatreMan/PMS and consultant job plans before they are submitted to the Director of Operations for authorisation.
  Surgery Clinical Board - The process for authorising and verifying claims will be revised so that it is in accordance with the revised UHB wide WLI policy (Finding 6 – Medium Priority);
- Cardiac Surgery Directorate - With regard to the identified claim for a WLI session which was a private patient list, there is a meeting arranged for April with the Clinical Director and Clinical Board Director and steps will be taken to recover the monies. (Finding 7 – Medium Priority)
- Specialist Clinical Board – As finding 6 above.
  Surgery Clinical Board - Additional RTT activity has been agreed for 17/18, which sets out the expected number of patients per additional session. This will form part of the weekly monitoring process of RTT activity (Finding 8 – Low Priority)
- Communication to directorates has been strengthened and a process in place to ensure information is circulated not only via email but verbally discussed as key Clinical Board meetings (Finding 9 – Low Priority)
- Directorates will be reminded of the importance of audit trails and the need to retain all relevant documentation relating to additional paid sessions. Directorate Managers to review processes to ensure robust audit trails are in place (Finding 10 – Low Priority); and
- Directorates will be reminded of the 90 day time frame for additional claims Directorate Managers to ensure that all staff are aware of the 90 day time frame for additional claims (Finding 11 – Low Priority).

2. CONCLUSION AND FINDINGS

In summary, progress against the eleven 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	2	1	1	-
MEDIUM	5	5	-	-
LOW	4	3	1	-
TOTAL	**11**	**9**	**2**	**-**

Testing was undertaken within the following Directorates to confirm compliance across the management responses cited;

- T&O Directorate
- Urology Directorate
- Cardiac Surgery
- Ophthalmology Directorate

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, satisfactory progress has been made whereby the majority of recommendations have been fully implemented.

However, there are two agreed management actions that have been partly implemented and require further progression 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 WLI Payments has improved to **Reasonable Assurance**.

Directorate Managers have put processes in place to address a number of the issues highlighted from the original review; and the management actions completed to date can be summarised as follows:

- Fixed WLI payment rates approved by the UHB are in place covering Consultant, junior grade medical staff and non-medical staff groups these are being accurately applied in line with their working contract on submitted claims for payment across the sampled Directorates (Findings 2 and 9 – Fully Actioned);
- Clinical Board management has formally reminded Directorates of the payment authorisation hierarchy and the need to ensure that

appropriate authorisation is applied accordingly to submitted claim forms (Finding 3 – Fully Actioned);

- The sampled Directorates have theatre schedules in place that identify the planned additional sessions to be worked and each has a database that facilitates monitoring of paid activity against agreed expenditure (Finding 4 – Fully Actioned);
- The sampled Directorates have a database that records WLI activity and on which the content of submitted claim forms are recorded and cross referenced to PMS/Theatreman and Consultant job plans prior to authorisation (Findings 5, 6, 7 and 8 – Fully Actioned);
- Investigation of the erroneous WLI payment identified that it actually related to an NHS patient on a clinical trial and had been incorrectly recorded as a private patient. Recovery of the monies paid was not therefore required (Finding 7 – Fully Actioned);
- Surgery Clinical Board has agreed its additional RTT activity for 2017/18 and this is subject to ongoing monitoring throughout the financial year (Finding 8 – Fully Actioned);
- The sampled Directorates have been reminded by Clinical Board management of the requirement to comply with the 90 day submission timescale and testing established this is being complied with (Finding 11 – Fully Actioned);

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

- The UHB has produced a WLI Payments Policy/Procedure and this has been disseminated to Directorates, but has yet to be finalised and approved by the organisation. Additionally, there are no local Directorate procedures in place for the management of WLI payments as they will work to the UHB Payments Policy/Procedure (Finding 1 – Partially Actioned).

  Management have provided an updated planned completion date for this action of June 2018.

- Testing identified that whilst Cardiac Surgery make the appropriate checks and accurately record and approve submitted claims, they do not retain copies of the fully authorised WLI Claim Forms as they are sent directly to Payroll. Therefore, at the present time a full audit trail does not currently exist and it is recommended that upon authorisation by the Clinical Board Director of Operations a copy should be taken and provided to Cardiac Surgery management for retention (Finding 10 – Partially Actioned).

2017/18 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.

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

20.5

Cardiff and Vale University Health Board

Residences

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

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

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Peter Cockburn, Head of Commercial Services

Committee: Audit Committee

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

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1. Introduction and Background

The review of Residences has been completed in line with the 2017/18 Internal Audit Plan.

The Health Board currently has approximately 200 rooms providing both long and short term accommodation for UHB staff, visiting staff and academics.

Accommodation at the University Hospital of Wales (UHW) consists of single study bedrooms within the Pembroke House and Carmarthen House tower blocks. At University Hospital Llandough (UHL), the Cwrt Llandough accommodation complex consists of single rooms, self-contained flats and family houses. These are provided via a partnership between the Health Board and Charter Housing. On call rooms are also available at the UHW and UHL sites.

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

2. Scope and Objectives

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

The purpose of the audit was to establish if residences are effectively managed across the Health Board in compliance with relevant legal and regulatory requirements and income is maximised.

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

- The Health Board has an appropriate plan/ strategy in place for the provision/ utilisation of residences;
- Appropriate processes are in place for the operational management of residence and these are documented and effectively communicate to relevant staff;
- Appropriate and up to date legal agreements are in place with all tenants;
- Residences comply with all relevant legal and regulatory requirements including Health & Safety and Fire regulations;
- Rental charges are appropriately set and all income due to the Health Board is identified in full and received from tenants in a timely and efficient way; and
- Appropriate performance reporting processes are in place on residences including occupancy rates and income levels. Periodic reports are submitted to appropriate management/ groups for review and required actions are taken.

3. Associated Risks

The potential risks considered in this review were as follows:

- Residences are not effectively provided, utilised or managed;
- Non-compliance with legal/ regulatory requirements;
- Loss of income; and
- Poor performance is not identified or addressed.

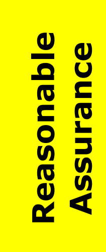
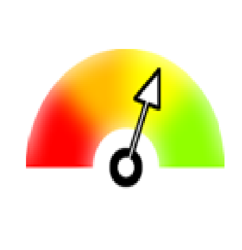
OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with establishment controls within the Residences is **Reasonable assurance**.

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

		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 review has identified that there are well-established processes in place for the day-to-day administration of residences. Current occupancy levels are high and the collection of rents and other income is effectively managed.

A number of issues were however identified as part of the audit. The Tenancy agreements currently being used are not fit for purpose and are also not being appropriately approved. The current pricing structure is overly complicated and has not been formalised. It was also noted that the Residences do not currently feature on the Estates and Capital risk register.

5. Assurance Summary

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

Assurance Summary					
1	Residences are not effectively provided, utilised or managed		✓		
2	Non-Compliance with legal / regulatory requirements			✓	
3	Loss of income				✓
4	Poor performance is not identified or addressed			✓	

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

Design of Systems/Controls

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

Operation of System/Controls

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

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

RISK: Residences are not effectively provided, utilised or managed

The following areas of good practice were noted:

- Utilisation of residences is currently high with the last reported rate for May 17 being 94.5%.

The following significant findings were identified:

- There is a complicated pricing structure in place for residences that varies if you are a student (free for F1s), UHB staff or patient relatives, dependent on the length of stay and what accommodation is chosen. This can also vary for long term residences that stay a set number of nights per week over the year. This pricing structure is not formalised;

- The management of residences is very manual and reliant on individual members of staff; despite this there are no standard operating procedures to encompass the daily operations undertaken; and
- There is no cancellation policy in place for the residences and deposits are not collected on reservation.

RISK: Non-Compliance with legal/ regulatory requirements

The following areas of good practice were noted:

- The Health board have received confirmation that they are exempt from the licensing associated with the Rent Smart Wales regulations.
- Residences are subject to appropriate statutory compliance assessments for areas such as fire safety, asbestos and legionella.

The following significant findings were noted:

- There is a tenancy agreement in place for residences, however this is not fit for purpose and has not been endorsed by the solicitors. There is no plan in place to improve this. Sample testing identified that the tenancy agreements in use are not being adequately managed; and

RISK: Loss of Income

The following areas of good practice were noted:

- All rental charges were justified to the informal pricing policy dependent on the length and classification of resident;
- Where rents were collected during the correct timescales, accurate amounts were also collected;
- Rents were accurately reported between the resident team, cashiers and finance to be accounted for and categorised between rent and bonds.

No significant findings were identified.

RISK: Poor performance is not identified or addressed

The following area of good practice was noted:

- A monthly dashboard performance report is prepared and reported to the Service Board. This includes details of occupancy rates and income, although the data is not consistently recorded every month.

The following significant finding has been identified:

- The UHB residences does not currently feature on the Capital & Estates risk register. There is therefore a lack of evidence to confirm that potential risks have been appropriately assessed and recorded.

Alongside the significant findings highlighted above, the review also identified a number of low priority findings which are detailed within the action plan at Appendix A. These issues are less significant and represent enhancements to the design or effectiveness of the current systems and controls.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**4**	**5**	**10**

Finding 1 - Tenancy Agreement (Operating effectiveness)	Risk
The historic tenancy agreement in place for residences, is not fit for purpose and had not been endorsed by the solicitors. The tenancy agreement works in conjunction with an information booklet/handbook, however this has no legal standing as it is not signed and there is no proof of receipt by the resident. A sample of 20 residences were selected to test tenancy agreements: • 3 residences were short term and therefore no tenancy agreement was expected; • 2/17 tenancy agreements were not able to be evidenced; 1 could not be found, 1 was not prepared due to just 2 months planned residence; • 3/15 tenancy agreements were not signed by the tenant; • 4/15 tenancy agreements were not signed by the Health Board; • All 11 tenancy agreements signed by the Health Board were not signed in accordance with the Scheme of Delegation which requires preparation by the Assistant Director of Planning - Capital and Estates and signature by the Director of Finance; and • 5/17 tenancy agreements contained outdated rental periods ending as far back as 2009. It is noted that a new tenancy agreement has recently been drafted and endorsed by the legal team. However this has not yet been implemented and does not therefore address the issues highlighted through the results of the current testing.	Non-Compliance with legal/ regulatory requirements

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Recommendation	Priority level
The new tenancy agreement should be finalised, approved and formally introduced as soon as possible. The UHB should then ensure that each long term resident has a new tenancy agreement in place that covers the rental period and is signed by both parties; the resident and an appropriate UHB delegate.	**High**
Management Response	**Responsible Officer/ Deadline**
Implementation of new tenancy agreement.	Peter Cockburn / 1St March 2018
Long term tenancy agreement to be reviewed every six months.	Damien Winston / 1st March 2018
Delegated manager under scheme of delegation to sign each tenancy agreement and verify signoff by resident.	Damien Winston / 1st March 2018

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Finding 2 - Pricing Structure (Control design)	Risk
There is a complicated pricing structure in place for residences that varies if you are a student (free for F1s), UHB staff or patient relative, dependent on the length of stay and what accommodation is chosen. This can also vary for long term residences that stay a set number of nights per week over the year. This pricing structure is not formalised.	Residences are not effectively provided, utilised or managed
Recommendation	**Priority level**
The UHB should prepare, approve and implement a formal pricing structure.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The pricing structure is currently under review to simplify.	Peter Cockburn / 1st March 2018

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Finding 3 - Standard Operating Procedures (Operating effectiveness)	Risk
The management of residences is very manual and reliant on individual members of staff, despite this there are no standard operating procedures to encompass the daily operations undertaken. It is noted that there is an SOP in place for the Hotel Perfect software system but this does not provide any detail on the specific operations undertaken as part of the Health Board's processes.	Residences are not effectively provided, utilised or managed.
Recommendation	**Priority level**
The UHB should prepare Standard Operating Procedures to cover all administration tasks relating to residences.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Daily standard operating procedures is being further developed and cross cover by administration staff are being implemented to build in further resilience.	Damian Winstone / 1st April 2018

20.5

Finding 4 - Risk Register (Operating effectiveness)	Risk
The UHB residences does not currently feature on the Capital & Estates risk register. There is therefore a lack of evidence to confirm that potential risks have been appropriately assessed and recorded. The potential risks would include a number of the issues identified within this report such as the historic tenancy agreements and legal / regulatory requirements.	Poor performance is not identified or addressed.
Recommendation	**Priority level**
The UHB should consider and document any risks relating to the provision of residences.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Risk Register for Residences to be developed. Estate compliance is already addressed as part of the wider UHB Estate Compliance Programme and risk register already identified and included on departmental and Service Board Register.	D Winstone / 1st March 2018

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Finding 5 –Cancellation Policy / Collection of Bonds (Control design)	Risk
There is currently no cancellation policy in place, therefore residences can be booked and cancelled last minute without penalty due to no deposits being collected on reservation. It is noted that bonds are collected for residences staying for a month or more. However, this is not always collected for overseas visitors due to the time it takes to return on departure. From sample testing of an expected 17 bonds to be collected, 3 were not collected and in addition 2 were collected at the incorrect amount. The 3 bonds not collected were for varying reasons: • Resident 1 was due to an agency being responsible for payment and overdue (as per finding 11); • Resident 2 was not collected as during check-in there was not a clear length of tenancy, however, the resident has stayed over the 1 month period; • Resident 3 was not collected due to the resident being an overseas visitor.	Residences are not effectively provided, utilised or managed
Recommendation	**Priority level**
The UHB should prepare, approve and implement a cancellation policy; this should include collection of bonds in advance for long term residences.	**Medium**

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Management Response	Responsible Officer/ Deadline
The priority will be focussed on the appropriate collection of bonds which will require immediate attention. Consideration of a suitable cancellation policy will be investigated to ensure the correct balance between short term occupancy and long term residences.	Peter Cockburn / 1st April 2018

Finding 6 - Plans/Strategies (Control design)	Risk
There are no specific documented plans or strategies in place in relation to the provision or utilisation of residences. The Head of Commercial Services has mentioned that accommodation issues are undergoing an options process to consider refurbishment investment or re-build, subject to funding.	Residences are not effectively provided, utilised or managed
Recommendation	**Priority level**
The UHB should document future plans for the provision and utilisation of residences.	**Low**
Management Response	**Responsible Officer/ Deadline**
The UHB is currently embarking on a significant master planning exercise for the UHB site and an estate rationalisation programme across the UHB. The provision of accommodation will be considered as part of this exercise. This process will likely take in excess of 12 to 18 months. Progress will be reported as part of the overall master planning exercise.	Damian Winstone

20.5

Finding 7 - Monthly Stats (Operating effectiveness)	Risk
A monthly stats report on overall occupancy rates and income is prepared and reported to the Service Board as part of the Commercial Services Dashboard. However, review of the dashboard submitted to the January Service Board meeting identified that the monthly residences income figures have not been completed since May 17. The % occupancy rates are also inconsistently reported with no figures included for August, September or December 2017.	Poor performance is not identified or addressed
Recommendation	**Priority level**
The UHB should ensure that all figures within the Commercial Services dashboard are consistently reported every month.	**Low**
Management Response	**Responsible Officer/ Deadline**
Dashboards to be updated via hotel perfect (accommodation database) on a monthly basis.	Damian Winstone / 1st March 2018

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Finding 8 - Hotel Perfect Drawbacks (Control design)	Risk
The UHB are now using a system called Hotel Perfect, which is designed for Hotels, whilst this is fit for purpose for the majority of functions required, it has its drawbacks: • You cannot make a booking for more than 100 days and therefore any long term tenants need to be 'checked out' and 'checked in' manually every quarter; and • A tenant cannot be checked in retrospectively on the system over 24 hours after the event, any bookings not checked in are automatically changed to 'no shows' and the debt is cleared. This causes problems for residences checking in on a Saturday, also when the admin officer is on leave as despite leaving comprehensive instructions the last time, no tenants were checked in/out on the system.	Residences are not effectively provided, utilised or managed
Recommendation	**Priority level**
The UHB should discuss these drawbacks with the Hotel Perfect System owners and implement processes to resolve them.	**Low**
Management Response	**Responsible Officer/ Deadline**
Hotel Perfect are working with the Health Board to address any issues with the database.	

20.5

Finding 9 - Rent Collection (Operating effectiveness)	Risk
Sample testing of an expected 16 collection of rents, 3 were in arrears: • Resident 1 was in arrears due to agency being invoiced who are yet to pay. At time of testing this was 2 months in arrears • Resident 2 was £270 in arrears; this resident has a history of paying odd amounts to the cashiers and pays the balance eventually. • Resident 3's rent was not collected via payroll. This was on the admin officers list of rents to collect instruction to payroll, however, a payroll error meant this was not added to the payroll run.	Loss of income
Recommendation	**Priority level**
The UHB should ensure all rents are paid in full within the agreed timescales. If an agency is paying the rent this should be agreed and communicated prior to the resident check-in.	**Low**
Management Response	**Responsible Officer/ Deadline**
The process and management for the collection of rents will be addressed with immediate effect.	D Winstone / Immediately

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Finding 10 - Charter Housing Void Rent (Operating effectiveness)	Risk
The management of residences available on the University Hospital of Llandough site is managed by Charter Housing, however, the Health board residences team hold the waiting list for rooms in Llandough Court and are responsible for ensuring the rooms are fully occupied once they are informed of vacancies. The Health board are then subsequently charged for any rooms that remain vacant as 'void rent'. There was an incident recently when CH did not inform the Health board that 3 rooms were about to become empty due to lack of management by new CH staff and it was too last minute to engage the waiting list, thus resulting in void rent charges.	Loss of Income
Recommendation	**Priority level**
The UHB should refer to the PFI contract/SLA to consider whether expectant vacant rooms must be communicated by Charter Housing to the Health Board within a certain timescale if void rents are to become chargeable.	**Low**
Management Response	**Responsible Officer/ Deadline**
Currently being reviewed by PFI Manager.	Jan Phelan / 1st April

20.5

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.

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

20.6

Cardiff and Vale University Health Board

Surgery Clinical Board - Anaesthetist Rota Management

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

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

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	Tony Turley, Assistant Medical Director
	Sian Crowley, Directorate Manager
Committee:	Audit Committee

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1. Introduction and Background

The review of anaesthetist rota management within the Surgery Clinical Board was completed in line with the 2017/18 Internal Audit Plan for Cardiff and Vale University Health Board.

All National Health Service organisations rely on a level of temporary 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 staff via a flexible, efficient and robust rota management 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 Surgery Clinical Board for the management of anaesthetist rotas, 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 is to establish if anaesthetic staff rotas are effectively planned and managed and the use of bank and agency staff is appropriately assessed and utilised.

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

- Anaesthetist rotas are drawn up via the CLWRota system 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 anaesthetic staff against demand and usage is appropriate and authorised; and
- All bank and agency shifts are effectively verified and authorised prior to payment.

3. Associated Risks

The potential risks considered in this review are as follows:

- 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 level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Anaesthetists Rota Management is **Reasonable Assurance**.

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

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

The CLWRota system provides an efficient and effective method for managing, communicating and co-ordinating the Health Board's Anaesthetists rotas. The messaging service enables accurate adjustments to the rotas at short notice which is essential to ensure that planned theatre time does not need to be cancelled. The anaesthetist job plans are built into the CLWRota system which reduces administrative time in completing the anaesthetist rotas. Any changes to the system are in real-time and as such the system is always up to date.

At the time of our review the Health Board did not have Standard operating procedure notes in place for the administration of the CLWRota system. This represents a risk to the effective on-going administration of the CLWRota system in the event of prolonged absence or changes to key personnel.

5. Assurance Summary

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

Assurance Summary					
1	Patient care is compromised due to inappropriate ward staffing levels and / skill mix;			✓	
2	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 have highlighted 1 issue that is classified as weakness in the system control/design for Anaesthetist Rota Management.

Operation of System/Controls

The findings from the review have highlighted no issues that are classified as weakness in the operation of the designed system/control for Anaesthetist Rota Management.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Risk 1: Patient care is compromised due to inappropriate ward staffing levels and /or skill mix.

The following areas of good practice were noted:

- Anaesthetists have a 2-week work plan and this template is included on CLWRota for all anaesthetists which facilitates the management of Anaesthetist Rotas.
- Anaesthetists are expected to give a minimum 6 week notice before any planned leave (i.e. Annual/Professional/Study) is approved – with some exceptional circumstances to this rule. This ensures that rotas can be completed 6 weeks in advance.

- Theatre sessions are split between morning sessions and afternoon sessions, which ensures, where possible, anesthetists are able to take a rest break.
- CLWRota includes a messaging system so the rota management administrators are able to send sms's or e-mails to all available anaesthetists where there is a gap that needs to be filled.
- CLWRota 'blocks' anaesthetists that are not available to work the sessions which ensures that the session cannot be inappropriately filled.
- Testing carried out on a sample of anaesthetists confirmed that they had correctly worked their allocated and contracted sessions during the sampled periods.

The following significant finding was noted:

- There are currently no Standard Operating Procedure notes in place for the administration of the CLWRota system.

Risk 2: Financial loss due to unnecessary usage and/or incorrect payment of bank and agency nursing

The following areas of good practice were noted:

- We were informed that the Health Board does not use bank or agency anaesthetist staff. The Health Board uses Locum anaesthetists, however these are substantive post Locums. Review of the financial ledger for the period under review confirmed that there were no Agency Staff costs.

We did not identify any significant findings under 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	**1**	**0**	**0**	**1**

Finding - ISS.1 - Rota Management Procedure Notes (Control design)	Risk
There are no Standard Operating Procedure (SOP) notes in place for the CLWRota system detailing how to carry out processes such as entering an anaesthetists template work plan onto CLW Rota, making changes to a template or informing Payroll/Workforce of all leave taken. The lack of an SOP could impact the management of the anaesthetist rotas if there are any prolonged absences within the team responsible for administering the system. At the time of the review, there were only three members of staff responsible for managing the CLWRota system. It is noted that the Health Board does have a Standard Operating Procedure in place for the 'Session Cancellation and Reutilisation Meeting' (SCRUM) which details the procedure around the cancellation and reutilisation of theatre sessions. However, review of the SOP identified that it does not make any reference to the processes in respect of the day to day administration of the CLWRota system.	Anaesthetist Rotas are not appropriately managed resulting in cancelled theatre sessions and potential deteriorations of patients' health.
Recommendation	**Priority level**
Standard Operating Procedure notes covering the administration of the CLW rota system should be developed and made available to all relevant staff.	High

20.6

Management Response	Responsible Officer/ Deadline
It is accepted by the Directorate that there is no written SOP for staff, although all three rota masters currently in post have been formally and comprehensively trained by the CLWRota team to carry out processes within the system. The CLWRota team provide remote and on-site support as requested/required. The rota masters are overseen by the Clinical Director and Deputy Clinical Directors who are also rota masters. There is a workflow chart for writing a weekly rota currently in place. Work has already commenced in developing a SOP and it is envisaged will be completed within the next few weeks.	Deputy Clinical Director/Anaesthetic Services Manager

20.6

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

Reference Number: UHB 069 **Version Number: 2**	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** T202

Safety Notices and Important Documents Management Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will develop and describe effective arrangements to ensure relevant actions are taken by individuals in response to any safety or governance information received by the UHB.

Procedures and other written control documents translate these principles into more detailed instructions or guidance including individual responsibilities.

Policy Commitment

Our Policy will ensure there is a consistent approach to the dissemination of Safety Notices and Important Documents.

This will assist staff to identify their roles and responsibilities and to ensure appropriate actions are taken with regard to Safety Notices and Important Documents.

In addition, we will have a robust audit trail providing evidence of compliance and action taken.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedures describe the following with regard to managing Safety Notices and Important Documents:

- The types of Safety Notices and Important Documents
- The arrangements for receipt, management and action required
- The role of the Liaison Officer

Other supporting documents are:
Records Management Policy
Records Retention and Destruction Protocol

Scope

This policy applies to all of our staff in all locations including those with honorary contracts.

Equality and Health Impact Assessment	The Policy relies on the generic Equality and Health Impact Assessment undertaken for Administrative-Type Policies.

Document Title: *Insert document title*	2 of 2	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Health System Management Board
Accountable Executive or Clinical Board Director	Director of Corporate Governance
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	Quality Safety and Experience Committee 9 August 2011		This was a revised document brought up to date from the former Trust
2	Quality Safety and Experience Committee		The document was reformatted and split into a policy and separate procedures and updated to reflect changes in structure and titles. The former Policy/Procedure is already embedded and there is no change to the UHB's commitment.

November 2017

22

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Fee Scheme 2018-19

This is a fee scheme prepared by the Wales Audit Office under section 24 of the Public Audit (Wales) Act 2013.

This fee scheme is laid before the National Assembly under section 24(4)(c) of the Public Audit (Wales) Act 2013.

Mae’r ddogfen hon hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Huw Vaughan Thomas
Auditor General for Wales

Isobel Garner
Chair, Wales Audit Office

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Fee Scheme

Introduction

1 This Fee Scheme has been prepared by the Wales Audit Office under section 24 of the Public Audit (Wales) Act 2013 (the Act) (Appendix 1). The Fee Scheme, following approval by the National Assembly's Finance Committee, provides the basis on which the Wales Audit Office charges fees.

2 The Board has listened carefully to stakeholder feedback in relation to our cost-efficiency agenda and the fee rates we set. In seeking the National Assembly's support for our Estimate for 2018-19, we proposed in the Estimate:

- A small (less than 1%) increase in fee rates to be offset by reductions in audit days and skills mix in order to deliver reductions in the median fee scales for most audited bodies. In real terms this represents a reduction of 5.6% since our rates were set in 2014-15.
- To continue in line with previous National Assembly agreement to fund National Fraud Initiative (NFI) work from our charge on the Welsh Consolidated Fund rather than through fees charged to participating bodies. Feedback told us that audited bodies welcome this approach.
- To design our performance audit work at Local Government and Health bodies to concurrently discharge the requirements of the Well-being of Future Generations (Wales) Act 2015 so as not to increase the overall amount of performance audit work required.
- To charge a fee for this work for Central Government bodies from April 2018; this fee to be discussed in advance with those bodies.
- To continue to provide public sector secondment opportunities for our accounting trainees, without impacting on fees charged for audit work.
- To maintain capacity for transformational thinking in our approaches to audit work. Feedback reinforced the need for us to do more developmental work as part of balancing the overall cost of audit on public bodies.

3 This Fee Scheme reflects the approved Estimate and in broad terms sets out:

- The enactments under which the Wales Audit Office charges audit fees.
- The arrangements for setting those fees, which comprise either:
  - fee scales that set out fee ranges for particular areas of audit work in local government; or
  - fee rates for work not covered by fee scales.

List of enactments

4 Appendix 2 sets out the enactments under which the Wales Audit Office may and must charge fees.

Fee rates and fee scales

5 Broadly, 68% of our expenditure is funded through fees charged to audited bodies. The remaining 32% is provided directly from the Welsh Consolidated Fund through vote of the National Assembly. Further information about our expenditure and funding is contained in annual estimates of income and expenditure which are laid before the National Assembly.

6 The Wales Audit Office does not generate profits on fees. Legislation requires that the fees we charge may not exceed the full cost of exercising the function to which the fee relates. Our fee rates are set at a level to recover that full cost.

7 There is a tension between providing audited bodies with an up-front fee for the work to be undertaken on specific audits and having a sufficiently flexible regime that recognises the inevitability of variances. We set our audit fees based on our estimated expenditure, the estimated skills mix and the estimated number of days required to complete the work. Where the required work is significantly greater than that originally estimated, as a result of complexities experienced during the audit, we may charge a higher fee, as permitted by legislation.

8 During 2017-18 we consulted widely on legislation governing the fee regime in Wales which is more complex than in other parts of the UK and creates inefficiency and additional cost for the public sector in Wales. The outcome of this consultation has been submitted to the Finance Committee and we await their response.

9 We went beyond the statutory fee consultation requirements and, in August 2017, consulted all audited bodies and other stakeholders on our fee scales and fee rates for 2018-19. We received responses from across the sectors we audit. Those responses told us that:

- Audited bodies value free participation in the National Fraud Initiative. Our Estimate includes provision for its continuation.
- There was concern from central government bodies about the need for us to charge for work under the Wellbeing of Future Generations Act. The Regulatory Impact Assessment of the legislation included evidence from us in relation to potential audit costs so we encourage those bodies to discuss further with their sponsoring departments.
- Audited bodies acknowledge the real terms reduction in our fee rates since 2014-15 but pointed to the significant reductions in their own funding due to austerity. As a result of audit efficiencies, our Fee Scheme reduces the median fee scales despite the proposed increase in hourly rates.

10 The Board welcomed the feedback and responds to it through this Fee Scheme and our Estimate.

11 Exhibit 1 sets out the hourly fee rates for audit staff .

Exhibit 1 – Fee rates for audit staff

Grade	Proposed fee rate (£ per hour) 2018-19	Current fee rate (£ per hour) since 2014-15
Engagement director	159	162
Audit manager	112	111
Performance audit lead	93	93
Financial audit team leader	76	75
Performance auditor	66	65
Financial auditor	57	56
Graduate trainee	44	43

12 We are required to prescribe fee scales for:

- work relating to the audit of local government bodies;
- work under the Local Government (Wales) Measure 2009; and
- data-matching work (NFI).

13 Fee scales for the audit of 2017-18 financial accounts and 2018-19 improvement audits and assessments are provided in Appendix 3 in relation to work conducted at unitary authorities, fire and rescue authorities, national park authorities, police and crime commissioners and chief constables, town and community councils and local government pension funds. A separate fee scale is provided in relation to the NFI.

14 Fee scales are a means of regulating the cost of public audit, through setting limits and by reviewing fees against those limits. Fee scales also provide a framework for auditors to assess the amount of annual audit work necessary and the fee to be charged for that work at a particular audited body.

15 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 the fee rates published in this Fee Scheme to the estimated team mix and hours of input required for the audit.

16 Auditors undertake grant certification work 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 calculated using the fee rates and reflecting the size, complexity or any particular issues in respect of the grant in question.

17 The fee rates apply to all audit work that the Wales Audit Office will charge for, except to the extent that the fee scales, where applicable, regulate the amount to be charged (or in the case of work done by agreements prior to 1 April 2014, rates are in terms as agreed). If it subsequently appears to the Wales Audit Office that the work involved in a particular audit differs substantially from that originally envisaged, the Wales Audit Office may charge a fee which differs from that originally notified.

18 In the case of the provision of other administrative, professional or technical services provided, fees will be charged in accordance with the relevant agreement, subject to such amounts being capped at the full cost of providing the service. To meet their statutory responsibilities, it is sometimes necessary for auditors to carry out work which goes beyond their general duties. Additional work can include reports in the public interest, extraordinary audit, special inspections and further work in relation to electors' questions and objections, and the prevention of unlawful expenditure. Charges for this type of work will reflect the nature of the work required.

19 Where specialist support or legal or other professional advice is required, this will be charged to audited bodies in addition to the cost of Wales Audit Office staff.

The Well-being of Future Generations (Wales) Act 2015

20 The Well-being of Future Generations Act requires specified public bodies to set and publish well-being objectives, take steps to meet those objectives and report annually on their progress. It also requires the Auditor General to carry out examinations into the extent to which those public bodies set objectives and take steps to meet them in accordance with the sustainable development principle.

21 During 2017-18, we are working with audited bodies named in the Act and the Future Generations Commissioner for Wales as we develop and test audit approaches to fulfil the Auditor General's duty under the Act.

22 For Local Government and Health bodies we will be designing our performance audit work to concurrently discharge the requirements of the Well-being of Future Generations (Wales) Act 2015 so as not to increase the overall amount of performance audit work required.

23 For Central Government bodies, we will however need to charge fees for this additional WFG work. As highlighted in our Fee Scheme for 2017-18, 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. Engagement directors will discuss the work required and associated fees with individual bodies as appropriate.

Charging of fees

24 Each body's Engagement Director will explain that body's skills' mix for the audit and the factors influencing the overall fee. Charging arrangements are agreed with audited bodies and may encompass one-off, periodic, regular or annual charging, as appropriate in the circumstances.

25 Audited bodies are expected to pay the Wales Audit Office's invoices within their performance target for creditor payments, usually 10 days in the public sector. We may charge for the administrative costs incurred in pursuing late payments.

26 On completion of audit assignments, we will assess the actual costs incurred in undertaking the assignment in comparison with the fee charged. 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.

Appendix 1 – Public Audit (Wales) Act 2013 – full text of section 24

(1) The Wales Audit Office must prepare a scheme relating to the charging of fees by the Wales Audit Office.

(2) The scheme must include the following:

- a a list of the enactments under which the Wales Audit Office may charge a fee;
- b here those enactments make provision for the Wales Audit Office to prescribe a scale or scales of fees, that scale or those scales;
- c where those enactments make provision for the Wales Audit Office to prescribe an amount to be charged, that amount; and
- d where no provision is made for a scale or scales of fees or for an amount to be prescribed, the means by which the Wales Audit Office is to calculate the fee.

(3) The scheme may, amongst other things:

- a include different provision for different cases or classes of case; and
- b provide for times at which, and the manner in which, payments are to be made.

(4) The Wales Audit Office:

- a must review the scheme at least once in every calendar year;
- b may revise or remake the scheme at any time; and
- c must lay the scheme (and any revision to it) before the National Assembly.

(5) Where the Welsh Ministers prescribe a scale or scales of fees under:

- a section 64F of the Public Audit (Wales) Act 2004 (fees for data matching); or
- b section 27A of the Local Government (Wales) Measure 2009 (Welsh Ministers' power to prescribe a scale of fees)

to have effect instead of a scale or scales prescribed by the Wales Audit Office, the Wales Audit Office must revise the scheme to include the scale or scales prescribed by the Welsh Ministers instead of those prescribed by the Wales Audit Office.

(6) If a revision made in accordance with subsection (5) is the only revision to a scheme, it does not require the approval of the National Assembly.

(7) The scheme takes effect when approved by the National Assembly or, in the case of a revision made in accordance with subsection (5), once it has been laid before the National Assembly.

(8) The Wales Audit Office must publish the scheme (and any revision to it) as soon as reasonably practicable after it takes effect.

22

Appendix 2 – List of enactments under which the Wales Audit Office may and must charge fees

Nature of work	Enactments
The Wales Audit Office may charge fees for the following activities	
• Audit of accounts by the Auditor General (other than local government accounts).	• Section 23(2) Public Audit (Wales) Act 2013
• Value for money studies undertaken by agreement.	• Section 23(3)(a)-(c) Public Audit (Wales) Act 2013
• An examination, certification or report under section 31 of the Tax Collection and Management (Wales) Act 2016 in respect of the Welsh Revenue Authority's Tax Statement.	• Section 23(3)(ba) Public Audit (Wales) Act 2013
• An examination under section 15 of the Well-being of Future Generations (Wales) Act 2015 (anaw 2) (examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle).	• Section 23(3)(ca) Public Audit (Wales) Act 2013
• Any functions of a relevant authority exercised by the Wales Audit Office or the Auditor General and undertaken by agreement, and any administrative, professional or technical services to be provided by the Wales Audit Office or the Auditor General by arrangement under section 19 of the Public Audit (Wales) Act 2013.	• Section 23(3)(d) Public Audit (Wales) Act 2013
• An extraordinary audit of the accounts of a local government body.	• Section 37(8) of the Public Audit (Wales) Act 2004
• Data-matching exercises.	• Section 64F(A1) of the Public Audit (Wales) Act 2004 • A fee scale must be prescribed for this work
• Advice and assistance provided by the Auditor General for registered social landlords.	• Section 145D(2) of the Government of Wales Act 1998
The Wales Audit Office must charge fees for the following activities	
• Work under the Local Government (Wales) Measure 2009.	• Section 27 of the Local Government (Wales) Measure 2009 • A fee scale must be prescribed for this work

Nature of work	Enactments
• Grant certification services.	• Section 23(4)(a) Public Audit (Wales) Act 2013
• Studies at the request of educational bodies under section 145B of the Government of Wales Act 1998.	• Section 23(4)(b) Public Audit (Wales) Act 2013
• Auditing the accounts of a local government body and undertaking studies by agreement with a local government body.	• Section 20(A1)(a)-(b) of the Public Audit (Wales) Act 2004 • A fee scale must be prescribed for the audit of the accounts of local government bodies
• Benefit administration studies for the Secretary of State. The Auditor General may conduct, or assist the Secretary of State in conducting, a benefit administration study only if the Secretary of State has made arrangements for the payment to the Wales Audit Office of a fee in respect of the study. The amount of the fee must be a reasonable amount agreed between the Secretary of State and the Wales Audit Office.	• Section 45 of the Public Audit (Wales) Act 2004
• Assisting Her Majesty's Chief Inspector of Education and Training in Wales with inspections of local authorities. The Auditor General for Wales shall not provide such assistance unless, before he does so, the Chief Inspector has agreed to pay the Wales Audit Office a fee.	• Section 41A of the Education Act 1997
• Programmes of studies relating to registered social landlords undertaken by agreement between the Welsh Ministers and the Auditor General. It shall be a term of every such programme that the Welsh Ministers must pay to the Wales Audit Office a sum in respect of the costs incurred.	• Section 145C(3) of the Government of Wales Act 1998

Appendix 3 – Fee scales for work undertaken at local government bodies

Unitary authorities

Fee scale for audit of 2017-18 accounts

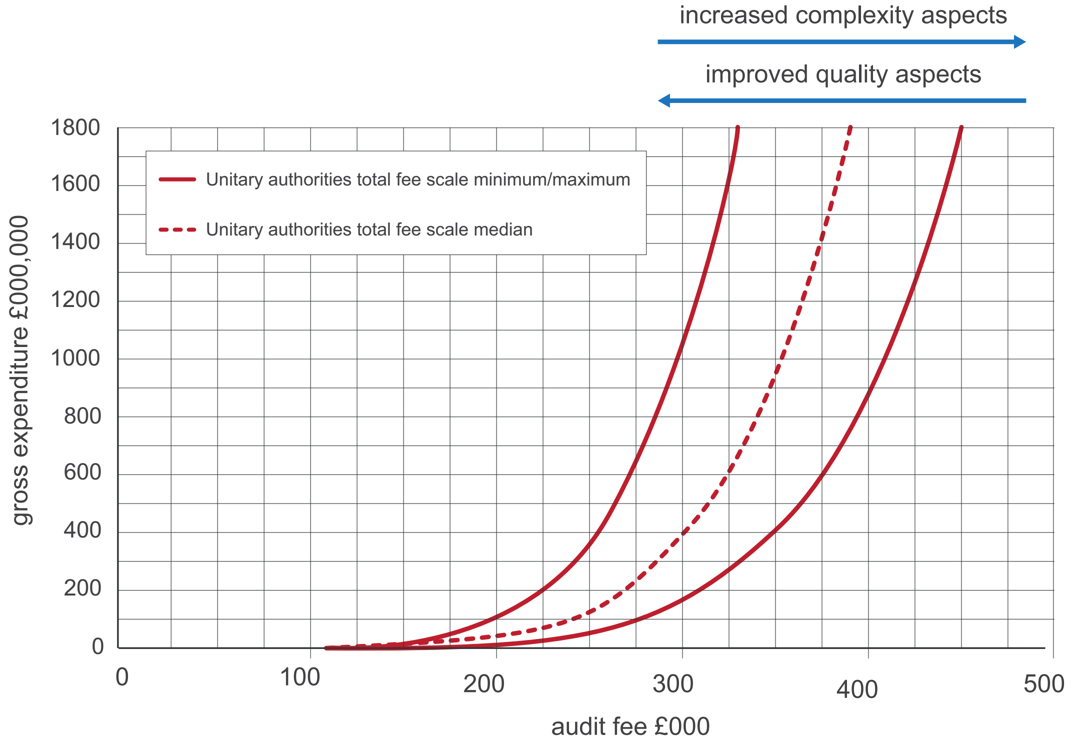
Gross expenditure £000,000	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
100	117	138	158	139
200	141	166	191	167
300	157	185	212	186
400	169	199	229	201
500	180	211	243	213
600	189	222	255	224
700	197	231	266	233
800	204	240	276	242
900	210	247	284	249
1,000	216	254	292	256
1,100	222	261	300	263
1,200	227	267	307	269

22

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

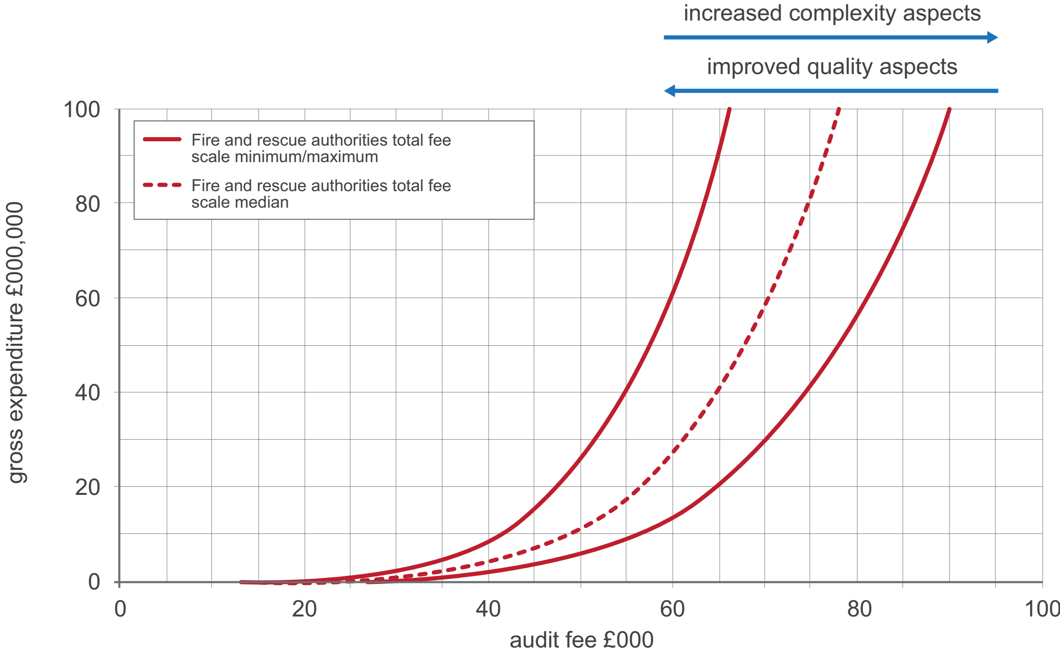
Gross expenditure £000,000	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
20	34	40	46	41
40	41	49	56	49
60	46	54	62	55
80	50	58	67	59
100	53	62	71	63

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

22

Graphic of audit total fee scale for fire and rescue authorities



National park authorities

Fee scale for audit of 2017-18 accounts

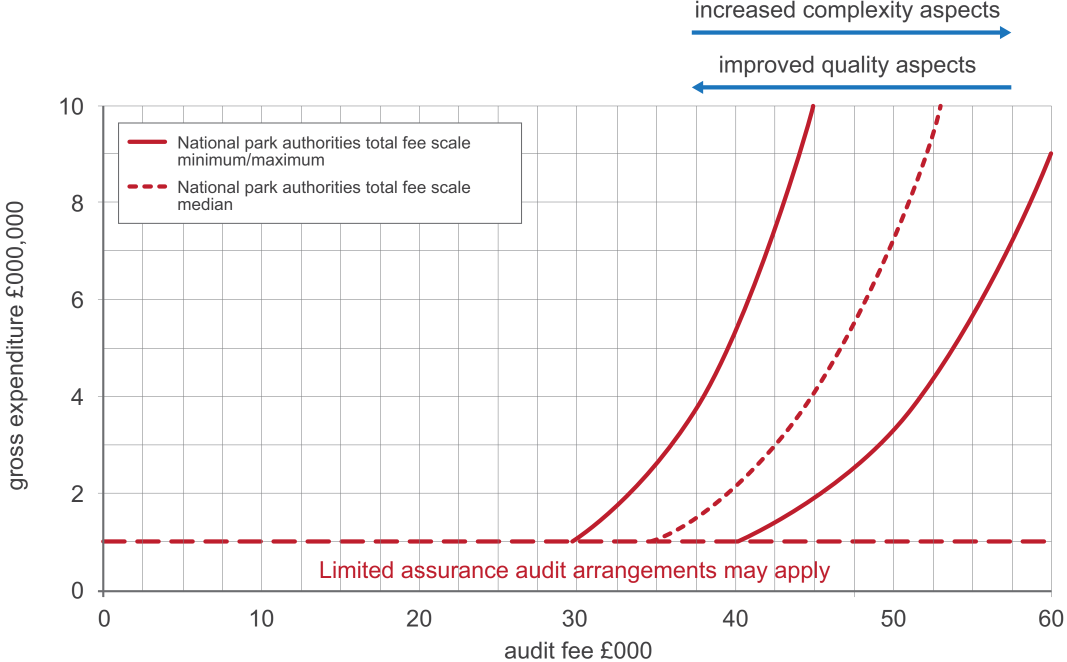
Gross expenditure £000,000	Fee range £000			Previous year median £000
	Minimum	Median	Maximum	
2	21	25	29	25
4	26	30	35	30
6	29	34	39	34
8	31	36	42	37
10	33	38	44	39

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.

Graphic of total fee scale for national park authorities



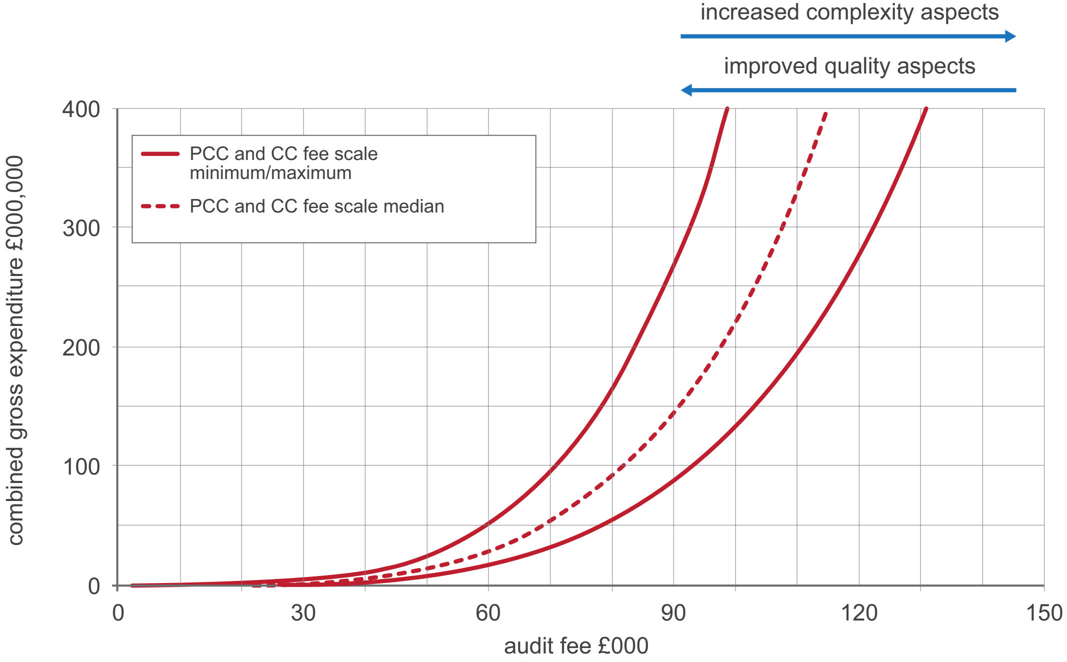
Police and crime commissioners and chief constables

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.

Fee scale for audit of 2017-18 accounts

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 1.

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 as shown above, there are a small number of other types of local government body where our prescription of the fee scale is a matter of converting the resource requirements into fees directly based on the costs of delivering the work or by applying the fee rates as set out in Exhibit 1. It remains the case that for audits of these bodies we apply a zero-based approach to audit planning.

For all types of local government body to meet his 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.

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

Fee scales for work undertaken under the National Fraud Initiative (data matching)

In order to support Welsh public bodies in combating fraud, the Auditor General conducts the National Fraud Initiative (NFI) in Wales on a biennial basis. The NFI is also run in England, Scotland and Northern Ireland. 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.

The Auditor General conducts the NFI using his statutory data-matching powers under Part 3A of the Public Audit (Wales) Act 2004.

Since April 2016, 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, so ensuring that voluntary participants are not charged a fee for participation. As required by legislation, the fees for mandatory participants are shown below.

Exhibit 2 – 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
All participants may also be provided with access to the NFI Application Checker (App Check).	Nil

Mandatory participants will also be provided with access to the NFI Application Checker without charge.

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