AUDIT COMMITTEE

31 MAY 2018, 8.30AM

Llandough Hospital, Boardroom, Llandough

AUDIT COMMITTEE

Thursday, 31 May 2018
8.30am – 11.00am
Llandough Hospital, Board Room, Llandough

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 held on 24 April 2018	*Chair*
5.		Action log following meeting held on 24 April 2018	*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: AUDIT AND COUNTERFRAUD			
7.	*10 mins*	Internal Audit Position Report and Updates: **Assignment** — **Assurance Rating** 1. Consultant Job Planning — Limited 2. Continuing Healthcare Follow-up — Limited **Please see part 2 agenda item 9 for full copies of audit reports*	*Head of Internal Audit*
8.	*5 mins*	Report of the Losses and Special Payments Panel	*Director of Finance*
PART 2: ITEMS FOR INFORMATION:			
9.		Internal Audit reports for information: **Assignment** — **Assurance Rating** 1. Integrated Medium Term Plan — Reasonable 2. Health and Care Standards — Reasonable 3. Emergency Unit 12 hour Target — Reasonable 4. Business Continuity Follow-up — Reasonable 5. Mortality Reviews — Reasonable 6. Rookwood Relocation Capital Scheme — Reasonable	*Head of Internal Audit*

		7. Neonatal Capital Scheme Reasonable	
REVIEW AND FINAL CLOSURE			
17.		Items to be deferred to Board / Committee	*Oral Chair*
18.		To note the date, time and venue of the next Committee meeting: **Tuesday, 25 September 2018 at 9.00am, Corporate Meeting Room, Headquarters, UHW**	

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

UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE
HELD ON 24 APRIL 2018
IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

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Present:

John Antoniazzi	Independent Member – Audit Chair
John Union	Independent Member - Finance
Dawn Ward	Independent Member – Trade Union

In Attendance:

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
John Herniman	Wales Audit Office
Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance
Robert Chadwick	Director of Finance
Tom Haslam	Wales Audit Office
Glynis Mulford	**Secretariat**

Apologies:

Mark Jones	Wales Audit Office

AC: 17/116 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone present to the meeting. Tom Haslam, Wales Audit Office introduced himself to the Committee and was greeted on attending his first meeting.

AC: 17/117 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 17/118 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings.

AC: 17/119 UNCONFIRMED MINUTES OF THE MEETING HELD ON 27 FEBRUARY 2018

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 27 February 2018.

AC: 17/120 ACTION LOG FROM MEETING OF 27 FEBRUARY 2018

The Committee **RECEIVED** the Action Log from the meeting of 27 February 2018 and **NOTED** the following:

AC 17/092 – Wales Audit Office Committee Update (District Nursing Services) - Mrs Carol Evans informed the Committee that the PCIC Clinical Board's Director of Nursing had completed a baseline assessment. The Executive Nurse Director will be taking the assessment to the Management Executive meeting. A copy had been sent to the Audit Committee Chair and a copy will be forwarded to the Director of Corporate Governance. **COMPLETE**

AC 17/073 – Wales Audit Office Review of Progress Update – Management of Follow-up Outpatients - The Chief Operating Officer presented a report to the Quality, Safety and Experience Committee (QSE). As the Committee was not fully assured a further report will be brought later on in the year. This item will continue to be monitored by QSE. **COMPLETE**

AC 17/072: Wales Audit Office GP Out of Hours Services - This item will be taken to the QSE Committee agenda setting meeting for further consideration. **COMPLETE**

15/008 – Business Continuity Planning – A follow up has been undertaken and will be brought to next Committee meeting. **COMPLETE**

AC: 17/121 INTERNAL AUDIT PROGRESS REPORT

The Chair raised concerns around setbacks with internal audit reports not being finalised in a timely manner by Clinical Boards and their departments. The Director of Corporate Governance stated that bi-monthly reports were presented to the Management Executive meeting and a timescale was agreed by the Executives and if necessary raised at operational level. The Committee was informed that at the forthcoming Board Development session, Simon Cookson would be talking to members on the importance and role of the Internal Audit service.

The Head of Internal Audit, gave an update on the Progress Report. The following was highlighted:

- In regard to assignments with delayed delivery, some reports had taken longer than anticipated to be process. This had been discussed with executives and was working with the organisation on the importance of getting reports through the system.
- Regarding outcomes from completed audit reviews, there had been six overall with positive outcomes, four were reasonable and one was limited.

- The two reasonable reports, Model Ward and IT Server Virtualisation, had a few recommendations to be followed up on.
- The Delivery of the Audit Plan 2018/19 highlighted that a few reports remained outstanding for completion. These were scheduled to come to main meeting in May. In addition, two limited reports were also expected to come forward to next meeting.
- The Internal Audits focused on areas of risk and it was recognised with 40 audits per year, it would be anticipated to have a small number of limited reports. This would not have an impact on the overall opinion, which will be reasonable. It was important for the Health Board to take action quickly on these.
- It was further explained if the outcome of a limited follow up report remained limited, this was due to actions not been followed up appropriately. Once it had been to the Audit Committee these had to be reported to Welsh Government. This was another level of escalation which could give further assurance to the Committee.
- An Annual Report and Opinion was being prepared to come to the following meeting. The different assurance domains in the Plan still allowed the Organisation a reasonable assurance.
- The Director of Corporate Governance stated that the Deloittes Financial Governance Review had substantial assurance which followed on from WAO and the information submitted to the Public Accounts Committee (PAC). The PAC were pleased with assurance and progress made on the report.

Deprivation of Liberties Safeguarding – Limited Assurance: An initial review of compliance with DoLs report was conducted in March 2016. A follow-up assessment of the report identified that it still sat at the end of assurance rating which remained limited. It was acknowledged that there had been progress with a couple of actions. There were four management actions that needed to be completed from the original review. Two actions were completed, one partially actioned and one had not been actioned which related around DoLs outstanding assessments. The number of assessments had increased but also the time to complete assessments had grown. It was recognized that in raising DoLs awareness there were more assessments to be completed. There was one new issue identified which was in delay with sign off at executive level. There have been a number of discussions with the Medical Director and additional information had been received. A further follow-up will be conducted in the 2018/19 plan.

Dr Graham Shortland, Medical Director stated in terms of training figures, this had been brought to every Mental Health Capacity and Legislation Committee (MHCLC) where it was acknowledged that training numbers were not sufficient. They had looked at ways of raising awareness by inviting Clinical Boards to present their strategy in regard to the Mental Capacity Act, which influences heavily the ability to deliver DoLs. Members were informed that it was encouraging to see the increase in number of referrals. The Cheshire West ruling had hit Health Boards across Wales significantly and had seen signing of DoLs assessments increase from one or two per

week nearly 600 per year. Awareness has been raised in terms of DoLs process and this had presented to Board. In terms of number of requests this had also increased.

Every three months meeting had been arranged to meet with Cardiff Council and the Vale Council. Fifty per cent of assessments completed across the LHBs were between 29 days and six months and realized this was too long. It was widely recognized there was a problem in Wales with regard to DoLs assessment. There was a need to have a process by which the managing authority for DoLs is seen as the Clinical Boards and the sign off by executives. A paper had been taken to Management Executives meeting in regard to this.

It was explained that in addition to the management response, there were figures available for staff training and will take forward to MHCLC. There were regular three monthly meetings with Cardiff Council and the Vale Council where plans for training are put in place. There was the ability to convince both councils that our urgent applications were most important. In December 2017, 25% of Cardiff Council assessments had been completed, the Vale Council completed 14% and the Health Board completed 61%. This demonstrated that the HB was doing significantly better than our local authority partners.

The Committee was assured that it would continue with training and the programme of education. It was recognized this area needed a high degree of senior assurance with regard to sign off. It was being considered for each Clinical Board to act as an independent function. For example, the Medicine Clinical Board could be a managing authority and the Mental Health Clinical Board would sign and authorize the assessments.

It was discussed and noted:
In response to the expected increases for future it was stated that we know there is a risk in terms of quality for patients and recording that they are deprived of liberty so appropriate care can take place but there is also a financial risk to this organisation. There had been an increase of 20% last year and anticipated 12% growth this year, although it was suggested this would flatten off, it was anticipated there would be continued growth in the requirement for this statutory function.

From the HIW report 2016/17 it was identified that Cardiff and Vale had a high percentage of authorization and out of 100 applications, 60 had been authorized. It was recognized that the authorization process and best interest assessment takes up the resource. Work will be undertaken looking at our thresholds for authorization. It was anticipated the numbers would plateau out and with the aforementioned in place, would see some improvement.

The report would be followed up in 6 months times. It was asked that in the next discussion we reflect the 50% of assessments completed across LHBs and would appreciate a conversation on what would be considered reasonable performance to take place with the Medical Director and internal audit for presentation to the Audit Committee in the follow-up report.

The Committee:

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

AC: 17/122 WALES AUDIT OFFICE INFORMATICS SYSTEMS IN NHS

Mr John Herniman, Wales Audit Office highlighted the key issues of the report which was a national study. This was to see if locally there could be learning gained and was presented at Committee for information. The recommendations were mainly directed at Welsh Government and other NHS bodies. The report will go forward to the Information and Governance sub-Committee to see if there is anything to be addressed. The report had been critical of national informatics in relation to effective and efficient patient care. The report looked at arrangements which identified weaknesses and delays on priority projects. The recommendations had been accepted and the report forwarded to the Public Accounts Committee who will have a further evidence session and the outcome from this will be a further report.

The report was commended by the Chair and stated this was vital to improve systems and reduce cost. There was wider discussion on local implementation and different ways of working.

The Committee:

- **NOTED** the report

AC: 17/123 WALES AUDIT OFFICE – AUDIT COMMITTEE AGENDA

The Committee **RECEIVED** and **NOTED** the above report from Wales Audit Office, who informed Members the report raised no significant issues on the Health Board accounts.

AC: 17/124 TRACKING REPORT ON WALES AUDIT OFFICE RECOMMENDATIONS

Mr Peter Welsh, Director of Corporate Governance presented the final update of the Management Response to the Committee. This will be changed in-year and were in discussions with the all Wales Board Secretaries as it was recognized the tool could be improved and look at best practice.

The Committee:

- **NOTED** the report

AC: 17/125 AUDIT ENQUIRIES TO THOSE CHARGED WITH GOVERNANCE AND MANAGEMENT

The Committee **REVIEWED** the draft response to the Wales Audit Office Enquiries and **APPROVED** its submission to the Wales Audit Office, subject to any agreed changes made by the Audit Committee and any further comments received from the Chief Executive and Chair.

AC: 17/126 INTERNAL AUDIT PLAN 2018/19

Mr James Johns, Head of Internal Audit, informed the Committee on how the work would be delivered and the strategic approach taken of the Internal Audit Plan and Charter. It was explained how the plan is developed, structured and the approach was described in relation to Public Sector Audit Standards.

In regard to improvements being made, the Head of Internal Audit stated that at times follow-up audits did fluctuate. Follow-up information was brought to the Committee and if it produced a limited assurance rating, a more detailed report would be presented. It was emphasized to the Organisation, the appropriateness of working together when issues are identified and for them to come through in a timely manner. It was stated that it should be reinforced how the organisation engages and works with Internal Audit in a timely and effective way of delivering the reports.

The Committee:

- **APPROVED** the Internal Audit Plan including the Strategy and Charter for 2018/19

AC: 17/127 HANDOVER OF CARE AT EMERGENCY DEPARTMENTS – WELSH AMBULANCE SERVICE TRUST INTERNAL AUDIT REPORT

Mr Peter Welsh, Director of Corporate Governance, presented the report and informed the Committee that all Health Boards had been asked for it to be presented for noting at each Audit Committee. This was also discussed at the all Wales Chairs meeting. There were implications for providers and there should be a collective view on management response. The report would for forward to the QSE Committee for monitoring and scrutiny.

ACTION: Report to go forward to QSE Committee

AC: 17/128 ITEMS FOR INFORMATION

Items for Information were **NOTED.**

AC: 17/129 REVIEW OF MEETING

There were no items to be reviewed.

AC: 16/130 URGENT BUSINESS

There was no urgent business.

AC: 16/131 DATE OF NEXT MEETING

The next Audit Committee and Workshop meeting is scheduled to take place at **9.00m** on **Tuesday, 22 May 2018** in the Corporate Meeting Room, Headquarters, UHW

AUDIT COMMITTEE – ACTION LOG FOLLOWING APRIL 2018 MEETING

MINUTE	DATE OF MEETING	SUBJECT	AGREED ACTION	ACTION TO	STATUS	
					OUTSTANDING	DATE FOR COMPLETION
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS						
COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)						
AC 17/092	27.02.18	WAO – Committee Update	To inform Committee how District Nursing Services in Wales is being processed internally for Health Board	C Evans		**COMPLETE**
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	**COMPLETE**
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	**COMPLETE**
AC 15/008	26.09.17	Business Continuity Planning	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 and P Welsh	The rationale 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	**COMPLETE**

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					them on BCP actions. IA have subsequently raised where it would be possible to undertake work in Q4 as originally planned.	

INTERNAL AUDIT	
Audit Committee	**May 2018**

Executive Lead : Director of Corporate Governance
Author : Head of Internal Audit, NWSSP Audit & Assurance Service, ext.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

RECOMMENDATION

The Audit Committee is asked to:

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

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.

The progress report highlights the conclusion and assurance ratings for audits finalised in that period. Nine audit reports have been finalised, seven with Reasonable Assurance and two audit reports have been issued with a Limited Assurance rating.

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

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

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. The report also provides, information regarding the areas requiring improvement, assigned assurance ratings.

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee May 2018

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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.

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 Audit Committee but have not met that deadline.

Audits planned for Audit Committee but not finalised			
Costing	Draft	Reasonable Assurance	Delay with the delivery of work within audit, due to rescheduling of other work during the year. Draft report issued 10th May, awaiting management responses.
RTT Performance Reporting Data Quality (inc. Cancer Targets)	Draft	Reasonable Assurance	Audit added to plan during the year. Work then had to be scheduled in alongside already planned reviews. Draft report issued 23rd April, awaiting management responses.
Shaping Future Wellbeing Capital Scheme	wip	----------	Delay with the delivery of work within audit.

3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

3.1 Nine audit 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 Assurance are reported in Section five. The two reports with Limited Assurance ratings are included as a full version of the report at Appendix B.

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FINALISED AUDIT REPORT	ASSURANCE RATING	
Integrated Medium Term Plan (IMTP)	Reasonable	
Health and Care Standards		
Emergency Unit 12 hour Target		
Business Continuity Follow up		
Mortality Reviews		
Rookwood Relocation Capital Scheme		
Neo Natal Capital Scheme		
Consultants Job Planning	Limited	
Continuing Healthcare Follow up		

4. DELIVERY OF INTERNAL AUDIT PLAN

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

In addition to the audit reports noted above, there are three audits still to be finalised. Two of the remaining audits, RTT Data Quality

(inc. Cancer) and Costing, have reached draft report stage and both of these having reasonable assurance ratings.

The final audit, to be completed as part of the plan, Shaping Future Wellbeing Capital Scheme, is still currently being delivered. The audit assignment schedule at Appendix A gives specific details as to the status of the planned and completed work.

There is no impact on the opinion of the remaining work and the assurance ratings form the two draft reports are included win the opinion.

4.2 Audit Outcomes – From the reviews finalised for this committee there are two reports with a Limited Assurance rating. This brings the total audits issued with a Limited Assurance rating for 2017/18 to six.

5. FINAL REPORT SUMMARIES

The report summaries below highlight the conclusion including the key findings from each of the audit reports which have been given a Reasonable Assurance rating. There are amongst the reports a small number of high priority recommendations which are important areas for management to address to improve the internal control environment.

There was one high priority recommendation within the Mortality Reviews Audit, two within the Cost Control Section of the Neo Natal Development Capital Scheme Audit and one action within the Business Continuity Follow up audit which hadn't been fully actioned since the original review.

5.1 Integrated Medium Term Plan (IMTP)

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Strategic Planning/IMTP is **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 Health Board had appropriate processes in place to ensure that its draft IMTP 2018-21 was produced in the required format and to the stipulated timescales for submission to Welsh Government.

The UHB objectives are detailed within the Shaping Our Future Wellbeing Strategy 2015-2025 and these were referenced within the UHB draft IMTP and also the three Clinical Board IMTPs that were reviewed. The Planning Department have assisted the Clinical Boards in producing their IMTPs and have also produced a template for them to utilise to develop their IMTPs.

The Clinical Boards have processes in place for producing their IMTPs; PCIC has development sessions whilst Surgery and Children & Women Clinical Boards have meetings to discuss and the individual Directorates produce IMTPs which feed into the Clinical Board IMTPs.

There were Project Opportunity Documents (PODs) produced by the Surgery and PCIC Clinical Boards and there was an audit trail between them and the Clinical Board IMTPs. The Children & Women Clinical Board did not have PODs as they have received funding from the South Wales Plan.

The Ophthalmology Directorate did not produce an IMTP in line with all the other Directorates within the Surgery Clinical Board.

The Strategy Development and Delivery Group is responsible for the production of the UHB's IMTP. The terms of reference for the Group have not been reviewed since August 2015 and it was not always quorate for the meetings reviewed.

As stated, the review has identified that the Health Board had robust processes in place for producing and submitting its draft IMTP 2018-21. However, at the time of reporting, a final IMTP had not been submitted to Welsh Government due to the need to complete further work on the financial and performance aspects of the plan. The overall assurance rating for the review therefore reflects the Health Board's current position.

5.2 Health and Care Standards

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Health and Care Standards is **Reasonable** assurance.

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

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

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

Review of a sample of the 12 aligned standards has confirmed that the agendas of the respective Groups / Committees are appropriately set up to reflect the criteria dictated in the Standards to which they are aligned.

Good initial progress has been made towards the completion of self-assessments of the Health Board's performance against the Standards for 2017/18.

The Health Board has an appropriate timetable in place for the finalisation and sign-off of the 2017/18 self-assessments and subsequent reporting of the outcomes to the Quality, Safety and Experience Committee. Due to the planned timescale for the production of the self-assessments and final report, they could not be reviewed as part of this audit. It is therefore noted that the Health Board will need to ensure that the actions are effectively completed as planned.

It is recommended that the Health Board continues with its plans for aligning the remaining 10 Standards over the next 2 years and further develops the operation of the identified Groups and Committees so that all of the 22 Standards are fully embedded across the organisation and performance against them is continually monitored.

5.3 Emergency Unit 12 Hour Target

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Emergency Unit 12 Hour Target 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 review noted good practice within the Clinical Board via the standardised approach to applying stop clocks and the availability of guidance to front line staff. Substantive testing undertaken as part of the

review has confirmed that the majority of stop clocks are being applied in accordance with the Welsh Government and Health Board guidance.

The Emergency Medicine Directorate has also introduced an effective process for internal review of the application of stop clocks. It is however noted that the governance oversight of this process would be further improved if the results were reported to an appropriate group.

The review also identified a further issue in relation to the application of specific stop clocks.

There were no high priority findings noted within this report.

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5.4 Business Continuity Planning Follow up

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

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

Meetings were held with the Head of Emergency Preparedness, Resilience and Response (EPRR) and a sample of three Clinical Boards: Surgery, Mental Health (MH) and Primary Community and Intermediate Care (PCIC); to gather an update on progress against the management responses cited.

The follow up review concluded that, based upon these discussions and review of the evidence provided, steps have been taken to improve BCP within the Health Board. However, despite this progress and due to the infancy of the guidance, the Business Continuity Plans are yet to be fully developed and documented and are therefore not completely embedded throughout the Health Board.

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 BCP has increased to **Reasonable Assurance**.

It is however noted that, despite this improved assurance, further work is still required to ensure that consistent documented Business Continuity Plans are in place across the whole Health Board. Progress against the outstanding actions will continue to be monitored as part of the regular, on-going follow-up process.

5.5 Mortality Reviews

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

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

The audit identified that the Health Board has appropriate processes in place to enable the completion of Level 1 and Level 2 mortality reviews. Completed reviews are subject to review, moderation and reporting to respective Quality and Safety Groups by the investigating clinicians.

Mortality information is regularly reported at Directorate, Clinical Board and Health Board level and monthly returns are provided to Welsh Government accordingly.

However, two key findings were identified that require management attention and action, namely; improvements to the Universal Mortality Review form to clarify the criteria to trigger a Level 2 review and the need to introduce and implement central processes to record and collate Level 2 reviews and their outcomes which would complete the mortality review cycle.

5.6 Rookwood Relocation capital Scheme

General compliance was noted with the established control frameworks in each of the objective areas sampled, particularly in relation to project governance.
However, at the time of the current review, clarity was required regarding the chosen procurement strategy for the project which will feed into the finalisation of the business case process [both approval within the UHB and Welsh Government].

At the current review we noted:

- the target cost was yet to be affirmed and there was slippage in the delivery programme, noting the target cost assessment was initially scheduled to be completed in November / December 2017 and subsequently deferred until April 2018; and
- additional costs had been incurred (estimated as £964,994 at the time of the current review), arising from the as a result of the withdrawal of the previous Designed for Life: Building for Wales supply chain partner.
-

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

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

5.7 UHW Neo Natal Development Capital Scheme

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the University Hospital of Wales Neo Natal Development is **Reasonable Assurance**. Six areas were covered within the audit and it was the cost control element where the high priority findings were identified.

The primary reasons for this level of assurance are:

- The evidence that the control and reporting systems operated by the UHB project management team and its advisers were appropriate for the current stage of the project.
- However, it was also reported that there were on-going risks that could still affect the programme for the MRI New Build and the Obstetrics 2 phases.
- Since completion of our fieldwork, the level of cost risk presented by the MRI New Build had been reduced following the agreement of the Target Cost for the base build (March 2018). We noted the current position with respect to the MRI design and costing process and the resultant reduction in the available contingency sum but still presents a significant cost pressure.

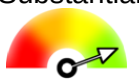
RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control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

Assignment Status Schedule 2017/18 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.	FINAL	Reasonable 	May
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		Q3/4	To provide assurance that the actions are progressing as planned with evidence available.	Final	Substantial 	Feb

Regulatory compliance- HTA action plan	COO		Q3/4	To provide assurance that the actions are progressing as planned with evidence available.	Final	Substantial 	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. FINAL May 18.	Reasonable 	May
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 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. FINAL	Reasonable 	Apr

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. FINAL	Limited 	May
DATA quality – EU 12 hour	Public Health			To be added As per CEO request.	Field work substantially complete. Exit meeting to take place. FINAL	Reasonable 	May
Data Quality – RTT	COO			Data Quality	draft	Reasonable	
Data Quality Cancers targets	COO			Data Quality	draft	reasonable	
Strategic Planning/IMTP	Director of Planning	Q4	Q4	Review on going delivery and monitoring of the plans.	FINAL	Reasonable 	May
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.		Sept
Deloitte action plan	Corporate Governance		Q4	Review progress with the implementations of agreed actions.	Final	Substantial 	Apr
Cost Improvement Programme	Director of Finance	Q3	Q3	Review the development and delivery of the improvement plans.	Audit deferred as scope overlapped with WAO coverage.	n/a	-----
Costing	Director of Finance	Q3	Q3	Scope as per work agreed at all wales costing group.	Assignment Brief agreed. Draft May 2018.	Reasonable	
WLI follow up	COO	Q2-3	Q3	Follow up on 16/17 report.	FINAL		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
Clinical governance quality & safety							
Annual Quality Statement	Director Nursing	Q1	Q1	Review content of AQS.	FINAL		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. FINAL	Limited 	April
Serious Incidents Management	Nursing	Q2/3	Q2	Review Incident Closures	FINAL	Reasonable 	Dec
Mortality Reviews	Medical	Q1-2	Q3	Review Process and actions taken.	Planning – brief prepared. Start delayed. Medical Director requested end of October for fieldwork commencement. Field work currently underway. FINAL 16/5/18	Reasonable 	may
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. All Reasonable or Substantial.	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
Virtulisation	Director of Therapies	Q3	Q3	Review the security and resilience of the updated virtualised environment.	Final.	Reasonable 	April
Cyber Security	Director of Therapies	Q2/3	n/a		Review deferred at request of UHB.	n/a	n/a.
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 21/11.	*Limited* 	Dec
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		Feb.

					anaesthetists' rotas as per discussions with COO. Delays in obtaining key information and agreement of report. . Finalised February		
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
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
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 during the audit. Final 16/5/18.	Limited. 	May
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*	 *Reasonable*	*Decem ber*
Organisational Values	Director of Workforce & OD.	Q3/4	Q3/4	Review controls in place to manage key risk areas within the process.	FINAL	reasonable 	April
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 requirements as required by WG.	Final report Reasonable assurance. .		Septem ber
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. FINAL		Februar y

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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. FINAL*	*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 based upon actual usage or informed estimates.	Draft report issued 7/9/17. Final 12/10		December
Neo Natal	Director of Planning	Q2/3		To review key aspects of the schemes	Final	Reasonable 	May
Rookwood Relocation	Director of Planning	Q2/3		To review key aspects of the schemes	Final	Reasonable 	May
Shaping Future Wellbeing Schemes	Director of Planning	Q2/3		To review key aspects of the early part of a scheme.	wip		

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Cardiff and Vale University Health Board

Audit Committee May 2018

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Cardiff and Vale University Health Board

Consultant Job Planning

Final Internal Audit Report

2017/18

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NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	C&V-1718-34
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Fieldwork completion:	16th March 2018
Draft report issued:	26th March 2018
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Final report issued:	16th May 2018
Auditor/s:	Ian Virgil - Deputy Head of Internal Audit. Ken Hughes - Principal Auditor.
Executive sign off:	Graham Shortland - Medical Director.
Distribution:	Peter Durning - Assistant Medical Director Dr. Richard Evans – Clinical Director Dr. Jennifer Thomas – Consultant in Rehabilitation
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 & 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 & 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 Consultant Job Planning was completed in line with the 2017/18 Internal Audit Plan.

The relevant lead Executive Director for the review is the Medical Director.

A job plan can be described in simple terms as a prospective, professional agreement that sets out the duties, responsibilities, accountabilities and outcomes of the consultant and the support and resources provided by the employer for the coming year.

Job planning became a central part of consultants' working lives with the agreement of the 2003 Amendment to the National Consultant Contract in Wales. This made explicit the link between job planning and a successful relationship between the consultant and their employer(s).

Job planning is a mandatory process that provides an opportunity to align the objectives of the NHS, the organisation and clinical teams with individually agreed outcomes in order to allow, consultants, clinical academics, managers and the wider NHS team to plan and deliver innovative, safe, responsive, efficient and high-quality care.

2. Scope and Objectives

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

The purpose of the review was to establish if Consultant Job Planning was managed and monitored appropriately in order to ensure that sufficient activity was undertaken to meet the needs of the Health Board.

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

- All consultants have up to date, accurate and agreed job plans in place;
- Job plans reflect the Health Board's activity requirements and available finances;
- Job plans include personal outcomes that are linked to the Health Board's organisational objectives and the level of achievement is subject to appropriate assessment;
- Job plans are subject to effective review on an annual basis or more regularly where changes in circumstances require;
- An effective team based approach to job planning is utilised to support individual job plans where appropriate and beneficial; and

- The job planning process complies with relevant guidance with all parties engaged and the level of compliance is effectively monitored and reported.

3. Associated Risks

The potential risks considered in the review were as follows:

- Sessions worked may not be sufficient to allow for adequate provision of the service; and
- Consultants job plans may not reflect actual conditions or be developed by mutual consent.

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 Consultant Job Planning is **limited assurance**.

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

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

The audit identified good practice within Consultant Job Planning in that there was detailed guidance readily available setting out the job planning process, the information that should be recorded and the format in which job plans should be recorded. It was also apparent from discussions with

the Clinical Directors interviewed as part of the review that there was a commitment at the top level of management to improve job planning for the delivery of safe and effective patient services that meet the needs of the patient, the individual consultants and the Health Board.

However, the same level of commitment to job planning was not evident at the Clinical Board level and there was little evidence of a robust job planning process being consistently undertaken on an annual basis. The quality of documentation reviewed was inconsistent, variable and generally poor, and for the majority of the sample tested the standard documentation recommended in the guidance was not being used. In addition, job plans were not provided to audit for all the sample of consultants selected for testing.

Consequently a number of high priority findings have been raised within this report relating to the failure of Clinical Boards to carry out job planning reviews on an annual basis and the lack of adequate documentation to support the number of Direct Clinical Care (DCC) and Supporting Professional Activity (SPA) sessions recorded for consultants in the Electronic Staff Record (ESR) system.

5. Assurance Summary

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

Assurance Summary					
1	Sessions worked may not be sufficient to allow for adequate provision of service.		✓		
2	Consultants job plans may not reflect actual conditions or be developed by mutual consent.		✓		

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weakness in the system control/design for Consultant Job Planning.

Operation of System/Controls

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

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Risk 1 - Sessions worked may not be sufficient to allow for adequate provision of the service:

The following areas of good practice were noted:

- The standard Health Board requirement for full time consultants is to deliver 10 sessions per week;
- The Health Board's preference is for consultants to deliver eight Direct Clinical Care sessions and two Supporting Professional Activities sessions each week;
- Additional sessions may be delivered in agreement with the relevant Clinical / Medical Director;
- Job plans can be used to identify the capacity available to meet key targets and outcomes contained within Directorate Service Delivery and Financial Plans.

The following significant finding was noted:

- Job Plans were not being completed by all consultants on an annual basis.

RISK 2 - Consultants job plans may not reflect actual conditions or be developed by mutual consent:

The following areas of good practice were noted:

- There is detailed guidance readily available that details the job planning process;
- The job planning guidance includes a standard job plan template and outcome form;
- The Assistant Medical Director (Workforce and Revalidation) provides Specific one to one job planning training to all new Clinical Directors and half day training sessions are also made available to all Clinical Boards on request.
- The Health Board has introduced a new simplified system for recording core job planning data within the ESR system and the associated data is regularly reviewed as part of the Clinical Board Performance meetings. There has been significant continuous improvement over the

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last twelve months in the number of completed job plans recorded by ESR.

- The Health Board requires that job plans should be signed off by both the consultant and their line manager as evidence of a mutually agreed job plan;
- Where appropriate, consultants can utilise a team or annualised hours job plan.

The following significant findings were noted:

- Job Plans were not provided for all consultants requested, the standard job plan template included in the UHB guidance was not being widely used and job plans were typically incomplete and of a poor standard;
- There was no evidence that outcome measures were being agreed and monitored;
- Individual, personalised schedules were not being completed by consultants that were on Team or Annualised Hours job Plans;
- Compliance levels with the job planning guidance for the sample of consultants tested was poor; and
- Only one of the Job Plans reviewed had been signed and dated by the Consultant and only three Job Plans had been signed by the Consultants clinical manager to evidence that job plans had been mutually agreed.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**3**	**2**	**1**	**6**

Finding 1- Annual Job Plans (Operating Effectiveness)	Risk
In accordance with Job Planning guidance issued by the Cardiff & Vale UHB, job planning must be completed annually for all consultants. The Welsh Government Consultants Contract also states that annual job plan reviews should ideally take place within one month of the consultants' incremental date. A sample of 28 consultants from across the Medicine and Children & Women's Clinical Boards was selected for testing to ascertain whether each consultant had a documented, individual job plan in place that had been completed or reviewed within the last 12 months. Despite multiple requests Job Planning documentation was not provided for 6/28 consultants selected for testing; one from the Medicine Clinical Board and five from the Children & Women's Clinical Board. Only 10/22 job plans received had been completed within the last 12 months, although documentation relating to 6 job plans was undated.	Sessions worked may not be sufficient to allow for adequate provision of the service.
Recommendation 1	**Priority level**
Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	High
Management Response	**Responsible Officer/ Deadline**
1. Processes are in place to support the completion and reporting of job planning activity. There is monthly reporting of the annual job planning process via the Clinical Board Performance reviews. There has been recent improvement in a	1. Clinical Board Directors – Monitor compliance on a monthly basis through the Clinical Board

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small number of Clinical Boards. Immediate steps will be taken by the Medical Director and the Director of Workforce to target those Clinical Boards with poor performance and those not significantly improving (5 out of 8) to request an improvement plan which will ask for reported improvement in annual job planning review rates over a period of three months. Clinical Board Directors should ensure that the Clinical Directors take responsibility for these being undertaken and have internal Clinical Board systems to monitor improvement.	Performance Reviews with joint review of improvement trajectory monitored via the Medical Director /Director of Workforce. Immediate request for improvement plan, documenting improvement trajectory over three months.
2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report – ouitlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	2. 15th June 2018 Medical Director /Director of Workforce.

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Finding 2 - Job Plan Documentation (Operating Effectiveness)	Risk
Job Planning documentation was only provided for 22/28 consultants tested. Review of the documentation provided identified a number of issues with the quality and completeness of the documentation: • The job plan template provided within the UHB Job Planning guidance had only been used for six of the job plans received. In accordance with UHB Job Planning guidance, use of the standard job plan template should be encouraged but is not compulsory as long as all the relevant information is provided. However the majority of non-standard job plans reviewed did not contain all the necessary information.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.

• The number and split of sessions between DCC and SPA recorded on ESR did not agree to job planning documentation for 13 of the 22 consultants that provided documentation; • Six of the 22 job plans provided were 'summary sheets' and did not provide any detail to support the number of sessions recorded in ESR; • The information provided in the job planning documentation reviewed was inconsistent with much of the information lacking detail of the tasks that would be carried out in each session; and • Some of the job planning documentation provided was incomplete.	
Recommendation 2	**Priority level**
The UHB job planning guidance should require consultants to use the standard Job Plan template contained within the guidance unless they can provide a valid reason for not doing so. Job Planning documentation should be completed in full and should include full details of the activities to be undertaken in each session. Line managers should ensure that the number and split of sessions recorded in ESR agrees to and is supported by a fully completed job plan.	High
Management Response	**Responsible Officer/ Deadline**
1. Clinical Board Directors and Clinical Directors should ensure that summary job plans data are submitted to the Medical Workforce Team on a regular basis so that updates can be made in the ESR system. This will be recognised by implementation of actions in Management Recommendation 1 in terms of outcomes.	1. Clinical Board Directors/Clinical Directors – one to three months.

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2. Medical Workforce to update ESR system with summary job plan data – this has been already reviewed by the Medical Director and Director of Workforce recently and there is no back-log of data to currently input into the system (maximum wait two weeks). Clinical Directors/DM will be able to submit to ESR and their data will be entered in a timely way. The previous guidance issued will be immediately reissued to Clinical Board Senior Teams for cascade to their Clinical Directorates.	2. Medical Director – Immediate.

Finding 3 - Outcomes Measures (Operating effectiveness)	Risk
A key requirement of the Job Planning process is that all consultants must have outcome measures agreed for the year ahead that reflect UHB operational targets and the use of SPA sessions. The UHB guidance states that outcome measures should be written in a format that is sufficiently detailed and can be measured, i.e. as SMART outcome measures. The UHB guidance also includes a template for recording and monitoring outcome measures. However no evidence was provided for any of the consultants tested that they had set and recorded outcome measures for the year ahead. There is therefore no assurance that outcome measures are being agreed and monitored.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation 3	**Priority level**
Clinical Board management must ensure that all consultants complete the outcome measures template contained within the UHB Job Planning guidance as part of the job planning process.	High
Management Response	**Responsible Officer/ Deadline**
1. Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. 2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report – outlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	1. Medical Director and AMD for Workforce and Revalidation – one month. 2. 15th June 2018 Medical Director/Director of Workforce.

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Finding 4 - Team & Annualised Hours Job Plans (Operating effectiveness)	Risk
Job planning documentation was only provided for 22/30 consultants tested. Of these, four consultants were on a Team Job Plan and two consultants were on an Annualised Hours Job Plan. In accordance with the UHB 'Guidance on Developing a Team Job Plan or Annualised Hours Plan', these should be supported by an individual personalised schedule based on their average NHS working week and any external commitments. However individual, personalised schedules were not provided for any of the consultants that were on Team or Annualised Hours job Plans.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation 4	**Priority level**
In accordance with the guidance, Clinical Board management should ensure that individual, personalised schedules are completed for all consultants that are on Team or Annualised Hours Job Plans.	Medium
Management Response	**Responsible Officer/ Deadline**
Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. This will emphasise the need for all members of a team to complete individually the team job plan.	Clinical Board Directors action – Issues by Medical Director and AMD for Workforce and Revalidation – one month.

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Finding 5 - Job Plan Training (Control Design)	Risk
It is noted that detailed, documented Job Planning guidance has been produced and made readily available by the UHB. Job planning training is also being delivered by the Assistant Medical Director (Workforce and Revalidation) to all new Clinical Directors and to Clinical Boards on request. However the results of the sample testing undertaken as part of the audit demonstrate that the level of compliance with the job planning process is poor.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation 5	
The UHB should consider developing additional methods of communication and / or training for both line managers and consultants to improve the completion rate and quality of consultant job plans.	Low
Management Response	**Responsible Officer/ Deadline**
A planned schedule for training should be refreshed and communicated, including sources of information available to Clinical Directors.	Assistant Medical Director Workforce Revalidation working with Medical Workforce Department/ LED/Communications Team Three months

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Finding 6 - Agreement of Job Plans (Operating effectiveness)	Risk
Job Plans should be mutually agreed and signed by both the Consultant and the appropriate clinical manager to evidence this agreement. However only one of the Job Plans reviewed had been signed and dated by the Consultant and only three Job Plans had been signed by the Consultants clinical manager. It was noted that the majority of job plans reviewed were stored in electronic format which does not lend itself to manual signatures. However there is a facility within all Microsoft Word and Excel documents which allows them to be signed off digitally.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation 6	**Priority level**
All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	Medium
Management Response	**Responsible Officer/ Deadline**
1. The job plan review does not require an actual signature but there does need to be a record of the job plan being agreed by all parties and signed. 2. An electronic job planning system will be trialled in Cardio Thoracic should provide a seamless and electronic system solution in the future, pending evaluation of the pilot and consideration of costs. This will include the ability for electronic sign off.	1. Clinical Board Director/CD - 3 months. 2. Assistant Medical Director – Workforce – 3 months review pilot progress.

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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.

Continuing Health Care Follow-Up

FINAL INTERNAL AUDIT REPORT 2017 /2018

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Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

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Cath Heath, Director of Nursing C&W
Paula Davies, Lead Nurse Community Child Health

Committee: Audit Committee

ACKNOWLEDGEMENT
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Please note:

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

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1. EXECUTIVE SUMMARY

This follow-up review of Continuing Health Care (CHC) has been completed in line with the Internal Audit Plan.

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

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

The risks considered in the previous review were as follows:

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

Follow up work was undertaken to determine whether progress / full implementation had been made relating to the following recommendations (R) and respective agreed management responses (MR):

- R: The UHB should accept the residual risk relating to these changes in care requirements *(from Child CHC or Funded Nursing Care to CHC).* (Finding 1, Medium Priority)

  MR: A recent Ombudsman ruling in 2015 has expressly advised the UHB when considering eligibility that the nurse assessor needs to look back at possible triggers before the date the individual has been referred for an assessment, this does then lead to cases where eligibility precedes panel authorisation. This is something we will need to continue to undertake in line with the ruling and NHS Continuing Healthcare policy;

- R: A timescale should be set to ensure the Head of Service Agreement (HoSA) is agreed promptly. (Finding 2, High Priority)

  MR: The HoSA is being reviewed following the Operation Jasmin work (Flynn Report). The review is being led by the joint Cardiff and Vale Local Authorities, timescales are currently unclear, the PCIC Director of Nursing will write to the LA leads and ask for an agreed timescale for conclusion of the work;;

- R: PCIC should ensure an annual review is carried out on existing CHC placements as per the framework and evidence of this review should be maintained on the patients file. (Finding 3, High Priority)

  MR: A schedule is in place to meet statutory requirements for review which is monitored at PCIC Service Delivery Group also at Welsh Government Complex Care Board. There is recognition both locally and

nationally that staffing establishments within the nurse assessor teams expected to undertake this work are limited and further put under pressure when safeguarding issues arise in Nursing homes which need immediate and often long term support. This risk is on the PCIC Risk Register and additional resources have been highlighted for potential investment in the PICI IMTP, the business case was not requested from the Executive team on this POD as a priority of funding;

- R: The Children CHC team should develop a local procedure that sets out how they adopt WG guidance. (Finding 4, Medium Priority)

  MR: The Community Child Health (CCH) Directorate will develop a local operational policy based on WG CC Guidance for Children. The policy will include:

  - The CVUHB Appeals Process as WG guidance is not specific; and
  - Recommendation of key performance indicators for children's CHC.

- R: Individual Service User Agreements should be produced to cover health aspects of child residential placements and KPIs developed/expanded to monitor performance internally. (Finding 5, Medium Priority)

  MR: The CCH Directorate will agree a process for KPIUs to be measured and reported on in line with other Directorate Performance Management;

- R: All new placements should have a placement agreement in place and be processed within the timescales required by guidance. Compliance with this target should be reported within the Performance Report. (Finding 6, Low Priority)

  MR: This is in place;

- R: A list of QA dates should be maintained with corresponding patients reviewed on these dates. Locality teams should ensure that QA summaries produced are kept to evidence decisions made. (Finding 7, Low Priority);

  MR: QA is held every Tuesday each week for 52 weeks, the date of the QA is entered on the top of the sheet. The QA sheet is not held with the individuals records as records generally transfer to the nurse assessor team on transfer of the patient. The nurse assessor team now have electronic records, it is hoped all records from January 2018 will be held in one place;

- R: PCIC should ensure an initial 3 month review is carried out on new CHC placements as per the framework and evidence of this review should be maintained on the patients file. (Finding 8, Low Priority);

  MR: Agreed – this will be undertaken if the staffing resource is available.

2. CONCLUSION AND FINDINGS

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

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

The follow-up review concluded that based upon discussions with relevant management and review of the evidence provided, some progress has been made on actions under the control of the Primary Community and Intermediate Care (PCIC) Clinical Board. However, there are still a number of actions that haven't been progressed and the required improvements have therefore not been made. The audit notes that the Health Board is reliant on collaboration with other authorities to aid progression with the Heads of Service Agreement.

Testing was undertaken across the localities on the completeness of the initial three month reviews to ensure they were performed. Three out of five of the reviews were delayed and therefore occurred after the three month period; two out of five of the reviews have not been completed. The CHC initial reviews are not occurring as dictated in the framework, staff resourcing issues are therefore halting progression with direct patient management. (Finding 8 – Not Actioned).

There has been some progress with actions in relation to the management of Children CHC. However, those relating to contracting arrangements and a protocol, as detailed below, have not been completed due to the complexity of the actions required. The audit does note that steps have been taken to ensure these develop in 2018.

Contracting arrangements with both councils and independent providers remain inadequate; the Health Board is working with the Local Authorities to develop a contract which includes an acceptable health component.

There is also currently work ongoing to develop a joint multi agency protocol for management of Child CHC and will encompass an operating procedure for the directorate. Key Performance Indicators (KPIs) have been agreed and will be reported from April 2018 in line with other Directorate Performance Management. (Findings 4 & 5 – Not Actioned).

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 CHC has remained as **Limited Assurance**. The main reason for the assurance rating not increasing is the limited progress made on the Child CHC side of things; despite the progress that has been made on the adult side.

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

- When patients are placed in Nursing homes under FNC and subsequently become CHC, both the CHC framework and the Ombudsman Office recommend any case that triggers an assessment for CHC, the assessor should look back to determine when the change in health need occurred as the statutory requirement for review is on an annual basis and patients could deteriorate and not be flagged to the UHB for reassessment. Therefore the Health Board have accepted the residual risk that funding occurs prior to CHC panel in the aforementioned cases. (Finding 1 – Fully Actioned);
- The Director of Nursing has written to the leads for both local authorities to understand the timescales for the update of the Heads of Service Agreement, there has been no response. There is however a jointly commissioned working group, attended by the Health Board, which have been tasked with updating the agreement. This has a proposed finish date of April 2018, however, this date has not been formally communicated. (Finding 2 – Partially Actioned);
- Completion of annual reviews are reported using the CHC Performance Report and is presented monthly to the PCIC Service Delivery Group. Whilst this is being monitored, it is noted that completion rates of these reviews is still low due to staff resources. (Finding 3 – Partially Actioned)
- The CHC Performance Report includes monitoring of compliance with the framework's defined timescales for the CHC assessment and placement process. (Finding 6 – Fully Actioned); and
- Quality Assurance paperwork for all localities is stored centrally in the Whitchurch Office and sample testing proved this to be accessible. (Finding 7 – Fully Actioned).

3. UPDATED MANAGEMENT RESPONSE

PCIC Management have provided the following updated responses for the 2 partially actioned high priority findings:

- R: A timescale should be set to ensure the Head of Service Agreement (HoSA) is agreed promptly. (Finding 2, High Priority)

7.2

Updated MR: The HoSA is being reviewed following the Operation Jasmin work (Flynn Report) and the Welsh Government requirement to have pooled Health and Local Authority budgets for Long term care by 2018. The review is being led by the joint Cardiff and Vale UHB and Local Authorities, timescales for completion is April 2018 in line with Welsh Government expectation;

- R: PCIC should ensure an annual review is carried out on existing CHC placements as per the framework and evidence of this review should be maintained on the patients file. (Finding 3, High Priority)

  Updated MR: There is no evidence that patients care has suffered or the UHB has experienced a financial impact in relation to the annual CHC reviews not being undertaken. The Annual review is only one process undertaken in ensuring the adequate monitoring of patients within nursing homes. Other regular checks and processes are also in place to ensure patients safety and financial robustness around funding.

Children & Women Clinical Board Management have provided the following updated responses

- **Contracting**: Community Child Health Directorate has held meetings with Cardiff Council to determine what existing contracts are in place for Children with jointly commissioned packages arranged through continuing care. The Directorate has since drafted an SLA / contract which it has started to issue prospectively for any placements in which health lead on commissioning. The Directorate is in communication with the Director of Social Services in the Vale of Glamorgan and has been informed that children will be included in a contracting review being undertaken with the UHB. Going forward the Directorate will need to consider if the recruitment of a Contracting /commissioning manager is possible.
- **Key Performance Indicators**: KPI's have been developed and agreed between the Directorate Management Team and discussed with peers in neighbouring Health Boards. Data has been collated from 1st March 2018. Reports will be submitted to the Directorate's Performance Management meetings from April. (The March meeting was cancelled).
- **Development of an Operational Policy /Protocol:** The directorate has commissioned an external expert to lead on the development of an integrated joint protocol which will be agreed between the Directorate and both Local Authorities. This work commenced in October 2017. The document will identify agreed thresholds for referral, account for each agencies statutory responsibilities, translate the current WG Guidance into local processes across agencies and outline individual and inter-agency processes to resolve disagreement and appeals. It was anticipated that a protocol would be drafted by March 2018, however,

due to the significant scoping required, across agencies, this has been delayed. The timeline for completion of this protocol is within the next 6 months. There is not a similar protocol for Children's CC currently available across Wales.

Continuing Healthcare Follow-Up

Cardiff and Vale University Health Board

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

REPORT OF THE LOSSES AND SPECIAL PAYMENTS PANEL	
Name of Meeting : Audit Committee	**Date of Meeting:** 22nd May 2018

Executive Lead : Director of Finance
Author : Head of Financial Accounting and Financial Services
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : £ 8.706m
Quality, Safety, Patient Experience impact: The appendix to the report outlines those agreed actions by panel members which will attempt to reduce the numbers of similar instances occurring in the future and hence reduce any impact on quality, safety and patient/carer experience.
Health and Care Standard Number: The contents of the report and the attached appendix cut across multiple health standards. Where merited, specific issues will be brought to the committees attention via separate papers.
Equality Impact Assessment Completed: Not Applicable

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RECOMMENDATION

The Audit Committee is asked to:

- **APPROVE** the write off of the losses and special payments outlined in the assessment section of this report:
- **NOTE** the minutes of the 16th May 2018 meeting of the Losses and Special Payments Panel.

SITUATION

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

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

BACKGROUND

The Losses and Special Payments Panel last met on 16th May 2018 to consider the 6 month period October 1st 2017 to March 31st 2018. This report informs the Audit Committee of the items considered at this meeting and the recommendations made for formal Audit Committee approval. The minutes of the last meeting of the Losses and Special Payments Panel are attached as Attachment 1. These minutes give more detail about the issues discussed at the meeting, including those items that have been recommended to the audit committee for approval.

ASSESSMENT

For the Financial Year 2017/18, the following losses have been identified for write off:

- £132,155 in respect of bad debt write offs for the year 1 April 2017 to 31 March 2018 (£91,330 of which was previously approved at the December Committee meeting);
- Clinical negligence claims of £7.439m and personal injury claims of £0.896m for the period 1 April 2017 to 31 March 2018 (£2.982m of which in respect of clinical negligence and £0.260m in respect of personal injury was previously approved at the December Committee meeting). For noting the income & expenditure charge suffered by the UHB in respect of such incidents was £2.374m;
- Small Claims Panel Losses of £4,597 for the period 1 April 2017 to 31 March 2018; (£2,190 of which was previously approved at the December Committee meeting);
- £22,129 in respect of Ex Gratia Payments made during the period 1 April 2017 to 31 March 2018; (£1,950 of which was previously approved at the December Committee meeting);
- £71,025 settlement costs re Employment Tribunal cases for the period 1 April 2017 to 31 March 2018; (£61,625 of which was previously approved at the December Committee meeting);
- £140,976.09 in respect of lost, damaged or obsolete stock for the period 1 April 2017 to 31 March 2018;

Attachment One

MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS PANEL HELD ON 16th MAY 2018.

PRESENT:

Mr C Lewis (Chair)
Mr A Crook
Mr S Monk
Mr A Williams
Mrs S Wicks
Mr R Hurton

APOLOGIES:

Mr C Greenstock
Mrs A Hughes
Mr R Cockayne

Minutes of Last Meeting

The minutes of the last meeting were reviewed for accuracy. Mr Hurton pointed that there were two issues to note within section 2 Debt Write Offs. Subsequent to the meeting it had come to light that two invoices approved for write off at the November panel meeting, had already been written off in 2016/17. The value of these invoices was £14,565. In addition there was an error on page 8 which stated that "The Panel recommended that the Audit Committee approve the write off of £92,546 in respect of Bad Debts for the period 1st October 2016 to 31st March 2017**."** **This should have read** The Panel recommended that the Audit Committee approve the write off of £91,330 in respect of Bad Debts for the period 1st April 2017 to 30th September 2017.

Except for these 2 issues, the group endorsed the minutes as an accurate record.

There was one matter arising which wasn't shown elsewhere on the agenda, This related to incidents which had occurred in the past where salary payments had been made into the wrong bank account. To help mitigate the problem, from May 1st, Mr Crook had amended the wording on staff changes and enrolment forms to make clear to all that they could suffer financial loss if they don't enter bank details correctly on these forms. Before doing this, Mr Crook had taken advice on the UHB's stance with NWSSP Legal Services**.**

Agenda Items

1. Clinical Negligence and Personal Injury Losses

Mr Monk presented the financial report on Clinical Negligence and Personal Injury losses for the Financial Year ending 31st March 2018.

The income and expenditure effect for the period was described as shown below: For comparison, the figures for the same period in 2016/2017 were also discussed

SUMMARY OF LOSSES

	2017/2018 £'000	2016/2017 £'000
Clinical Negligence	52,476	68,240
Personal Injury	811	253
Total Loss	53,286	68,493
Less WRP Receipts	-50,913	-66,000
Total Net Cost to the UHB	2,374	2,493

With respect to clinical negligence claims, Mr Monk advised that there had been a reduction in gross expenditure (before reimbursal from the Risk Pool) by £15.8m. This was a result of a number of factors. Firstly, the value of cases that turned from possible to certain to settle has reduced significantly from last year (-£25.4m) as has the number (-36) and value (-£21.0m) for new cases. Mrs Wicks said that she felt that these were reflective of solicitors being less willing to take on speculative cases than they had been in previous years. Offsetting these reductions was a net increase in quantums of existing cases of £27.3m, which reflects the fact that all quantums now fully reflected the revised discount rate which the Lord Chancellor announced in February 2017.

The impact of all recorded Personal Injury claims had been a gross I&E charge of £0.811m. Within this there were 30 new claims that had a gross I&E cost of £0.125m. Where quantums have moved there was a gross I&E cost of £0.427m and movements in the probability of cases had led to a cost of £0.426m.

Recommendation

The Panel recommended that the Audit Committee note that following expected reimbursement from the WRP, the net expenditure incurred by

the UHB on these Clinical Negligence and Personal Injury claims was £2.374m for the Financial Year ending 31st March 2018.

Finalised Clinical Negligence (including Redress) Claims

During the twelve months ending 31st March 2018, there were 101 claims (where liability had been conceded and settlements paid) which had concluded at a total settlement costs (net of CRU recovery) of £7.439m (which are treated as a loss). The UHB also incurred £0.302m in legal fees re these cases and was successful in recovering £6.298m from the Welsh Risk Pool and Welsh Government for these claims, resulting in a net cost to the UHB of £1.443m.

Finalised Personal Injury Claims

During the year, 48 claims where liability had been conceded and settlements paid have concluded at a total settlement cost of £0.896m (which are treated as a loss). The UHB had also incurred £0.118m in defence fees and was successful in recovering £0.459m from the WRP for these claims, resulting in a net cost to the UHB of £0.555m.

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

Recommendation

The Panel recommended that the Audit Committee approve the write off of the settlement costs of claims finalised in the period 1st April 2017 – 31st March 2018. The value of these claims finalised was - Clinical Negligence - £7.439m. Personal Injury - £0.896m.

2. Debt Write Offs

Mr Williams presented a report on proposed invoice write offs for the period 1st October 2017 to 31st March 2018.

These were as follows

Category of Debt	Value	No
Dental	55	4
Medical Records	863	37
Payroll	5,782	15
Overseas Patients	20,454	12
Private Patients	15,224	41
Misc	13,012	29
Total	**55,390**	**138**

Mr Williams stated that the invoices to be written off relating to overpayments of salary include 2 invoices totalling £5k where the debtor has been declared bankrupt and no further action will be taken to recover the amounts due.

As well as being referred to CCI Credit Management all overseas debts over £500 are referred to Data Share which is monitored by the Home Office, any person with an outstanding invoice trying to enter the UK will be flagged and payment demanded before entry/visa is granted.

In respect of private patient invoices, the majority of the invoices to be written off referred to small balances due on insurance company invoices where either the charge has been disputed or it is patient excess which we have been unable to collect.

These invoices have been put forward for write off by the Private and Overseas Patient Manager as all avenues for collecting the debt have been exhausted. Where possible all debts have been referred to CCI Credit Management.

Of the 29 invoices in the Miscellaneous category totalling £13k there was 1 invoice for £12k to be approved. This invoice related to a commercial trials charge to Icon Clinical Research (Eire). The trial closed prematurely and an invoice for the activities to date was raised but remains unpaid. The write off request has been authorised by Dr Shortland, The Medical Director.

Mr Williams outlined that The UHB has implemented and is implementing a number of measures making it easier for debtors to pay and so facilitating requests for upfront payment. For example, The Health Board has recently implemented a Touch Tone 24/7 telephone payment service that allows for electronic payment of invoices to be made 24/7 and we have recently purchased an ‘On-Line’ and ‘Smartphone/Tablet’ package that will further enhance the Health Board’s ability to receive payments by various methods.

Mr Williams reconfirmed that after its meeting of 22nd November 2017, the Losses & Special Payments Panel recommended to Audit Committee that the £91,330 be written off for bad debts relating to the first six months of the year. It has subsequently come to light that this figure included 2 invoices which had already been written off in 2016/2017. Hence the correct value of write offs in the first six months of this financial year was £76,765 giving a total of £132,155 for the year 2017/18

Mr Williams also presented the group with a table comparing the amount to be written off in 2017-18 to amounts written off in previous years.

	2013/14		2014/15		2015/16		2016/17		2017/18	
	Value	No	Value	No	Value	No	Value	No	Value	No
Accommodation	1,598	5	0	0	8	1	1,049	8	0	0
Dental	629	35	90	7	130	10	81	6	203	15
Medical Records	2,127	75	1,182	48	360	22	650	35	1,070	47
Payroll	32,629	46	15,229	18	2,004	7	20,025	53	12,639	26
Private Patients	2,675	22	4,573	18	4,578	32	24,325	28	23,764	63
O/Seas Patients	62,700	23	24,761	38	53,011	48	16,475	10	58,632	40
IVF Wales	825	5	0	0	0	0	31,026	24	0	0
Misc	9,860	65	122,466	68	17,787	50	78,685	61	35,847	54
	113,043	**276**	**168,301**	**197**	**77,877**	**170**	**172,315**	**225**	**132,155**	**245**

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Recommendation

The Panel recommended that the Audit Committee approve the write off of £132,155 in respect of Bad Debts for the period 1st April 2017 to 31st March 2018.

3. Permanent Injury Losses

Mr Monk presented a report on permanent injury costs for the financial year 2017-18. He explained that permanent injury allowances were approved by the NHS Pensions Agency and the long term costs were picked up by the UHB. The costs must be treated as losses and should be noted by the Panel. The UHB made payments on a quarterly basis to the Pensions Agency based on bills received from them.

There were a total of 27 cases ongoing, which in expenditure terms had cost the UHB £0.980m. There were payments made in the same period of £0.266m. During the year a new case had been approved by NHS Pensions Agency and this had contributed significantly to the costs for the year.

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

Recommendation

The Panel recommended that the Audit Committee be asked to note the impact on expenditure of £979,794 (for the Financial Year Ending 31st March 2018).

4. Employment Tribunal Costs

Mr Crook presented a paper outlining the claims and costs for the period 1st April 2017 to 31st March 2018.

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

Fourteen of these cases were live as at March 31st 2018. Six of the 14 cases had previously been reported to the Losses and Special Payments Panel, and the remaining eight cases had been submitted to the Employment Tribunal since 30th September 2017.

One case had been withdrawn during the period and £9,400 had been paid in settlement costs re the two cases for which we had reached settlements during the period.

Recommendation

The Panel recommended that the Audit Committee approve the write off of £71,025 in respect of Employment Tribunal Settlements for the period 1st April 2017 to 31st March 2018 (noting that £61,625 of which had been approved previously by the Audit Committee).

5. Ex Gratia Payments and Other Losses

Mr Monk presented a report on costs for the period 1 October 2017 to 31 March 2018. Mr Monk noted that there were 11 ex-gratia losses totalling £20,179 made in the six months under consideration.

Ten of the cases were the result of the independent review/ombudsman process. One incidence relates to a fine and interest levied by HMRC re VAT recovered in error.

Recommendation

The Panel recommended that the Audit Committee approve the write off of the losses incurred in the period 1st April 2017 to 31st March 2018 amounting to £22,129 (noting that £1,950 of this has previously been approved by the Audit Committee).

6. Security Losses

Mr Cockayne was not able to attend the meeting; but had tabled a report for consideration. Only one incident had been reported to the security department during the year. The incident was potentially significant; but was still under investigation as at 31st March 2018. It was anticipated that this would be concluded for the November panel meeting. There were therefore, no losses to be approved.

7. Small Claims Panel Losses

Mr Monk presented a report on costs for the period 1 October 2017 to 31 September 2017. During that period 16 claims had been settled at a total cost of £2,407.

The report explained that lack of accurate record keeping is still a problem across most clinical boards which has resulted in seven claims being paid as the investigation has shown that they are unable to account for the loss. Five claims were paid as items were lost while changing bed sheets or when they had been sent to the laundry by mistake. Accidental damage resulted in three settled claims and the final one related to reimbursement of travel expenses re a cancelled appointment.

No one clinical area seemed to have a major problem with claims which the panel found to be encouraging.

Recommendation

The Panel recommended that the Audit Committee approves the write off of the £4,597 in respect of compensation payments which had been paid during the Financial Year 2017-18 (noting that the Audit Committee approved £2,190 in relation to this at its December meeting).

8. Report of the Counter Fraud Manager

A report on fraud investigations undertaken during the second six months of 2017/18 was received in the absence of Mr Greenstock.

The panel noted that all potential fraud and irregularity investigations were regularly discussed with the Finance Director and then reported to the Audit Committee. An update on the current position of fraud cases under investigation was reported to the Audit Committee on 24th April 2018.

As at 31st March 2018, there are no cases reported, which have been closed in the period, from which the Health Board were then not able to recover any of its costs. However, there are a total of forty nine (49) cases still under investigation and which have an estimated potential total loss of approximately £195k.

Recommendation

The Panel asked The Audit Committee to note that there were no losses to report for the period.

9. Voluntary Early Release Payments

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

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

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

There had been 2 payments during the final 6 months of the year totalling £0.024m.

Recommendation

The Panel recommended that the Audit Committee note the £24,247 paid in Voluntary Early Release Payments made during the final 6 months of 2017/18.

10. Stock Write Offs

Mr Hurton presented a report on stock identified for write off during the year to March 31st 2018. During this period there were 12 instances of obsolete stock totalling £0.097m (2016/17 £0.272m) and instances of lost or damaged stock totalling £0.044m (2016/17 £0.089m). The Group noted that the figures, represented a significant improvement on the levels reported in 2016/17.

Recommendation

The Panel recommended that the Audit Committee approves the write off of the £140,976 in respect of lost, damaged or obsolete stock during 2017-18.

11. Any Other Business

Mr Hurton confirmed that the next meeting of the panel would be in November 2018.

Cardiff and Vale University Health Board

Strategic Planning/IMTP

Final Internal Audit Report

2017/18

9.1

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditor/s:	Ian Virgill (Deputy Head of Internal Audit) Lucy Jugessur (Principal Internal Auditor)
Executive sign off:	Abigail Harris, Executive Director of Planning
Distribution:	Marie Davies, Deputy Director of Planning Christopher Dawson-Morris, Corporate Strategic Planning Lead Mike Bond, Director of Operations Rachel Burton, Director of Operations Chris Darling, Programme Manager
Committee:	Audit Committee

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

Disclaimer notice - Please note:

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1. Introduction and Background

The review of Strategic Planning - IMTP was completed in line with the 2017/18 Internal Audit Plan.

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

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of the IMTP, 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 areas that the audit sought to provide assurance on are:

- The delivery and development of the IMTP is appropriately aligned to Welsh Government's expectations as set out in the NHS Wales Planning Framework;
- The IMTP has been developed to ensure delivery of the UHB long term strategy
- Clinical Board plans are aligned to the UHB Strategy
- The UHB has ensured plans are subject to rigorous internal scrutiny and assurance.

Review and testing of the Clinical Board processes was carried out within the following 3 sampled Clinical Boards:

- Surgery;
- Primary, Community & Intermediate Care (PCIC); and
- Children and Women.

3. Associated Risks

The potential risks considered in this review were as follows:

- The IMTP fails to deliver the UHB objectives;
- Adequate monitoring and scrutiny mechanisms are not in place.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Strategic Planning/IMTP is **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 Health Board had appropriate processes in place to ensure that its draft IMTP 2018-21 was produced in the required format and to the stipulated timescales for submission to Welsh Government.

The UHB objectives are detailed within the Shaping Our Future Wellbeing Strategy 2015-2025 and these were referenced within the UHB draft IMTP and also the three Clinical Board IMTPs that were reviewed. The Planning Department have assisted the Clinical Boards in producing their IMTPs and have also produced a template for them to utilise to develop their IMTPs.

The Clinical Boards have processes in place for producing their IMTPs; PCIC has development sessions whilst Surgery and Children & Women Clinical Boards have meetings to discuss and the individual Directorates produce IMTPs which feed into the Clinical Board IMTPs.

There were Project Opportunity Documents (PODs) produced by the Surgery and PCIC Clinical Boards and there was an audit trail between them and the Clinical Board IMTPs. The Children & Women Clinical Board did not have PODs as they have received funding from the South Wales Plan.

The Ophthalmology Directorate did not produce an IMTP in line with all the other Directorates within the Surgery Clinical Board.

The Strategy Development and Delivery Group is responsible for the production of the UHB's IMTP. The terms of reference for the Group have not been reviewed since August 2015 and it was not always quorate for the meetings reviewed.

As stated, the review has identified that the Health Board had robust processes in place for producing and submitting its draft IMTP 2018-21. However, at the time of reporting, a final IMTP had not been submitted to Welsh Government due to the need to complete further work on the financial and performance aspects of the plan. The overall assurance rating for the review therefore reflects the Health Board's current position.

5. Assurance Summary

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

Assurance Summary					
1	The IMTP fails to deliver the UHB objectives			✓	
2	Adequate monitoring and scrutiny mechanisms are not in place			✓	

** 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 Strategic Planning/IMTP.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for Strategic Planning/IMTP.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Risk 1: The IMTP fails to deliver the UHB objectives

The following areas of good practice were noted:

- Audit reviewed the Shaping Our Future Wellbeing Strategy 2015-2025 document against the draft IMTP 2018-21. It was identified that there were flows from the Strategy to the IMTP as there were a number of sections that were detailed in both documents including Health Board Profile and Health Board Strategy. In addition, the UHB IMTP refers to information reported in the Shaping Our Future Wellbeing Strategy.
- Ten strategic objectives were introduced in the Shaping Our Future Wellbeing Strategy and included a summary of actions to achieve these objectives and measurable outcomes. Within the UHB IMTP these 10 strategic objectives are referred to, including wellbeing goals.
- There are service standards and outcomes for cancer, dementia, dental and eye health, long term conditions, maternal, mental health and stroke detailed within the Shaping Our Future Wellbeing Strategy. The major health conditions are referred to within the UHB IMTP along with details of the priorities for these during the IMTP period.
- There is a timetable in place for the IMTP process and it was evident that the key dates had been achieved so far.
- The UHB draft IMTP was taken to the Board Closed Session on the 25th January 2018 for noting and was sent to the Welsh Government by the 31st January 2018.
- The structure, presentation and content of the draft UHB IMTP was in compliance with the main requirements stated within the Welsh Government NHS Wales Planning Framework 2018/21.
- The Clinical Boards are responsible for producing their own individual IMTPs and these were developed in conjunction with the IMTP template that has been produced by the Planning department.
- All 3 of the sampled Clinical Boards had robust internal processes in place for producing their individual IMTPs. These ensured appropriate input from all Directorates / Divisions, staff members and other stakeholders along with effective scrutiny and approval.
- Audit reviewed the final IMTPs for each of the 3 sampled Clinical Boards to establish if key issues were adequately fed upwards into the Health Board's draft IMTP. The following was noted for each Clinical Board:
  - Surgery - Key priorities identified within the Surgery Clinical Board IMTP were also recorded within the UHB IMTP; such as Community Musculoskeletal Assessment & Treatment Service (CMATS), Community Audiology, ENT centralisation, Regional Ophthalmology service and centralisation of complex elective vascular.

- PCIC - There was a section within the UHB IMTP on Primary Care and Community Services and a lot of the information was captured from the PCIC IMTP. The detailed actions for 2018/19 that were recorded in the PCIC IMTP were confirmed as primary and community care priorities within the UHB IMTP.
- The background and achievements detailed in the Maternal & Child Health section of the UHB IMTP, including the opening of the Children's Resource Facility and improvements in waiting times associated with access to the Neurodevelopment services, were also detailed within the Children and Women IMTP. The priorities within the Children and Women Clinical Board IMTP have flowed into the priority actions within the Maternal and Child Health section of the UHB IMTP.

- Both Surgery and PCIC effectively utilised PODs for developing their Clinical Board plans and the outcomes of these were appropriately detailed within their individual IMTPs and the overall Health Board draft IMTP.
- There were no PODs for the Children and Women Clinical Board as they received significant investment from the South Wales Plan for paediatrics, obstetrics and neo natal. Therefore this funding was obtained through a different process to the PODs.

The following significant finding was noted:

- The Ophthalmology Directorate within the Surgery Clinical Board has failed to produce an IMTP unlike the other Directorates in Surgery.

Risk: Adequate monitoring and scrutiny mechanisms are not in place

We identified the following areas of good practice:

- The Health Board IMTP was taken to the Board closed session on the 25 January 2018 for information.
- There is a Strategy Development and Delivery Group who are responsible for setting the "framework for the UHB's strategic planning cycle including the production of the UHB's Integrated Medium Term Plan."
- The IMTP for the Surgery Clinical Board was discussed at the Clinical Board meeting on the 26 January 2018 including confirming the key priorities for the Clinical Board and within each of these priorities are benefits, interdependencies, risks/mitigation and milestones, priorities: regional agenda, priority CRP priorities, priority workforce change priorities and critical enablers.
- The PCIC IMTP was taken to the Clinical Board meeting on the 29 November 2017 and the members noted the content of the document. It was highlighted that a number of staff within PCIC had been involved in the production of the IMTP through the development sessions that had been held. The PCIC IMPT was scrutinised within the PCIC development

sessions. Furthermore, the IMTP was discussed at the PCIC Service Delivery Group meetings.

- The Children and Women IMTP was reviewed and discussed at the Clinical Board meetings. In addition, there were workshops held to discuss and review the IMTP for the Clinical Board.
- Audit was advised that all the Clinical Board IMTPs are sent to the Planning Department and they will review and scrutinise all of them to assess the information that will be input into the overall UHB IMTP.

The following significant finding was noted:

- The Strategy Development and Delivery Group terms of reference have not been reviewed since the 6th August 2015 and attendance at the meetings is not always appropriate.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

9.1

Finding 1 - Ophthalmology Directorate IMTP (Operating effectiveness)	Risk
It was agreed within the Surgery Clinical Board that all the Directorates would produce their own individual IMTPs to inform the overall Surgery IMTP. All the Surgery Directorates provided completed IMTPs apart from Ophthalmology as there was no Clinical Director in place and there were internal issues within the Directorate.	The IMTP fails to deliver the UHB objectives.
Recommendation	**Priority level**
Management must ensure that the Ophthalmology Directorate produce their own individual IMTP to ensure comprehensive coverage of the whole of the Surgery Clinical Board.	**Medium**
Management Response	**Responsible Officer/ Deadline**
As identified the Ophthalmology IMTP was not completed for 17/18 due to particular operational challenges. The Clinical Board will ensure the directorate complies with the process for 18/19.	Mike Bond, Director of Operations, Surgery Clinical Board. To be completed by October 2018

9.1

Finding 2 - Strategy Development and Delivery Group (Operating effectiveness)	Risk
The terms of reference for the Strategy Development and Delivery Group state that the group is responsible for managing the production of the UHB's IMTP. The terms of reference for the Group have not been reviewed since August 2015 despite the fact that it is stated they should be reviewed on an annual basis. Furthermore, the terms of reference confirm that there should be 8 members present for the group to be quorate. Review of the notes of the 5 meetings held between July 17 and February 18 identified that 2 meetings were not quorate. In addition, a number of members failed to attend any or only attended a few of the meetings.	Adequate monitoring and scrutiny mechanisms are not in place.
Recommendation	**Priority level**
The Strategy Development and Delivery Group's terms of reference should be reviewed regularly to ensure that they are appropriate. In addition, the membership of the group should be reviewed to ensure that the correct staff are attending and therefore will attend on a regular basis.	**Medium**
Management Response	**Responsible Officer/ Deadline**
We will review the functioning of the Strategy Development and Delivery Group as part of our review of the 2018/21 planning cycle. We will make any necessary revisions to the structure and terms of reference of the group by July 2018 in order for changes to be made ahead of the 2019/20 IMTP cycle.	Christopher Dawson-Morris, Corporate Strategic Planning Lead July 2018

9.1

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.

9.1

Prioritisation of Recommendations

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

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

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

Cardiff and Vale University Health Board

Health and Care Standards

Final Internal Audit Report

2017/18

9.2

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Ruth Walker, Executive Nurse Director
Distribution:	Carol Evans, Assistant Director Patient Safety and Quality Alexandra Scott, Patient Safety and Quality Assurance Manager
Committee:	Audit Committee

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

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1. Introduction and Background

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

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

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

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

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

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

2. Scope and Objectives

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

The purpose of the review was to establish if the UHB has adequate procedures in place to ensure that the standards are effectively utilised to improve clinical quality and patient experience and that appropriate processes are in place to assess performance against the standards.

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

- The Health & Care Standards are effectively implemented across the whole Health Board and are being utilised to improve the quality and safety of services;
- An appropriate process is in place to assess performance against the standards during 2017/18; and
- The Health Board has appropriate processes in place to oversee, monitor and report the utilisation and assessment of the standards.

3. Associated Risks

The potential risks considered in the review were as follows:

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

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Health and Care Standards is **Reasonable** assurance.

9.2

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

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

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

Review of a sample of the 12 aligned standards has confirmed that the agendas of the respective Groups / Committees are appropriately set up to reflect the criteria dictated in the Standards to which they are aligned.

Good initial progress has been made towards the completion of self-assessments of the Health Board's performance against the Standards for 2017/18.

The Health Board has an appropriate timetable in place for the finalisation and sign-off of the 2017/18 self-assessments and subsequent reporting of the outcomes to the Quality, Safety and Experience Committee. Due to the planned timescale for the production of the self-assessments and final report, they could not be reviewed as part of this audit. It is therefore noted that the Health Board will need to ensure that the actions are effectively completed as planned.

It is recommended that the Health Board continues with its plans for aligning the remaining 10 Standards over the next 2 years and further develops the operation of the identified Groups and Committees so that all of the 22 Standards are fully embedded across the organisation and performance against them is continually monitored.

5. Assurance Summary

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

Assurance Summary					
1	The Standards are not effectively utilised across the Health Board			✓	
2	The Health Board is not aware of its performance against the standards			✓	

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

6. Summary of Audit Findings

From a review of the processes underpinning the utilisation, embedding and assessment of the Health and Care Standards in 2017/18 the following points can be noted under the individual risks:

Risk 1 - The Standards are not effectively utilised across the Health Board:

- The Health Board has made further progress during 2017/18 towards ensuring that the Health and Care Standards are effectively embedded across the organisation and are being appropriately utilised.
- As part of its on-going 3 year plan, the Health Board has aligned a further 6 of the standards to existing Groups or Committees who are then responsible for the effective utilisation and assessment of the

9.2

Standards. This means that 12 of the 22 Standards have now been aligned to Groups or Committees with the plan being that the remaining 10 are aligned over the next 2 years.

- Testing carried out on a sample of 3 of the groups or committees confirmed that their agendas are appropriately set up to reflect the criteria dictated in the Standards to which they are aligned. The sampled Groups and Committees and their respective Standards were:
  - Safeguarding Group – Standard 2.7 Safeguarding
  - Falls Delivery Group – Standard 2.3 Falls Prevention
  - Medicines Management Group – Standard 2.6 Medicines Management

Risk 2 - The Health Board is not aware of its performance against the standards:

- At the time of attending the 3 sampled Groups / Committees, good initial progress had been made towards completing a self-assessment of the Health Board's position against their respective Standards during 2017/18. However it is noted that the processes undertaken by the Groups / Committees needs to be further developed in order to ensure effective input from all Clinical Boards.
- The Clinical Boards are actively engaged in preparations for the completion of self-assessments against the 10 Standards that have not yet been aligned to Specific Groups / Committees. Review of a sample of 3 of these Standards confirmed that, at the time of the Audit, all 8 Clinical Board's had completed an appropriate self-assessment of their position against the Standard during 2017/18. The sampled 3 Standards were:
  - Standard 1.1 Health Promotion, Protection & improvement
  - Standard 3.5 Record Keeping
  - Standard 6.3 Listening and Learning from Feedback
- There is a timetable in place for the final completion of the self-assessment SBARs against the 12 Standards under the continual monitoring process and the remaining 10 Standards during May 2017.
- The completed self-assessment SBARs will be subject to formal sign-off by Executive and Independent member leads and details of the UHBs compliance against the Standards is scheduled to be reported to the September meeting of the Quality, Safety and Experience Committee.
- Details of the proposed approach to the utilisation and assessment of the Standards and monitoring of progress were reported to and agreed by the Quality, Safety and Experience Committee.

Appendix A - Assurance opinion ratings

Audit Assurance Ratings

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

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

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

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

9.2

Cardiff and Vale University Health Board

Emergency Unit - 12 Hour Target

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

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	Ian Virgil – Deputy Head of Internal Audit.
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Distribution:	Richard Evans – Clinical Board Director.
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Committee:	Audit Committee.

ACKNOWLEDGEMENT
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1. Introduction and Background

The Medicine Clinical Board Director requested a review of the application of the 'Stop Clock' in relation to the Emergency Unit (EU) 12 Hour Target as an addition to the 2017 /18 Internal Audit plan. The relevant lead Executive Director for the review is the Chief Operating Officer.

The NHS Wales Outcome Framework 2016-17 includes the performance measure; 'No patient to spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge'.

The Health Board is required to report the number of patients who breach this measure to Welsh Government on a monthly basis.

Welsh Government guidance provides details of clinical instances when the Health Board can invoke a 'stop clock' for patients who had not been admitted, transferred or discharged from the Emergency Unit.

A recent analysis by the Health Board's Informatics team has suggested that there had been an increase in the number of patients that had a stop clock, where their length of stay was above 12 hours in the Emergency Unit.

2. Scope and Objectives

The purpose of the audit was to establish if stop clocks are being appropriately applied in accordance with Welsh Government guidance.

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

- Appropriate, up to date guidance on the application of stock clocks is available to all relevant staff and is in accordance with approved Welsh Government criteria;
- Where stop clocks have been invoked for patients within the Emergency Unit these have been appropriately applied in accordance with Welsh Government criteria;
- The Emergency Medicine Directorate has established a robust internal process for reviewing the application of stop clocks; and
- The outcomes of the internal review process are effectively reported within the Medicine Clinical Board and key issues are effectively escalated.

3. Associated Risks

The potential risks considered in this review were as follows:

- Non-compliance with Welsh Government reporting requirements; and
- Issues are not effectively identified, reported and 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 the Emergency Unit 12 Hour Target 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 review noted good practice within the Clinical Board via the standardised approach to applying stop clocks and the availability of guidance to front line staff. Substantive testing undertaken as part of the review has confirmed that the majority of stop clocks are being applied in accordance with the Welsh Government and Health Board guidance.

The Emergency Medicine Directorate has also introduced an effective process for internal review of the application of stop clocks. It is however noted that the governance oversight of this process would be further improved if the results were reported to an appropriate group.

The review also identified a further issue in relation to the application of specific stop clocks.

There were no high priority findings noted within this report.

5. Assurance Summary

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

Assurance Summary					
1	Non-compliance with Welsh Government reporting requirements.			✓	
2	Issues are not effectively identified, reported and 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 no issues that are classified as weakness in the system control/design for EU 12 Hour Target.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for EU 12 Hour Target.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

RISK: Non-compliance with Welsh Government reporting requirements.

We identified the following areas of good practice:

- The Welsh Government supplied guidance to all Health Board Directors of Planning /Performance and Heads of Information on the 9th July 2011. This guidance sets out the clinical criteria for the application of stop clocks for patients who spent longer than 12 hours within the Emergency Department. The Emergency Medicine Directorate subsequently produced appropriate local guidance that expands on the criteria. It is noted that this local guidance hasn't been formally endorsed by Welsh Government.
- In terms of a pan Wales approach, there was evidence that suggests the local guidance is generally in line with the reporting position in Abertawe Bro Morgannwg UHB, but the auditor could not verify any benchmarking with other Health Boards.

- This guidance was readily available to staff within the EU when the auditor performed a walk through.
- There is a national Unscheduled Care Measures Group with membership from various Heath Boards including Cardiff and Vale and Welsh Government that is tasked with exploring opportunities to implement a different approach to measures and indicators of unscheduled care services.

We identified one significant findings in relation to this risk:

- During substantive testing, two issues were identified in relation to the correct and timely application of stop clocks and the availability of back up evidence.

RISK: Issues are not effectively identified, reported and addressed.

We identified the following areas of good practice:

- The Directorate has introduced an internal process for monitoring and reviewing the application of stop clocks. A stop clock procedure document is in place for this process however it is noted that this document was only produced as at January 2018, at the request of the auditor to show a documented process.
- All breaches of the 12-hour target are investigated and verified by the Directorate Management team and any that have been inappropriately applied are reversed via the Information team.
- 12-hour Breach trend reports are received from the Performance and Information team that split the breeches by specialty, clinical board etc.
- Within the Clinical Board Quality, Safety and Experience Committee, discussion around waiting times within Acute/Emergency Medicine is a standard agenda item under timely care.

We identified one significant findings in relation to this risk:

- The outcomes of the process for the internal review of stop clocks should be reported within the Medicine Clinical Board in order to further improve the governance oversight.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding 1 - Stop Clock Compliance (Operating effectiveness)	Risk
Within the Health Board there were sixty-Four instances where "stop clocks", not associated with transfers through the EU, were applied after 8 hours and prior to 12 hours, from the period October to December 2017. The reasons for these stops are: 1. Clinical Exception. 2. Patient under Observation. The audit sampled 20 of these instances, to establish the level of compliance to the Health Boards guidance on the application of stop clocks. Results highlighted the following issues; 1. The auditor identified six instances where there was a delay in applying the stop clocks. This has meant that the patients have been unnecessarily recorded as breaching the 4-hour target. The application of these stop clocks were in compliance with the Health Boards guidance and did not have an effect on the 12-hour compliance. 2. The Auditor identified one instance with limited evidence of compliance to the stop clock guidance. If this stop clock was not applied, the 12-hour timescale would have been breached. The Directorate manager confirmed that there was not enough evidence to justify a stop clock in this instance. 3. Two files had no evidence available via the clinical portal to support the application of the stop clock.	Non-compliance with Welsh Government reporting requirements.

9.3

Recommendation 1	Priority level
Management will remind staff around the importance of timely and correct application of the stop clocks. The instance above re 12-hour breach will be updated, in accordance with requirements.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Reminder sent to all staff in Emergency Medicine.	Loretta Reilly, Directorate Manager – Emergency Medicine (Complete)

9.3

Finding 2 - Monitoring (Operating effectiveness)	Risk
Statistical information surrounding 12 hour targets are noted through the main Clinical Board performance mechanisms and the Clinical Board Quality and safety meetings highlight discussions around waits within Acute/Emergency Medicine as part of the standard agenda item under timely care. It is also noted that the Directorate has recently introduced a process for monitoring and reviewing the application of stop clocks. The governance oversight of this process would be further improved if the results were formally reported within the Medicine Clinical Board.	Issues are not effectively identified, reported and addressed.
Recommendation 2	**Priority level**
Management will ensure that the results of the internal monitoring process are regularly reported to an appropriate group within the Medicine Clinical Board.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A report on the monitoring of the application of Stop Clocks will be a standing item on the Medicine Clinical Board's monthly Quality and Safety meetings	Loretta Reilly, Directorate manager – Emergency Medicine (April 2018)

9.3

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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9.3

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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Business Continuity Planning Follow-Up

FINAL INTERNAL AUDIT REPORT 2017/2018

Cardiff and Vale University Health Board

Private and Confidential

9.4

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

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Auditors: Ian Virgill, Deputy Head of Internal Audit;
Kimberley Rowe, Principal Internal Auditor

Executive sign off : Abigail Harris, Executive Director of Planning

Distribution: Angela Stephenson, Head of Emergency Preparedness, Resilience & Response

Committee: Audit Committee

ACKNOWLEDGEMENT

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1. EXECUTIVE SUMMARY

The follow-up review of Business Continuity Planning (BCP) was completed in line with the Internal Audit Plan.

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

The original BCP Internal Audit report was finalised in February 2015 and highlighted a total of three issues which resulted in an overall assurance rating of Limited Assurance.

A subsequent follow-up review was completed in May 2016. This identified that whilst some progress has been made towards implementing the agreed management actions, there were still a number of issues to be addressed and the rating therefore remained at Limited Assurance.

The risk considered in the previous review was as follows:

- The UHB cannot provide an adequate service in the event of a significant event or in the face of adverse conditions.

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

- Finding 1 (High Priority):
    - Responsibility for leading on BCP to lie with the Executive Director of Strategy and Planning;
    - In light of the Clinical Board authorisation process, it is now appropriate that BCP becomes a routine agenda item for both Governance and Audit meetings; and
    - At a strategic level, support for UHB wide plans will be via the Civil Contingency function. Local/ operational plans will continue to be the responsibility of individual Clinical Boards, with a framework provided from the Planning Department.
- Finding 2 (High Priority):
    - With guidance from the Planning Department, Clinical Boards will set out formally their arrangements for BCP. Clinical Board triumvirates are required to formally review all escalation/ business continuity/ recovery documents within their areas of responsibility.
- Finding 3 (Low Priority):
    - A formal guidance document and BCP template has been developed. This has been piloted within two areas and is now ready for further dissemination. The required roll out will occur on an incremental basis during 2015.

- There is risk in the current civil contingency model, with capacity limited by a single Civil Contingency Manager. The Executive Director of Strategy and Planning will review the Civil Contingency model for business continuity requirements.

2. CONCLUSION AND FINDINGS

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

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

9.4

Meetings were held with the Head of Emergency Preparedness, Resilience and Response (EPRR) and a sample of three Clinical Boards: Surgery, Mental Health (MH) and Primary Community and Intermediate Care (PCIC); to gather an update on progress against the management responses cited.

The follow up review concluded that, based upon these discussions and review of the evidence provided, steps have been taken to improve BCP within the Health Board. However, despite this progress and due to the infancy of the guidance, the Business Continuity Plans are yet to be fully developed and documented and are therefore not completely embedded throughout the Health Board.

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 BCP has increased to **Reasonable Assurance**.

It is however noted that, despite this improved assurance, further work is still required to ensure that consistent documented Business Continuity Plans are in place across the whole Health Board. Progress against the outstanding actions will continue to be monitored as part of the regular, on-going follow-up process.

The EPRR Team have put processes in place to address a number of the issues highlighted from the original review and thus the management actions progressed to date can be summarised as follows:

- Responsibility for leading on Business Continuity Management has been formally assigned to the Executive Director of Planning to ensure that there is a suitable overarching system and process in place to enable success. Their responsibility is to oversee the EPRR agenda within the UHB by means of receipt of annual reports to the Executive Board. (Finding 1 – Fully Actioned);
- BCP has been added to the agenda at Clinical Board meetings, this has been demonstrated by both Surgery at their Health and Safety Group and PCIC Clinical Board with their EPRR BC Task and Finish Group; whilst MH had BCP on their H&S meeting agenda, this was not discussed. The Emergency Planning Forum was re-established but due to lack of attendance has since disbanded. It is planned that assurance will be gained over the implementation and compliance with the BC policy and BCM process within Clinical Boards via quarterly meetings of the Director of Operations chaired by the Chief Operating Officer. The first meeting of this kind took place on 2 May 2018. (Finding 1 – Fully Actioned);
- The EPRR team have produced detailed BCP Guidance that sets out what is expected by the CB Triumvirate team, the respective Directorate Managers/ Service Leads and staff throughout the whole UHB. Conversations with the sampled Clinical Boards confirm that this guidance has been shared and communicated. The guidance includes templates as appendices which are helpful tools to support Clinical Boards and their Directorates in developing and documenting their BCPs. (Finding 1 – Fully Actioned);
- In recent months the Business Continuity Policy and the aforementioned guidance has been approved by the Management Executive Team, the Resource and Delivery Committee and most recently the Board on the 29 March 2018. Whilst it has been demonstrated that this guidance has been circulated to the Clinical Boards and recently published on the intranet, due to its infancy the requirements are not fully embedded within the Health Board. (Finding 3 – Partially Actioned);
- There is a Head of Emergency Preparedness, Resilience and Response (EPRR) for the Health Board who leads on BCP. The Civil Contingency model was reviewed and a business case put forward for two new posts, only one was approved and has been filled; they are part of the EPRR team and not directly responsible for BCP. Business Continuity needs to be embedded and managed throughout the Health Board, to enable this a number of leads have been assigned for the Clinical Boards and Corporate functions. (Finding 3 – Fully Actioned).

The significant, high priority, issue that remains from the original review can be summarised as follows:

- The EPRR team have begun to accumulate BCPs from across the Health Board, but at the time of fieldwork these plans do not cover all areas of the Health Board. Where plans have been supplied, these are not in the prescribed format set out by the templates within the BC guidance. Our review of the 3 sampled Clinical Boards identified that none had any documented BCPs in place.

  The audit has noted that whilst plans are not formally documented, that does not mean that there are not processes in place to manage business continuity in the event of some types of incidents. (Finding 2 – Not Actioned)

The audit has noted that PCIC have made active, positive steps to progress BCM by establishing an EPRR BC Task and Finish Group with a key purpose to:

- *To ensure business continuity plans are in place for key PCIC services and agree a reviewing schedule to review and update plans. The audit notes that these plans are still being developed.*
- *To ensure an adequate response by the Clinical Board in the event of a major incident. This has been demonstrated by PCICs learning from prior events, they undertook an exercise after the recent adverse weather conditions and also attended the NHS response conference following the Manchester Arena attack. They have also developed local guidance on major incidents and ensure they have a senior manager on call to deal with events that might affect business continuity 365 days a year.*
- *To plan and facilitate regular training exercises to test the preparedness, response and resilience of PCIC services. They have designed resilience training for its staff in conjunction with the EPRR team.*
- *To allocate and track actions related to progressing PCIC Clinical Board's emergency preparedness.*

Business Continuity Follow-Up

Cardiff and Vale University Health Board

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.

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

9.4

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*
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Cardiff and Vale University Health Board

Mortality Reviews

Final Internal Audit Report

2017/18

9.5

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Auditors:	Ian Virgill, Stuart Bodman
Executive sign off:	Dr Graham Shortland, Executive Medical Director
Distribution:	Dr Tony Turley, Assistant Medical Director, Quality and Safety Joy Whitlock, Quality and Safety Improvement Manager
Committee:	Audit Committee

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1. Introduction and Background

The review of Mortality Reviews was undertaken and completed in line with the 2017/18 Internal Audit Plan.

The relevant lead Executive Director for the review is the Medical Director.

In 2013 the Chief Medical Officer for NHS Wales recommended that all patients who die in a hospital in NHS Wales have a mortality review. The purpose of the reviews is to generate learning about the quality of care and treatment and to identify and act on any concerns in the post-Francis era of candour.

Case note mortality reviews are a 2-stage process – the first is a universal mortality review (Level 1), which is an initial screening of all deaths. If any concerns are identified, that individual's case is subject to a more in depth Level 2 review. This involves an in-depth case note review which can, where necessary coordinate with the Putting Things Right process.

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 completion of Mortality Reviews, 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 review was to establish if the appropriate level of mortality reviews are being completed for all deaths within the Health Board.

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

- The UHB has appropriate policies and procedures in place for the completion of mortality reviews in line with Welsh Government requirements and these are effectively communicated to relevant staff;
- Level 1 mortality reviews are appropriately completed for all deaths within the UHB's hospitals;
- Level 2 mortality reviews are appropriately identified and effectively completed where required;
- All completed reviews are accurately recorded within a central database;
- Effective processes are in place for monitoring and reporting the level of compliance with required mortality reviews, both within the UHB and to Welsh Government;
- A robust review / validation process is in place to assure the accuracy and quality of completed mortality reviews; and

- Outcomes from the mortality review process are effectively reviewed, analysed and reported at a Directorate, Clinical Board and Health Board level and actions are taken to address issues identified.

3. Associated Risks

The potential risks considered in this review are as follows:

- Non-compliance with Welsh Government requirements to report level 1 reviews; and
- Threats to patient safety / opportunities to improve mortality rates not identified or addressed / 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 Mortality Reviews 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 audit identified that the Health Board has appropriate processes in place to enable the completion of Level 1 and Level 2 mortality reviews. Completed reviews are subject to review, moderation and reporting to respective Quality and Safety Groups by the investigating clinicians.

Mortality information is regularly reported at Directorate, Clinical Board and Health Board level and monthly returns are provided to Welsh Government accordingly.

However, two key findings were identified that require management attention and action, namely; improvements to the Universal Mortality Review form to clarify the criteria to trigger a Level 2 review and the need to introduce and implement central processes to record and collate Level 2 reviews and their outcomes which would complete the mortality review cycle.

5. Assurance Summary

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

Assurance Summary					
1	Non-compliance with Welsh Government requirements			✓	
2	Threats to patient safety / opportunities to improve mortality rates not identified or addressed / 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 1 issue that is classified as a weakness in the system control/design for Mortality Reviews.

Operation of System/Controls

The findings from the review have highlighted 2 issues that are classified as a weakness in the operation of the designed system/control for Mortality Reviews.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

RISKS 1 & 2: Non-compliance with Welsh Government requirements and potential threats to patient safety / opportunities to improve mortality rates not identified or addressed / implemented.

The following areas of good practice were noted:

- The UHB has appropriate procedures in place to enable the completion of mortality reviews in line with Welsh Government requirements and these are effectively communicated to medical staff.
- The Health Board has a Universal Mortality Review form in place that should be completed for all inpatient deaths, by the doctor completing the death certificate. This form covers the minimum standard questions required for a level 1 mortality review and identifies where a level 2 review may be required.
- All completed Universal Mortality Review forms are subject to review by the Patient Safety and Quality Team and are recorded on the Electronic Mortality Audit Tool (EMAT) database.
- For all deaths that are flagged as requiring a level 2 review, the EMAT database automatically issues an Email to the relevant consultant highlighting the need for a level 2 review to be completed.
- Level 2 reviews are being undertaken by the relevant Consultant medical staff and the outcomes of these are being reported to Directorate Quality and Safety Groups when appropriate for further evaluation and identification of lessons to be learned and / or actions to be taken.
- Data on the percentage level 1 review compliance and the number of level 2 reviews indicated is extracted from the EMAT database and reported to the Medical Director, Quality, Safety and Experience (QS&E) Committee and Board.
- All Directorates have access to the EMAT database and can view crude mortality data for their areas. The Assistant Medical Director, Patient Quality & Safety utilises the data provided from the mortality reviews to identify issues / trends including peaks in mortality rates, differences in weekend / weekday rates and Differences in mortality rates following admission through UHW / Llandough MAUs.
- A Mortality Review pro-forma is submitted to Welsh Government on a monthly basis.
- A six monthly report on Mortality Data and Mortality Review is produced by the Quality & Safety Improvement Manager and reported to the QS&E Committee. The report includes data on

mortality rates and analysis of the triggers for level 2 reviews along with highlighting key mortality issues, trends and developments.

The following significant findings were noted:

- The Health Board is currently reporting an average 80% compliance rate with the requirement to complete a level 1 review for all in-patient deaths.
- A question cited on the Universal Mortality Review form pertaining to the need to trigger a Level 2 review may be misleading in content.
- The UHB does not currently have a system in place for centrally monitoring and reporting the completion of all triggered Level 2 reviews covering all clinical specialities, as it does with Level 1 reviews.

7. Summary of Recommendations

The audit findings and 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**	**2**	**0**	**3**

Finding 1: Documentation and centralisation of Level 2 Mortality Reviews (Control Design)	Risk
Testing was undertaken on a sample of deaths that were flagged as requiring a level 2 review. For each of the sample, it was identified that Emails were appropriately sent to the relevant consultants from the EMAT database highlighting the need for a review. As part of our testing we received Emails back from the relevant consultants confirming that the required Level 2 reviews had been undertaken and where appropriate, findings that required action and 'lessons learned' were presented to Quality and Safety Groups. However, none of the responding consultants were able to provide any documented evidence of the completed Level 2 reviews. It is noted that the UHB does not currently have a procedure in place that states how consultants should evidence or record the completed level 2 reviews. There is also no central process in place for monitoring and recording if the required level 2 reviews have been completed.	Non-compliance with Welsh Government requirements and Potential Threats to patient safety / opportunities to improve mortality rates not identified or addressed / implemented.
Recommendation 1	**Priority level**
Best practice would dictate that the UHB should introduce a mechanism of central oversight and implement processes that collate, monitor, record and report all completed Level 2 reviews that cover all clinical specialities, such as currently happens with Level 1 reviews.	**High**

9.5

Management Response	Responsible Officer/ Deadline
Work is underway to design an all-Wales Level 2 mortality screening tool. The UHB has a representative on the national steering group (Quality and Safety improvement Manager - Joy Whitlock). The draft version has been circulated via the clinical boards to test and feedback comments which will be relayed to the national group. The Audit Committee is asked to extend the normal deadline period to August 2018 so as to align with the completed All-Wales Work.	Quality and Safety improvement Manager / August 2018
Similarly a once for Wales approach is being followed to procure a platform to record the level 1 and level 2 mortality reviews. Current forerunner under development is the Datix Cloud. The prototype will be available in the next couple of months with the intention to procure a system in October. A discussion/decision will be required regarding the UHB developing our own solution against the general direction of the Wales approach. The decision will need to be aligned to the introduction of the medical examiner role in England and Wales – timescale to be determined. The Audit Committee is asked to extend the normal deadline period to October 2018 so as to align with the completed All-Wales Work.	Medical Director / October 2018

9.5

Finding 2: Completion of Level 1 review (Operating Effectiveness)	Risk
The audit has highlighted that appropriate processes are in place within the Health Board to enable the completion of level 1 mortality reviews. However the average monthly percentage of inpatient deaths that have a mortality review completed (as reported to the December 17 Quality, Safety and Experience Committee) is only around 80%.	Non-compliance with Welsh Government requirements and Potential Threats to patient safety / opportunities to improve mortality rates are not identified or addressed / implemented.
Recommendation 2	**Priority level**
The Health Board must ensure that level 1 mortality reviews are completed for all inpatient deaths.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A review of the current paper trail will be undertaken and improved as necessary. Clinical Boards will be reminded of the need to complete the level one reviews at the time of death certification as acquiring the notes afterwards is often difficult due to the current process of managing case notes of deceased patients in medical records. A meeting will take place with the CD for Internal Medicine to review their processes as they have the most deaths in the UHB. The Medical Director will note the findings of the Internal Audit in the June HSMB Meeting to ensure the Clinical Boards are reminded of their responsibility to complete level one reviews.	Quality and Safety improvement Manager / July 2018 Quality and Safety improvement Manager / June 2018 Medical Director/June 2018

9.5

Finding 3: Death Database Form (Operating Effectiveness)	Risk
One of the Universal Mortality Form questions pertaining to the need to trigger a Level 2 review is written as a 'double negative'. Bereavement Office staff stated that this has caused confusion to many doctors who complete the form and as such has given rise to incorrect completion (yes being a no and vice-versa) and the potential triggering of unnecessary 'Level 2' investigations to be undertaken by Consultants/Registrar clinical staff. Conversely, there is a risk of a 'Level 2' investigation not being undertaken when one would be required. It is noted that whilst the narrative causes confusion, no action has been taken to escalate the issue to management with a view to amending the question into a more understandable format. The wording of the question on the form is 'Is there any documentation, or lack of it, that suggests that the following procedures were not carried out? (Answering "no" would indicate that they were appropriate)'	Non-compliance with Welsh Government requirements and Potential Threats to patient safety / opportunities to improve mortality rates are not identified or addressed / implemented.
Recommendation 3	**Priority level**
The Universal Mortality Review form question pertaining to the need to trigger a Level 2 review should be revised and re-written to improve clarity and remove ambiguity as to its application.	**Medium**

9.5

Management Response	Responsible Officer/ Deadline
The wording on the form and subsequent IT development was so that any 'yes' answer would trigger a level 2 review. The double negative was a calculated risk. Given this feedback we will review and revise it.	Quality and Safety improvement Manager / July 2018

Appendix B - Assurance opinion and action plan risk rating

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9.5

Prioritisation of Recommendations

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

Final Internal Audit Report

Cardiff & Vale University Health Board

2017/18

9.6

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance

- +
Previous review rating Reasonable Assurance

Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)
Cardiff & Vale University Health Board

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9.6

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Executive sign off	Abigail Harris, Executive Director of Planning
Distribution	Geoff Walsh, Director of Capital, Estates and Facilities Jeremy Holifield, Head of Capital Planning
Committee	Audit Committee

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

Cardiff & Vale University Health Board

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1. Introduction and Background

The project aims to provide accommodation to support the future configuration of specialist neuro and spinal rehabilitation at University Hospital Llandough and elderly care services at St David's Hospital in Cardiff, thus enabling the Rookwood Hospital Charity to dispose of the Rookwood Hospital site.

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

Subsequent to the prior audit, the original Full Business Case (FBC) was endorsed by the Board (25 May 2017) and submitted to the Welsh Government for approval in the sum of circa £30m. Subsequent to the submission of the FBC, the original Supply Chain Partner withdrew from the project and the UHB were required to appoint a new contractor. The scope of the current audit focused on the period subsequent to the new appointment.

Market testing / discussions with the supply chain were ongoing to determine a 'not to exceed' figure by December 2017; with a view to submit an updated FBC in January 2018 [this was subsequently revised to April 2018 and therefore outside of the scope of the current audit].

2. Scope and Objectives

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

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

- **Follow up -** Review the status of previously agreed audit recommendations and associated management actions.
- **Governance Arrangements -** Assurance that appropriate governance arrangements were established for the current project phase e.g. including operation of effective reporting and accountability lines via the Project Board to the Investment Decision Maker.
- **Appointment and Contracting -** Assurance that appropriate contract documentation had been completed in accordance with the current phase of the project to protect the interests of the UHB;

including any novation (where required) from the prior contractor and clarity of design liability.

- **Cost Monitoring and Reporting -** Assurance that adequate cost control systems were operating including:
    - Cost reporting: that there was effective control and reporting of the time and cost position;
    - Novation: costs associated with the novation of design responsibility were clearly understood, challenged and reported; and
    - Refresh of Market Testing / Target Cost Production: to ensure the Project Board was effectively informed on any impact on the value for money assessment **
- **Project Management -** Assurance that generally accepted project management techniques were appropriately applied in relation to the management of risk, changes, time, cost and quality.

*** The appointed Cost Advisers were undertaking a market testing exercise to assist in the target cost production and provide assurance that value for money had been obtained. At the date of the review, the work had not been completed and approval was received from the Director of Capital, Estates & Facilities to remove this element of work from the current review (to be considered at subsequent audits).*

3. Associated Risks

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

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

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

However, at the time of the current review, clarity was required regarding the chosen procurement strategy for the project which will feed into the

finalisation of the business case process [both approval within the UHB and Welsh Government].

At the current review we noted:

- the target cost was yet to be affirmed and there was slippage in the delivery programme, noting the target cost assessment was initially scheduled to be completed in November / December 2017 and subsequently deferred until April 2018; and
- additional costs had been incurred (estimated as £964,994 at the time of the current review), arising from the as a result of the withdrawal of the previous Designed for Life: Building for Wales supply chain partner.

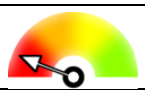
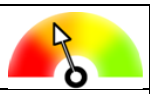
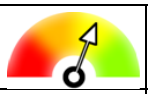
Accordingly, against this context the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the re-provision of Specialist Neuro and Spinal Rehabilitation and Elderly Care Services from Rookwood Rehabilitation Hospital is **Reasonable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

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

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

5. Assurance Summary

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

Assurance Summary					
1	Follow Up				✓
2	Governance				✓

Assurance Summary					
3	Appointment and Contracting			✓	
4	Cost Monitoring and Reporting			✓	
5	Project Management				✓

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

Design of Systems/Controls

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

Operation of System/Controls

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

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6. Summary of Audit Findings

Follow Up

We sought assurance that previously agreed management actions had been implemented. The status of these actions arising from the previous review (May 2017) was as follows:

Closed	Outstanding	Superseded	Total
3	-	1	**4**

The detail in support of the above summary is included in **Appendix B**. The status has been determined noting that a revised FBC is scheduled to be presented to the Board for approval, prior to submission to the Welsh Government, and updated for the amendments resulting from the change in Supply Chain Partner (SCP).

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

Governance

We sought assurance as to the adequacy of programme governance arrangements including the linkage with existing Board/ Committees, structures, accountability, roles and responsibilities etc.

The project structure was formally developed and established within the Outline Business Case (OBC).

Robust decision making processes were established for the project. A Project Board and a Project Team were established with appropriate terms of reference with monthly meetings being held. Accountability to the Board was demonstrated via the Specialist Services Major Project Board supported by the Specialist Rehabilitation and Clinical Gerontology Project Team.

The last Project Team meeting was held in October 2017. Noting the appointment of a new contractor, current programme and project objectives related to the update of the previously approved FBC. With no new messages to convey (noting no alteration in the service requirements for the scheme i.e. only construction / cost issues being reaffirmed), the decision was taken to defer the Project Team meetings and for all Rookwood related issues to be discussed at the Capital Management Group meetings until approval to the revised FBC was obtained.

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

Appointment and Contracting

We sought assurance that appropriate contract documentation had been completed in accordance with the current phase of the project to protect the interests of the UHB; including any novation (where required) from the prior contractor and clarity of design liability.

Noting the withdrawal of the original Supply Chain Partner from the Designed for Life: Building for Wales framework, the UHB were required to appoint an alternative contractor. Guidance was sought from NWSSP: Specialist Estate Services (SES) regarding the options available to the UHB which would minimise the overall delay to the project and enable the retention of the existing design team.

The following options were presented to the Capital Management Group with the latter deemed the most favourable:

1. Direct appointment of the existing design team by the UHB; noting the value of the FBC works would require a full OJEU procurement process.

2. Utilise the Designed for Life 3 Framework; noting the legal implications for existing SCP's to substitute their design teams for those used by the previous contractor [UHB expressing a desire to retain the existing design team appointments for inherent knowledge and expertise].
3. Utilise alternative National Construction Frameworks (e.g. SCAPE Framework); noting the ability to retain the existing design team and appoint a suitable contractor.

Whilst approval for the choice of framework was provided at both UHB and Welsh Government (WG) level, the consideration of the contractual options available within the SCAPE Framework, the advantages and disadvantages of each (including implications on contractor pricing mechanisms) had not been determined **(recommendation 1)**.

The signed delivery agreements were evidenced for the following:

- Provision of project management, cost management, architectural, structural and M&E design: The scope of work related to stage 4 activities, together with a review of the stage 3 design and works costs. The delivery agreement applied for the period 1st November 2017 to 30th April 2018 [proposed submission date of the FBC to Welsh Government]. There was evidence of agreement signed by all relevant parties; however, the date of signing [22 November 2017] was post the contract commencement date **(recommendation 2)**;
- Supply Chain Partner: The scope of work related to stage 4 activities and Design Management Services. The agreement had been signed appropriately by both parties for the current stage of the project.

Whilst **reasonable assurance** has been determined, confirmation of the contract option to be applied will be required as part of the Full Business Case approval process.

Cost Monitoring and Reporting

We sought to establish an assessment of the adequacy of the data collated, evaluated and reported, representing the cost position of the project.

Highlight reports, prepared by the Head of Capital Planning, were presented to the Project Team. Noting the deferral of team meetings to the Capital Management Group [as the FBC process progresses], the last highlight report was prepared in October 2017.

The financial summary provided to date provided the following synopsis:

OBC approved capital cost	£16,344,102 (inc. VAT)
Original FBC	£29,984,014 (inc. VAT, net VAT reclaim)

No further cost information (to that detailed above) had been made available through reporting to the Capital Management Group; only acknowledgement of the 'not to exceed' cost of £19,700,469 presented by the contractor in December 2017; with further work to be undertaken on the Stage 4 design to establish an FBC cost by the end of April 2018 (revised date).

The Cost Adviser prepared a further report providing a comparison of the proposed FBC with that prepared by the previous contractor. Capital costs had increased by £964,994 to £30,949,008 with the major reasons for the increase cited as:

- Additional fees in producing the new FBC costs and associated documents;
- Inflation: increase of 5.6% in the PUBSEC index from the quarter in which the original FBC was prepared to the current quarter [4th quarter 2017]; and
- The loss of reclaimable VAT as a consequence of changes in the procurement route i.e. the utilisation of the Scape Framework rather than the Designed for Life: Building for Wales Framework.

It was reported that there had been no alterations to the design/works content of the scheme; the current contractor market tested the works at University Hospital Llandough (UHL); and the previously prepared costs for work at the CRI would be used (updated for preliminaries, fees, and risk) **(recommendation 3)**.

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

Project Management

We sought to assess whether adequate project management arrangements were established and operated that included the management of progress to deliver the full business cases; time and cost performance; risk and performance monitoring.

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

The Change Management strategy was included within the original FBC [approved by the UHB Board in May 2017].

No changes to the management processes previously defined relating to the relocation exercise were evidenced.

The project risk register was considered routinely with the top risks being reported within the monthly Welsh Government dashboard reports. At the date of the review, the total quantified risk was £1,750,000 of which £1,167,000 was attributable to the SCP and £583,000 to the UHB.

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

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Current year recommendations	-	2	1	**3**
Actioned since fieldwork / draft report stage	-	*2*	-	***2***
Recommendations to be addressed	-	-	*1*	***1***

Finding: Procurement Strategy	Risk
In order to appoint a new contractor, the UHB adopted the SCAPE Framework. SCAPE is a public sector, single contractor framework (therefore requiring no mini-competition). The framework enables the works to be procured using the NEC Engineering and Construction Contract using either Option A (Priced Contract with Activity Schedule) or Option C (Target Contract with Activity Schedule of Short Contract). The paper presented to the Capital Management Group (July 2017) does not provide sufficient detail on the intricacies of the preferred choice of procurement strategy; and subsequent reporting does not provide reference to the chosen option within the framework. Clarity on the chosen option is required to assist the SCP in their pricing mechanism and consideration of the risks and rewards associated with the project.	Value for money may not be achieved. The UHB's ability to make informed decisions may be reduced.
Recommendation 1	**Priority level**
The Procurement Strategy will be defined, within the FBC and consider all of the advantages / disadvantages if utilising the chosen framework and the options therein **(D)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Other contractual options available in the SCAPE Framework were not considered so as to align the contract with Designed for Life parameters i.e. the use of NEC Option C. The contract option adopted is indicated in the FBC.	Director of Capital, Estates & Facilities Actioned since fieldwork

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Finding: Contract Documentation	Risk
Copies of the delivery agreements for the following were obtained: • Provision of Project Management, Cost Management, Architectural, Structural and M&E design; and • Supply Chain Partner The Project Management [et al] delivery agreement was signed [22 November 2017] after the contract commencement date for work on stage 4 activities and the review of stage 3 design and works costs.	Risk of financial exposure in event of contractor failure.
Recommendation 2	**Priority level**
At future schemes contract documentation will be signed prior to the commencement of the respective commissions/works **(O)**	**Low**
Management Response	**Responsible Officer/ Deadline**
Noted and accepted.	Director of Capital, Estates & Facilities At future schemes

9.6

Finding: Finalisation of FBC	Risk
Whilst acknowledging the on-going work to establish the revised target cost, noting the delays encountered on the relocation project to date, timely approval and submission of the FBC to the WG is imperative.	Appropriate approvals have not been sought. Increased cost pressures on the UHB in the event of WG approval below expectation.
Recommendation 3	**Priority level**
Appropriate, timely internal approval will be sought for the change in capital cost and supporting assumptions, prior to submission to the WG **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
After completion of the audit fieldwork, Chair's Action approved the FBC prior to submission to the WG.	Director of Capital, Estates & Facilities Actioned since fieldwork

9.6

Prior ref	Recommendation	Action / Status	Updated responsibility and timescale	Current year priority rating
Medium				
2 & 3	Appropriate internal approval will be sought for the increase in capital cost and supporting assumptions, prior to submission to Welsh Government **(O)** The Board will be asked to approve the additional revenue associated with the project, and confirm the source of funding **(O)**	**Closed** The FBC prepared following conclusion of the 16/17 audit review was presented to the Capital Management Group and Business Case Approval Group prior to submission to Board in May 2017. It was highlighted that engagement had taken place some time ago and that more funding (capital and revenue) than originally anticipated was required.	N/A [Noting that a revised FBC is to be presented to the Board for approval, updated for the amendments resulting from the change in SCP]	N/A
Low				
1	As has been included in previous reports, the Capital Procedures Manual should be revised to include the requirement for a Project Director's Acceptance Certificate signed by the Chief Executive and Project Director **(O)**	**Closed** Whilst the completion of a certificate is acknowledged as best practice amongst other Health Boards, the UHB's Capital Manual states the role of Project Director is assigned to the Director of Capital, Estates	N/A	N/A

Prior ref	Recommendation	Action / Status	Updated responsibility and timescale	Current year priority rating
		& Facilities for all major capital schemes. Review of WG Dashboard Reports confirms this; therefore the current arrangements are deemed to be an acceptable mitigating control.		
4	Management will establish the mitigating controls with Welsh Government for cost increases likely to be encountered in the time period following approval of the FBC and commencement of site works at UHL and CRI **(O)**	**Superseded** Noting the departure of the main contractor from the project, work had been undertaken to reappoint package subcontractors under the new SCP, therefore permitting current figures to be reflected in the FBC (to be submitted). Current market testing work remains on-going.	N/A [Noting that a revised FBC is to be presented to the Board for approval, updated for the amendments resulting from the change in SCP]	N/A

9.6

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

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

9.6

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

University Hospital of Wales Neo Natal Development

Final Internal Audit Report

2017/18

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

Reasonable Assurance

- +

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9.7

Review reference:	SSu CV 1718_01
Report status:	Final
Fieldwork commencement:	4th September 2017
Fieldwork completion:	12th March 2018
Draft report issued:	16th March 2018
Draft report clearance meeting:	20th March 2018
Management responses received:	5th & 27th April 2018
Final report issued:	30th April 2018
Auditor:	David Catterall
Executive sign off	Abigail Harris, Executive Director of Planning
Distribution	➢ Geoff Walsh, Director of Capital, Estates and Facilities ➢ Jeremy Holifield, Head of Capital Planning
Committee	Audit Committee

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

Please note:

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

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

This review of the Neonatal development at the University Hospital of Wales has been completed in accordance with the agreed internal audit plan.

A Business Justification Case (BJC) was developed identifying the need to refurbish HDU and SCBU as part of the wider refurbishment and reconfiguration of the Neonatal and Obstetric services at UHW.

BJC 1 was submitted in October 2015 and received Welsh Government approval in November 2015 with associated funding of £7.472m. This was subject to a prior audit (July 2016) that provided a reasonable level of assurance. These elements of work were subsequently completed and handed-over to the University Health Board (UHB), in April 2017.

A further BJC 2 was produced for the remaining phases of the programme (e.g. ICU, support accommodation, clinical support, office accommodation), with Welsh Government approval received in November 2016.

In February 2017, further approval was received for the addition of a replacement MRI, accordingly the total approval for BJC2 was £37.092m with an anticipated completion date of 25th February 2019.

Noting the above, and the current stage of the project delivery programme, this audit has not sought to assess compliance with the Welsh Government approval mechanisms applied to date.

As noted, this is the second interim audit of the development and focused on the works included within the second business justification case and the addendum for the MRI and sought to gain assurance that appropriate arrangements were established to deliver these elements of the project.

2. Scope and Objectives

The scope and remit of the audit included the following:

- **Previously Agreed Management Action -** A review of the status of previously agreed management action.

- **Governance Arrangements** – to obtain assurance that current governance arrangements were adequate to provide assurance to the Board in relation to the project.

- **Contract –** to obtain assurance that the appointment of the contractor and advisers complied with local and national protocols. To ensure that an appropriate contract strategy had been implemented that protected the interests of the UHB.

- **Cost Control and Reporting -** assurance that adequate cost control and reporting systems were operated (internally and by external agents).

- **Programme Management –** To ensure that appropriate arrangements were in place to manage the project programme, including a review of action to assess and manage the impact of delays.

- **Risk Management –** assurance that arrangements were in place to identify, assess and mitigate/manage key project risks. The risk profile is then monitored against available contingencies.

- **Change Management -** appropriate arrangements were in place to control project changes, ensuring that the time/ cost implications are adequately considered by management prior to instruction.

- To identify any **other issues** material to the successful achievement of the project's objectives.

3. Associated Risks

The potential risks considered in the review were as follows:

- Inadequate organisational and governance arrangements are in place;
- The contract strategy applied does not offer best value and/or protect the interests of the Health Board;
- The cost reporting and monitoring systems at the project are inadequate;
- Programmes are poorly controlled leading to delays and disruption;
- Risks are not adequately identified and/ or poorly managed.
- The time and cost implications of changes are not adequately considered by management prior to instruction, leading to loss of control of time and cost.

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 University Hospital of Wales Neo Natal Development is **Reasonable Assurance**.

The primary reasons for this level of assurance are:

- The evidence that the control and reporting systems operated by the UHB project management team and its advisers were appropriate for the current stage of the project.
- However, it was also reported that there were on-going risks that could still affect the programme for the MRI New Build and the Obstetrics 2 phases.
- Since completion of our fieldwork, the level of cost risk presented by the MRI New Build had been reduced following the agreement of the Target Cost for the base build (March 2018). We noted the current position with respect to the MRI design and costing process and the resultant reduction in the available contingency sum but still presents a significant cost pressure.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Governance arrangements				✓
2	Contract				✓
3	Cost Control & Reporting		✓		
4	Programme Management			✓	
5	Risk Management			✓	
6	Change Management			✓	

** 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 were classified as weakness in the system control/design for the Neo Natal Development.

Operation of System/Controls

The findings from the review have highlighted **five** issues that were classified as weaknesses in the operation of the designed system/control for the Neo Natal Development.

Previously Agreed Management Action

We sought to review actions to address outstanding recommendations agreed at the previous audit (issued July 2016), review the effectiveness of the current implementation of prior recommendations and re-considered their action status, where applicable.

The status of agreed management action arising from previous audit reports was as follows:

Priority	H	M	L	Total
Number of Recommendations	**2**	**5**	**4**	**11**
Recommendations Implemented/Closed	**2**	**4**	**3**	**9**
Recommendations not Implemented	**0**	**1**	**1**	**2**

Please see **Appendix B** for detail.

Summary of Audit Findings

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

9.7

Governance arrangements

We sought to confirm that current governance arrangements were adequate to provide assurance to the Board in relation to the project.

An approved project structure had been established and detailed within both the Project Execution Plan (PEP) and the Business Justification Case (BJC2). Key roles and responsibilities supporting the project management structure had been defined and allocated.

Whilst noting the above, the previous audit (undertaken during 2016/17), made a low priority recommendation with regard to the use of a Project Director's certificate of acceptance. This recommendation remains outstanding.

A Project Board had been established within the governance structure, with appropriate terms of reference. The Project Board reported to the UHB via the newly established Strategy & Engagement Group alongside the Capital Management Group. Key stakeholders were represented on the Project Board and members regularly attended the scheduled meetings. Meetings were minuted and key decisions and monitoring of key areas in accordance with the terms of reference was evidenced.

A Project Team was also established (providing operational support to the Project Board), with appropriate skills and resources to progress the project. The Project Team's progress on key tasks was effectively

managed. The Project Manager and Cost Adviser produced regular monthly progress reports on the project.

Noting the established project structure and report arrangements through to the Board, we determined **substantial assurance** in relation to current governance arrangements.

Contracts

We sought to confirm that the appointment of the contractor and advisers complied with local and national requirements. Also that an appropriate contract strategy had been implemented that adequately protected the interests of the UHB.

The procurement strategy for the Supply Chain Partner (SCP) and advisers was documented within the original Business Justification Case.

The contract between the UHB and main contractor was originally executed for phase 1a & phase 1b works. The form of contract applied was the NEC3 Option C: Target Cost with Activity Schedule.

9.7

The procurement plan allowed for anticipated future phases to be added to the building contract via the issue of Compensation Events. However, as the project progressed, the UHB was advised that this approach was likely to create commercial management and legal issues. The UHB sought to eliminate this risk and following advice from NWSSP Specialist Estates Services (SES) and the framework legal advisers, the building contract was amended (via a Deed of Variation), to include 'sectional completion' for each of the identified phases. In summary these are:

BJC1:

Section 1 : Phase P1b & 1b (delivered)

BJC2:

Section 2 : Phase 3 (delivered)

Section 3 : OBS 1 (delivered)

Section 4 : Demolition (MRI) (on site)

Section 5 : MRI new build (including P2B) (pre-construction)

Section 6 : Phase 2A (pre-construction)

Section 7 : OBS 2 (pre-construction)

All contract documentation was appropriately executed on behalf of the UHB, its supply chain partner and advisers respectively. Each section was

let and confirmed with the supply chain partner (main contractor) following agreement of the Target Cost.

Noting the process of determining the contract strategy for Phases 2-7 involving professional advice from SES and the framework lawyers, and taking account of the current position regarding the letting of the works to the main contractor, we have determined **substantial assurance** in respect of contracts.

Cost Control & Reporting

We sought to confirm that adequate cost control and reporting systems were operated at the project.

The Cost Adviser produced monthly reports that contain adequate information for cost control purposes. The Project Manager also produced monthly reports and provided detailed commentary on the contract progress, commercial position and risk profile.

The UHB produced regular Monthly 'Dashboard reports' that were presented to the Project Board and Capital management Group, prior to their submission to Welsh Government. Regular meetings were held with Welsh Government to review progress and any issues arising at the project.

The latest Project Manager's Report, dated February 2018, was reviewed together with the corresponding Financial Statement. *Following issue of our Draft Report we also reviewed the Project Manager's Report and Financial Statement issued in March 2018.* In summary, the key issues reported in respect of costs were as follows:

- The BJC2 works were forecast to be "affordable" within the total approved funding allowance by the Cost Adviser. Although this assessment, by the Cost Adviser, included contingency considerations applied to OBS2 and MRI works, it excluded all risk register values (These were however included in the Project Manager's Report).
- At the time of the main audit fieldwork (February 2018), and based on current works cost forecasts, only 42% had been procured and 58% was subject to a Pre Tender Estimate. *(However following the issue of our Draft Report in March 2018 the Target Cost had been agreed for the MRI new build. The Project Manager's Report in March stated that 84% of the works had now been procured. The remaining 16% related only to the Obstetrics 2 works.)*
- The MRI new build presented a "significant level of commercial risk and /or design risk" that could put "severe pressure on the remaining contingency". The current PTE was valued at £10.36 million.

However, the budget within the approved BJC was only £7.44 million. A variance of £2.92 million. Key reasons determined for the cost escalation were:

- the size of the building had increased;
- the engineering strategy had changed due to additional clinical accommodation being included in level 1; and
- the building orientation had changed; and sprinklers had been included throughout the building.

We were advised that any increases in project costs would need to be funded from the existing project contingency of £4,127,339. However, the affordability would not be affirmed until design was completed and associated costs had been validated by the Cost Adviser *(Following the issue of our Draft Report in March 2018 the Target Cost had been agreed for the MRI new build in the sum of £10.64 million).*

- In February 2018, the Cost Adviser reported that once all **known** liabilities were accounted for, the remaining contingency would be £1.582 million for all remaining phases. However, if the combined value of construction & pre- construction risk registers (£1.401 million) were also deducted, the balance of contingency would be just £181k (*In March 2018 the Project Manager reported that the remaining contingency was now £1.654 million and the combined value of construction and pre construction risk was reduced to £1.035 million. The balance of contingency would therefore be increased to £618.6k).*
- The Cost Adviser concluded that a definitive affordability assessment would not be able to be completed until all of the MRI works had been procured (*As stated above, the MRI new build Target Cost was agreed in March 2018. Also, the Obstetrics 2 Target Cost was in the process of being up-dated to Q2 2018 prices).*

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The decision to develop the plans for the MRI new build and introduce changes to the scope and content of those plans has had a negative effect on the ability to achieve early cost certainty with respect to this phase of the project. Consequently, the UHB was exposed to significant cost risks (see also Risk Management).

Noting the above, and the nature of the works, assurance is also required that any design proposals fully consider the size/weight of proposed equipment requirements and that appropriate/timely structural surveys/advice is provided to inform the design solution (considering additional work requirements, time implications (delays) and additional costs. Accordingly, we have recommended that the design for the MRI new build should be concluded and frozen as soon as possible, including

affirmation of structural issues and design elements for the MRI installation, so that the total costs and affordability of the project can be affirmed. Only then can the significant risks of overspending against the approved budget be mitigated *(We note that the Risk register includes allowance for this risk).* **(Recommendation 1)**

We have also recommended that the value of identified risk should be included within the affordability assessment. **(Recommendation 2)**.

At future projects, increased focus should be given to obtaining a definitive statement of affordability at an early stage of the planning process. This should involve the identification and assessment of the expected risk profile, completion and sign off of the design. **(Recommendation 3).**

We concluded that adequate systems of reporting of costs were operated by the Cost Adviser and Project Manager. However, we noted the current position with respect to the MRI design and costing process and the resultant reduction in the available contingency sum. We have also taken account of the reduction in risk following the agreement of the Target Cost for the MRI New Build. Accordingly, we have determined **limited assurance** in respect of overall cost control.

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Programme Management

We sought to confirm that appropriate arrangements were in place to manage the project programme, including a review of actions to assess and manage the impact of delays.

The project programme and assessment of the management of delays was performed and reported at a number of levels, including: Project Team; Project Board; Capital Management Group; Strategy & Engagement Group; Health Board (as necessary); and Welsh Government.

Key (Monthly) reports included: the Project Highlight Report; the Project Dashboard Report; and the Project Manager's Report.

The Project Manager confirmed that all construction phases were contained within one master programme. Progress and status for each phase was reported separately.

The Project Manager provided a detailed summary of progress and delays on each of the defined sections of the contract. As at February 2018, the following was noted:

- all construction phases were contained within one master programme. Progress and status for each phase were reported individually, with damages to be applied at each section and compensation events issued extending the sectional completion dates

as appropriate. Gain/ pain share and target costs were also managed at individual sectional completion elements;

- Obstetrics 1 (OBS1) (section 3) works were reported to have achieved completion on 20th December 2017, the contract completion was 5th December 2017. There was delay in issuing the completion certificate whilst a late change in the tap specification was investigated.
- the Demolition Programme (section 4) had reported a 10-week delay. The Project Manager reported that this had been validated and signed off by the UHB.
- MRI New Build (Section 5) had a reported programme duration of 74 weeks 2 days. This section was reported to have started on 4th December 2017 with drainage diversions and piling mat installation. The works were reported to be "on programme". However, we were advised that the piling works were expected to incur delays.
- an initial delay of one week in the formation of the piling mat was reported due to below ground obstructions hindering drainage diversions. The discovery of asbestos was reported to also have hindered progress to the piling mat. This caused the piling contractor to commence work one week later than originally programmed. However, the main contractor was reported to be hopeful that the delay could be mitigated.
- it was also reported that the piling works had not progressed at the planned rate due to the discovery that the ground strata was found to be different to that indicated on the ground investigation reports originally provided to the piling contractor. It was reported that this would have a detrimental impact on the programmed works and costs. We have recommended that a formal evaluation of the adequacy of the ground investigation reports should be undertaken and any recourse against relevant advisers determined. **(Recommendation 4)**
- Opportunities to accelerate the programme were also reported to be being explored. One proposal by the main contractor was to offer early cot spaces in December 2018, rather than March 2019. This would require the UHB to accept and manage several operational constraints.
- It was reported that the UHB had also requested the contractor to identify opportunities for programme acceleration. A proposal from the main contractor was reported to offer 26 days benefit at a cost of £110k. Savings on preliminary costs would however, reduce this cost. A decision on this would be required in May 2018.

The following programme and progress issues were reported with respect to the pre-construction elements:

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- Obstetrics 2 works information and target cost were reported to have been issued. An up-date is to be made prior to commencement of works in May 2018.
- Obstetrics 2 plant design was reported to be unacceptable to the UHB as it conflicted with other UHB works. A revised proposal was progressing through the detailed design process.
- MRI Building design was reported to have progressed as per the agreed 1:200 layouts and information has been issued to the market for pricing. 'Option 2' layout changes were reported to have been incorporated into the agreed scope and should provide value added efficiencies. However, users were reported to have requested further changes ('Option 3'), which were not included within the agreed scope. We have recommended that design changes should be minimised in order to ensure that costs can be effectively managed. User requests for additional changes that do not fall within the agreed scope should be discouraged. **(See Recommendation 3)**
- There were on-going design issues reported regarding data points; type of scanners and sprinkler systems.

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We were satisfied that appropriate arrangements were in place to manage the project programme, including a review of action to assess and manage the impact of delays. There was also evidence that opportunities for early hand-over of completed sections were actively being explored. Noting the above, we determined **reasonable assurance** with regard to Programme management.

Risk Management

We sought to confirm that arrangements were in place to identify, assess and mitigate/manage key project risks and that the risk profile was monitored against available contingencies.

We confirmed that an appropriate risk register was maintained which identified key risks on the project. The risks that were included on the register were wide ranging and affected both the project and the Neonatal service. Mitigating actions had been identified and action taken was recorded for high risk items.

The Project Manager and Cost adviser also assessed the value of risk on a monthly basis. As at March 2018, key risks included those relating to:

- Disruption / Delay created by the MRI New Build programme;
- Design changes and assumptions;
- Scope gap between MRI base build and specialist installation;

- Duration of contracted works and achievement of programme;
- Equipment budget; and
- Condition of existing hospital engineering infrastructure and potential problems of connecting new services.

We previously noted in the 'Cost Control & Reporting' section of this report that the MRI new build presented a significant level of commercial risk and /or design risk that could put "severe pressure on the remaining contingency". The risks will only be mitigated once the design for the MRI new build is concluded and frozen, including affirmation of structural issues and design elements for the MRI installation, so that the total costs and affordability of the project can be affirmed.

We have recommended that risk mitigation plans need to continue to be actively managed by the UHB, contractor and design team so as to avoid unnecessary additional delays or cost pressures **(Recommendation 5).**

We were satisfied that arrangements were in place to identify and assess key project risks. The risk profile was also being monitored against available contingencies. However, noting the current level of risks still remaining on the project and the continued need for active risk management, we determined that **reasonable assurance** in respect of overall risk management.

Change Management

We sought to confirm that arrangements were in place to control project changes, ensuring that the time/ cost implications were adequately considered prior to instruction.

We confirmed that a robust contractual change mechanism was in operation on the project in accordance with the NEC contract, the Designed for Life Framework and UHB requirements. Contractual relationships existed and operated effectively to manage any required changes in programme or costs.

There was an approved procedure for issuing contract changes (compensation events/variations). The University Health Board has strengthened the contractual procedure through the addition of a preliminary procedure requiring completion and authorisation of a 'Project Issues Form' (PIF). This ensures that an early assessment of requested changes is performed prior to detailed evaluation of costs. The contractual requirements were documented within the Project Execution Plan.

Contractual timelines were adhered to with regard to change management actions.

The requirement to obtain approval of a PIF prior to issue of a PMI assists in ensuring that change management approvals are obtained prior to progressing with site works on site.

The UHB has documented the requirements for Contract Change and Cost Control within its Capital Projects Manual.

A monthly summary position with respect to change management is reported by the project manager.

Noting the robust operation of the procedure for managing changes to the project, but also taking account of the need to minimise design changes in order to ensure that costs can be effectively managed **(See Recommendation 3),** we have determined **reasonable assurance** for the change management process.

6. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	2	3	0	5
Prior recommendations outstanding	0	1	1	2
TOTAL	**2**	**4**	**1**	**7**

Action Plan

Finding 1: Cost Control – Affordability of MRI New Build	Risk
The Designed for Life: Building For Wales framework arrangements normally require 70-80% design completion to ensure robust costing at market testing stage. The decision to develop the plans for the MRI new build and introduce changes to the scope and content of those plans has had a negative effect on the ability to achieve early cost certainty with respect to the current phase of the project. Consequently, the UHB was exposed to significant cost risks. In February 2018, the Project Manager reported that the MRI new build presented a "significant level of commercial risk and /or design risk" that could put "severe pressure on the remaining contingency". The current PTE was valued at £10.36 million. However, the budget within the approved BJC was £7.44 million. A variance of £2.92 million. In summary, the size of the building had increased, the engineering strategy had changed due to additional clinical accommodation being included in level 1. The building orientation had changed and sprinklers had been included throughout the building. The project contingency had to fund the shortfall. However, the final figure would not be known until the design is complete and costs have been validated by the Cost Adviser.	Significant risks of overspending against the approved budget.

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Action Plan

Finding 1: Cost Control – Affordability of MRI New Build	Risk
Noting the above and the nature of the works, assurance is also required that any design proposals fully consider the size/weight of proposed equipment requirements and that appropriate/timely structural surveys/advice is provided to inform the design solution (considering additional work requirements, time implications (delays) and additional costs.	
Recommendation 1	**Priority level**
The design for the MRI new build will be concluded and frozen as soon as possible, including affirmation of structural issues and design elements for the MRI installation, so that the total costs and affordability of the project can be confirmed.	**High**
Management Response 1	**Responsible Officer/ Deadline**
The design solution has been informed, as far as is practicable, by considering the specification information provided by potential MRI suppliers.	Director of Capital, Estates and Facilities. 31 May 2018

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Finding 2: Cost Control – Value of Risk	Risk
The Cost Adviser has reported that the BJC2 works were forecast to be "affordable" within the total approved funding allowance. However, whilst this assessment included contingency considerations applied to both the OBS2 and MRI works, it excluded all risk register values. The Cost Adviser reported in February 2018 that once all known liabilities are accounted for, the remaining contingency would be £1.582 million for all remaining phases. However if the combined value of construction & pre- construction risk registers (£1.401 million) were also deducted, the balance of contingency would be reduced to circa £181k. (*In March 2018 the Project Manager reported that the remaining contingency was now £1.654 million and the combined value of construction and pre construction risk was reduced to £1.035 million. The balance of contingency would therefore be increased to £618.6k.)*	Risk of disregarding value of identified risk in the assessment of affordability.
Recommendation 2	**Priority level**
The value of identified risk will be included within the assessment of affordability.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Whilst the recommendation is accepted regarding inclusion in the Cost Adviser report, it is worth noting that the overall cost setting of the project, taking into account the potential risk liability, is identified in the Project Manager's report, Project dashboard and Capital Management report.	Director of Capital, Estates and Facilities. 31st May 2018

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Finding 3: Cost Control - Affordability	Risk
The MRI new build design had been significantly amended during the project planning stages i.e. • The size of the building had increased; • the engineering strategy had changed due to additional clinical accommodation being included in level 1; • the building orientation had changed; and • sprinklers had been included throughout the building. Noting the above, the final cost and affordability will not be determined until the design is complete and costs have been validated by the Cost Adviser. 'Option 2' layout changes were reported to have been incorporated into the agreed scope and should provide value added efficiencies. However users were reported to have requested further changes ('Option 3'), after details had been issued to the market, which were not in the agreed scope.	Risks of additional costs and lack of affordability within approved funding.
Recommendation 3	**Priority level**
i) An agreed timetable should be developed for design completion and validation of cost estimates. Any subsequent issues arising from the same will be formally reported to the project Board.	**High**

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ii) At future projects, increased focus should be given to obtaining a definitive statement of affordability at an early stage of the planning process. This should involve the identification and assessment of the expected risk profile and completion and sign off of the design. iii) Design changes should be minimised in order to ensure that costs can be effectively managed. User requests for additional changes, made after details have been issued to the market, and that do not fall within the agreed scope, should be discouraged.	
Management Response 3	**Responsible Officer/ Deadline**
. The design has been developed in conjunction with a design development programme, with the market testing programme allied thereto. . Whilst accepting the principle of the recommendation, it has not been possible to determine a definitive statement of affordability from the outset due to the phased progression of the scheme. A detailed Pre-tender Estimate was produced for each phase and updated as design developed, to be superseded by the Target Cost when agreed. The risk profile, however, was established at the outset, in separate risk registers for pre-construction and construction phases, and managed actively through the phased progression of the scheme. . We agree with this recommendation and have actively adopted this approach throughout.	Actioned Director of Capital, Estates and Facilities.

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Action Plan

Finding 4: Programme Management – Survey Information	Risk
The Project Manager reported an initial delay of one week in the formation of the piling mat due to below ground obstructions hindering drainage diversions. The discovery of asbestos had also hindered progress. However, the main contractor was reported to be hopeful that the delay could be mitigated. However, it was also reported that the piling works had subsequently not progressed at the planned rate, due to the discovery that the ground strata was different to that indicated on the ground investigation reports originally provided to the piling contractor. It was reported that this would have a detrimental impact on the programmed works and costs.	Unreliable survey information presents risk of programme delays and additional costs.
Recommendation 4	**Priority level**
A formal evaluation of the adequacy of the ground investigation reports will be undertaken and any recourse against advisers determined.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
The ability to carry out an extensive ground investigation survey was impeded by the existing MRI building occupying a large proportion of the surface area of the courtyard, prior to its demolition.	Actioned Director of Capital, Estates and Facilities.

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Finding 5: Risk Management	Risk
The Cost Adviser noted in February 2018 that only circa 42% (value %) of BJC 2 works have been procured and circa 58% of works were subject to a Pre Tender Estimate. Although the Works were being reported as 'affordable', it was recognised that there was a significant level of commercial risk and/or design risk that could increase the works costs and put pressure on the project contingency. Following agreement of the MRI New-build Cost in March 2018, we acknowledge that this risk has significantly reduced. However, as at March 2018, key risks included those relating to: • Disruption / Delay created by the MRI New Build programme • Design changes and assumptions • Scope gap between MRI base build and specialist installation • Duration of contracted works and achievement of programme • Equipment budget • Condition of existing hospital engineering infrastructure and potential problems of connecting new services.	Risks may not be mitigated and cause additional costs and or delays to the project.

Action Plan

Recommendation 5	Priority level
Risk mitigation plans will continue to be actively managed by the UHB, contractor and design team, so as to avoid unnecessary additional cost and/ or delays to the project.	**Medium**
Management Response 5	**Responsible Officer/ Deadline**
The finding is factually correct at time of compiling the report. Risk has been actively managed from the outset of the project and 'known unknowns' accounted for. The latest PM report (March 2018) identifies 84% or works procured and 16% relating to Obs 2, which has been procured but is subject to inflationary increase before agreement of the Target Cost in April 2018.	Director of Capital, Estates and Facilities. 31st May 2018 and on-going.

Review of Previous Recommendations

No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
High Priority Recommendations					
8	The SCP contract should be executed as soon as possible and the Design Team novated to the SCP.	Director of Capital, Estates and Facilities 31 July 2016	Closed	N/A	N/A
9	Contracts should be executed as soon as possible for all Design Team Consultants.	Director of Capital, Estates and Facilities 31 July 2016	Closed	N/A	N/A
Medium Priority Recommendations					
4	Regular monthly progress reports should be provided by the Project Manager.	Director of Capital, Estates and Facilities 31 August 2016	Closed	N/A	N/A

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Review of Previous Recommendations

No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
5	The Board should be made fully aware of the reasons why the current position regarding the contract letting for works associated with BJC2 has arisen, the risks and implications of the available options and the recommended course of action.	Director of Capital, Estates and Facilities 31 August 2016	Closed	N/A	N/A
6	Requests for 'Single Tender Action' should be approved and reported to the Audit Committee in accordance with Standing Financial Instructions and the current UHB Scheme of Delegation. The Estates Department's Capital Projects Manual pro-forma, Single Tender Action Request form should be brought into line with the requirements of the Scheme of Delegation. Approval signatures for all Single Tender Actions should be	Director of Capital, Estates and Facilities 31 August 2016	Outstanding	Agreed	Director of Capital Estates and Facilities 31 May 2018

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No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
	obtained in accordance with the requirements of SFIs.				
10	A system of performance monitoring of the SCP and consultant design team should be established and operated in accordance with the requirements of the Designed for Life Framework.	Director of Capital, Estates and Facilities 31 August 2016	Closed	N/A	N/A
11	Careful and robust management of the Health Board's risks will be required to limit any potential capital shortfall.	Director of Capital, Estates and Facilities 31 August 2016	Closed	N/A	N/A
Low Priority Recommendations					
1	The role of the Investment Decision Maker should be confirmed as the Board, in accordance with best	Director of Capital, Estates and Facilities	Closed	Future Business Cases will include this.	N/A

Review of Previous Recommendations

No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
	practice guidance, and the UHB's Capital Projects Manual.	31 October 2016			
2	The role of the Senior Responsible Owner should be identified consistently in the Project Execution Plan and the Business Justification Case. Any delegation of these responsibilities from the Chief Executive should be confirmed in writing to ensure compliance with best practice guidelines and the UHB Capital Projects Manual. The role of the Project Owner as defined in the BJC should be clearly distinguished from that of the Senior Responsible Owner.	Director of Capital, Estates and Facilities 31 October 2016	Closed	Future Business Cases will include this.	N/A
3	The Capital Procedures Manual should be revised to include the requirement for a Project Director's Acceptance Certificate signed by the Chief Executive and Project Director.	Director of Capital, Estates and Facilities 31 October 2016	Outstanding		Director of Capital Estates and Facilities 31 May 2018

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University Hospital of Wales Neo Natal Development Cardiff & Vale University Health Board

Review of Previous Recommendations

No:	Recommended Action	Responsibility & Timescale	Action Status	Management Comment	Updated Responsibility & Timescale
7	The summary scoring record should include details of the composition of the evaluation panels involved in interview and evaluation of tendering organisations.	Director of Capital, Estates and Facilities 31 October 2016	Closed	N/A	N/A

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University Hospital of Wales Neo Natal Development

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*

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University Hospital of Wales Neo Natal Development

Cardiff & Vale University Health Board