# Bundle Audit Committee 26 February 2019

Agenda attachments

00 - Agenda Public 26th February v5.docx

| | |
|---|---|
| 1 | Welcome and Introductions<br>*John Union* |
| 2 | Apologies for Absence<br>*John Union* |
| 3 | Declarations of Interest<br>*John Union* |
| 4 | Minutes of the Committee meeting held on 4 December 2018<br>*John Union*<br>4 - Minutes Public December v4.docx |
| 5 | Action Log - 4 December 2018<br>*John Union*<br>5 - Action Log Public v3.docx |
| 6 | Chairs Action taken since last meeting<br>*John Union* |
| 7 | ITEMS FOR REVIEW AND ASSURANCE |
| 7.1 | Internal Audit Progress Report<br>*Ian Virgill*<br>7.1 - Cv AC A&A cover Feb19.docx<br>7.1a - CV AC A&A progress report February 2019.pdf |
| 7.1.1 | Legislative / Regulatory Compliance Report - Limited<br>*Nicola Foreman*<br>7.1.1 - Legislative Compliance Final report.pdf |
| 7.1.2 | Information Governance: GPDR Report - Limited<br>*Sharon Hopkins*<br>7.1.2 - GDPR Final report.pdf |
| 7.1.3 | Surgery Clinical Board - Medical Finance Governance Report<br>*Mike Bond*<br>7.1.3 - Surgery Medical Finance Governance Final report.pdf |
| 7.1.4 | Medicine Clinical Board - Internal Medicine Follow-up Report<br>*Geraldine Johnston*<br>7.1.4 - Internal Medicine Follow-Up Final report.pdf |
| 7.2 | Wales Audit Office - Audit Plan 2019<br>*Mike Usher*<br>7.2 - WAO 2019 CVUHB Audit Plan Final.pdf |
| 7.3 | Governance Improvement Programme<br>*Nicola Foreman* |
| 7.4 | Annual Report Timetable 2018/19<br>*Nicola Foreman*<br>7.4 - Draft 2018-19 Annual Report Timetable.docx |
| 7.5 | Wales Audit Office Structured Assessment 2018/2019<br>*Mike Usher*<br>7.5 - CVUHB Structured Assessment report 2018.pdf |
| 7.6 | Auditor General Annual Report<br>*Mike Usher* |
| 7.7 | Closure Report: Audit of Cardiff and Vale Contractual Relationships with RKC Associates and Its Owner<br>*Nicola Foreman* |

7.7 - UHB's Contractual Relationships with RKC Associates Ltd and its Owner - closure report.docx

7.7.1 - Action Plan Updated 06.02.2019.doc

8 ITEMS FOR APPROVAL / RATIFICATION

8.1 Audit Committee Annual Report 2018/2019

*Nicola Foreman*

8.1 - AC Annual Report - covering report[2291].docx

8.1.1 - AC Annual Report.docx

8.2 Audit Committee Workplan 2019/2020

*Nicola Foreman*

8.2 - AC Work plan 2019.20 - covering report[2289].docx

8.2.1 - Audit Committee Work Plan 2019.20 v2-.xlsx

8.3 Audit Committee Terms of Reference 2019/2020

*Nicola Foreman*

8.3 - Audit Terms of Reference - covering report[2288].docx

8.3.1 - Audit Committee TOR.pdf

8.4 Audit Inquiries to those charged with governance and management

*Robert Chadwick*

8.5 - AC Feb 19 - Audit enquiries to those charged with governance and management.docx

8.5.1 - Audit enquiries to those charged with governance and management.docx

8.5 Committee Self- Assessment

*Nicola Foreman*

8.4 - AC Self Assessment - covering report[2290].docx

8.4.1 - Audit Committee Self Assessment.docx

8.6 Review of Standing Orders

*Nicola Foreman*

8.6 - Audit Commitee_Draft Covering Paper for Standing Orders.docx

8.6.1 - UHB Standing Orders Reservation and Delegation of Powers_Feb2019_with tracked changes.pdf

8.7 Capital Ordering Authorisation Protocol

*Robert Chadwick*

8.7 - Capital Ordering protocol cover report.docx

8.7.1 - Capital Ordering protocol.doc

9 ITEMS FOR NOTING AND INFORMATION

9.1 Internal Audit Reports

9.1.1 Claims Reimbursement

*Substantial*

9.1 - Claims Reimbursement Final report.pdf

9.1.2 Performance Reporting Data Quality - Non RTT

*Substantial*

9.2 - Performance Reporting - Non RTT Final report.pdf

9.1.3 Renal IT System

*Reasonable*

9.3 - Renal IT final report.pdf

9.1.4 Contract Compliance

*Reasonable*

9.4 - Contract Compliance Final report.pdf

9.1.5 CD&T Clinical Board - Bank, Agency

*Reasonable*

9.5 - CDT Bank Agency and Overtime Final Report.pdf

9.1.6 Estates Time Recording / Kronos System

*Reasonable*

9.6 - Estates Kronos System Final Report.pdf

10 ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE

| | | |
|---|---|---|
| | *John Union* | |
| 11 | REVIEW OF THE MEETING | |
| | *John Union* | |
| 12 | DATE AND TIME OF NEXT MEETING | |
| 13 | Tuesday, 23 April 2019 at 9.00am - Corporate Meeting Room, Headquarters, UHW | |

# AGENDA

**AUDIT COMMITTEE**
**Tuesday, 26 February 2019**
**Corporate Meeting Room, Headquarters, UHW**

| | | |
|---|---|---|
| **1.** | Welcome & Introductions | John Union |
| **2.** | Apologies for Absence | John Union |
| **3.** | Declarations of Interest | John Union |
| **4.** | Minutes of the Committee Meeting held on 4 December 2018 | John Union |
| **5.** | Action Log – 4 December 2018 | John Union |
| **6.** | Chairs Action taken since last meeting | John Union |
| **7.** | **Items for Review and Assurance** | |
| **7.1** | Internal Audit Progress Report | Ian Virgill |
| | **Limited Assurance Reports:**<br>7.1.1 - Legislative / Regulatory Compliance Report<br>7.1.2 - Information Governance: GDPR Report<br>7.1.3 - Surgery Clinical Board – Medical Finance Governance Report<br>7.1.4 - Medicine Clinical Board – Internal Medicine Follow-up Report | Ian Virgill |
| **7.2** | Wales Audit Office - Audit Plan 2019 | Mike Usher |
| **7.3** | Governance Improvement Programme | Presentation<br>Nicola Foreman |
| **7.4** | Annual Report Timetable 2018/2019 | Nicola Foreman |
| **7.5** | Wales Audit Office Structured Assessment 2018 | Mike Usher |
| **7.6** | Auditor General Annual Report 2018 | Mike Usher |
| **7.7** | Closure Report: Audit of Cardiff and Vale Contractual Relationships with RKC Associates and its Owner | Nicola Foreman |
| **8.** | **Items for Approval/Ratification** | |
| **8.1** | Audit Committee Annual Report 2018/2019 | Nicola Foreman |
| **8.2** | Audit Committee Workplan 2019/2020 | Nicola Foreman |
| **8.3** | Audit Committee Terms of Reference 2019/2020 | Nicola Foreman |
| **8.4** | Committee Self-Assessment | Nicola Foreman |
| **8.5** | Audit Inquiries to those charged with Governance and Management | Robert Chadwick |
| **8.6** | Review of Standing Orders | Nicola Foreman |
| **9** | **Items for Noting and Information** | |
| **9.1** | **Internal Audit Reports**<br><br>**Assignment** **Assurance Rating**<br>1. Claims Reimbursement Substantial | Ian Virgill |

| | | |
|---|---|---|
| | 2. Performance Reporting Data Quality – Non RTT Substantial<br>3. Renal IT System Reasonable<br>4. Contract Compliance Reasonable<br>5. CD&T Clinical Board – Bank, Agency & Overtime Spend Reasonable<br>6. Estates Time Recording / Kronos System Reasonable | |
| **10** | **Items to bring to the attention of the Board/Committee** | |
| | | |
| **11** | **Review of the Meeting** | |
| | | |
| **12** | **Date and time of next Meeting** | |
| | Tuesday, 23 April 2019, at 9.00am – Corporate Meeting Room, Headquarters, UHW | |

**MINUTES OF AUDIT COMMITTEE**
**ON 4th DECEMBER 2018**
**CORPORATE MEETING ROOM, HEADQUARTERS, UHW**

| | | |
|---|---|---|
| **Present:** | | |
| John Union | JU | Chair - Audit |
| Charles Janczewski | CJ | Vice Chair |
| Dawn Ward | DW | Independent Member – Trade Unions |
| | | |
| **In Attendance:** | | |
| Simon Cookson | SC | Internal Audit |
| Nicola Foreman | NF | Director of Corporate Governance |
| Tom Haslam (part) | TH | Audit Manager, Wales Audit Office |
| Fiona Jenkins (part) | FJ | Consultant in Public Health |
| Christopher Lewis | CL | Deputy Director of Finance |
| David Poland | DP | Internal Audit |
| Mike Usher (part) | MU | Sector Lead, Wales Audit Office |
| Ian Virgil | IV | Deputy Head of Internal Audit |
| | | |
| **Secretariat:** | | Sheila Elliot |
| | | |
| **Apologies:** | | |
| | | |
| Eileen Brandreth | EB | Independent Member - ICT |
| Craig Greenstock | CG | Counter Fraud Manager |
| James John | JJ | Head of Internal Audit |
| Mark Jones | MJ | Audit Manager, Wales Audit Office |

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|---|---|---|
| **AC 18/066** | **WELCOME AND INTRODUCTIONS**<br><br>The Chair welcomed everyone to the meeting.<br><br>The Chair asked that everyone note the changes to the Committee: John Union was with immediate effect taking over the role of Chair and Eileen Brandreth would join the Committee. Ruth Walker has stood down from this Committee as her role was overlapping with Dawn Ward. | **ACTION** |
| **AC 18/067** | **APOLOGIES FOR ABSENCE**<br><br>Apologies for absence were noted. | |
| **AC 18/068** | **DECLARATIONS OF INTEREST**<br><br>The Chair invited Members to declare any interests in the proceedings. Mr Charles Janczewski declared that he was Chair of the WHSSC Quality and Patient Safety Committee. | |

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| **AC 18/069** | **MINUTES OF THE BOARD MEETING HELD ON 25th SEPTEMBER 2018**<br>**Resolved – that:**<br><br>(a) Members of the Audit Committee received and approved the minutes of the meeting held on 25th September 2018. |
| **AC 18/070** | **ACTION LOG FOLLOWING THE LAST MEETING**<br><br>**AC 18/022: Internal Audit Progress Report: Business Continuity Plan**<br>An update, was provided later on in the meeting - see minute reference 18/078.<br><br>**AC 18/050: Consultant Job Planning: Limited Assurance**<br>This will be undertaken in the first quarter of 2019/20 Internal Audit Plan. Action complete.<br><br>**AC 18/051: internal Audit Reports**<br>Clinical Boards were reminded of the need to respond to the Internal Audit report.<br><br>**AC 18/053: Continuing Health Care and Follow Up**<br>This review will be put into the Internal Audit Plan for 2019/20. Action complete.<br><br>**AC 18/054: WAO Report on Medical Equipment**<br>An update was provided later in meeting – see minute reference 18/071. Action Complete.<br><br>**AC 18/056: Tracking Report on WAO Reports**<br>An update was provided later in meeting – see minute reference 18/076. Action Complete.<br><br>**AC 18/057: Structured Assessment 2017**<br>Actions outstanding from the 2017 Structured Assessment would be addressed in the 2018 report. Actions would be tracked by the Corporate Governance Directorate.<br><br>**AC 18/058: Post Payment Verification**<br>This item would be reviewed in the Audit Committee meeting in April 2019.<br><br>**Resolved – that:**<br><br>(a) The Committee reviewed and noted the action log for the meeting held on 25th September 2018. |
| **AC 18/071** | **WALES AUDIT OFFICE REPORT ON MEDICAL EQUIPMENT MANAGEMENT RESPONSE AND ACTION PLAN UPDATE**<br><br>The Executive Director of Therapies and Health Science introduced the report and stated that WAO auditors were happy with the progress |

which had been made. The current Action Plan with 8 recommendations in the paper were all at stages of either amber or green. The recommendations were discussed:

- Medical Equipment Report had been circulated in addition to the report on Health Care Standard Equipment.
- Feedback had been received from Clinical Boards on the audit requirements. There should be a nominated person for each Clinical Board.
- Medical Devices Safety Officers need to have a risk register for medical equipment.
- A full inventory was in place and on track to deliver in April 2019
- There was no register of equipment under £5k. A question was raised about Clinical Boards advising on the feasibility of producing a register of equipment under £5k. A Medical Equipment Procurement Officer is now in post and standardising the approach to purchase and decommissioning. A register for £5k equipment could become part of this person's role.

**Resolved – that:**

(a) The Audit Committee Members noted the update on progress received from the Director of Therapies and Health Science.
(b) WAO to investigate and give feedback on equipment registers under £5k. TH

**AC 18/072** **WAO PROGRESS REPORT**

Mike Usher, Sector Lead, presented a paper and the following points were raised:

- Charitable Funds Committee happening the following week would discuss the finance.
- Planning for 2018/19 has started and would be documented at the February Audit meeting.
- Regional findings had been sent to the Partnership Board.
- The structured assessment was ongoing and on target for delivery to the UHB by mid-December.
- Follow-up of previous work would meet the April deadline.
- Exhibit 4 on orthopaedic follow-up had been undertaken at every Health Board and was expected in April 2019.
- Work on operating theatres in 2015 was being followed up.
- Work on IM&T recommendations in 2014 was being followed up
- Director of Corporate Governance would be a focal and liaison point for WAO.
- Responses to queries would be given at next Committee meeting on an ongoing basis so that there was an audit trail and things were not lost.
- Cardiff Out of Hours report revealed Clinical Leaders did not have enough time to monitor care.

**Primary Care Planning Update**

David Poland introduced the report on Phase 2 of the Primary Care Services and the following points were raised:

- Now moving into Phase 3 and should be consistent with the Welsh Government Plan.
- A survey performed earlier in the year of other professional groups such as pharmacists, dentists, ophthalmologist gave a good response.
- The KPI's and the dashboards were being assessed.
- There were concerns about population growth and this needed to be reviewed.
- There were issues around cluster maturity and whether leaders had time to do their role.
- Some progress had been made on shifting resource but there were still significant challenges to be overcome.
- How to change a project to a mainstream service and how the budget needs to be continued for the mainstream service.
- Regarding multi-professional roles there are often issues getting through the system regarding job specifications and bands.
- Primary Care is a priority and the performance report is focussed on Secondary Care.
- Oversight on Primary Care reporting was better but reporting was still required.
- Primary Care performance was not good. Barriers had been identified and recommendations made and accepted.
- The Assistant Director of Finance had seen this but reports should come to the Audit Committee via Management Executives.
- Clusters involve multiple partnerships.

**Resolved – that:**

(a) The Audit Committee reviewed and noted the report.
(b) The Audit Committee noted that the Health Board is making progress on plans and delivering care to patients.

**AC: 18/073** **BOARD ASSURANCE FRAMEWORK**

The Director of Corporate Governance introduced the report. She stated that the Board Assurance had been presented to the Board last Thursday and it had been approved. Work was in progress on this and actions and details were being refined and the BAF would be presented back to the Board in January 2019.

The BAF would replace the CRAF and top level risks would be reported to the Board via the risk registers so the Board also had oversight of high operational risks.

Some registers are very good and over time would all be standardised with critical risk areas and key objectives.

**Resolved – that:**

(a) The Audit Committee reviewed and noted the BAF and the work which had been done by the Director of Corporate Governance.

**AC: 18/074** **TERMS OF REFERENCE**

The Director of Corporate Governance introduced the report. She stated that the Terms of Reference were last reviewed by Committee in 2016 and should be approved by the Board on an annual basis. The Terms of Reference are being updated but there are no significant changes. A final set would go to Board at end of March 2019 and would be brought to the Audit Committee at end of February. Any alterations to be back with Director of Corporate Governance by end of December 2018.

**Resolved – that:**

(a) The Audit Committee reviewed the draft Audit Committee Terms of Reference and agree to bring back to the meeting in February 2019. NF

**AC: 18/075** **AUDIT COMMITTEE WORKPLAN**

The Director of Corporate Governance introduced the report. She stated that she had identified some gaps in the old Plan and so had produced a new plan for 2019/2020.

Mike Usher, Welsh Audit Office mentioned the Annual Audit Report would go to February 2019 meeting to cover a full Year.

Charles Janczewsk mentioned there should be an induction program for new committee members and Director of Corporate Governance stated that there should be a development session with Committee and the Board early next year.

**Resolved – that:**

(a) The Annual Workplan both to be presented to February 2019 Meeting for final sign-off. NF

(b) That a Board Development session be undertaken on the role of the Audit Committee. NF

**AC: 18/076** **INTERNAL AUDIT PROGRESS REPORT**

Ian Virgil provided the Committee with an update on the delivery of the agreed audit plan. He identified some areas of slippage.

The Estates Time Recoding Meeting has occurred and the meeting of the PCIC interface was planned. Dawn Ward, Independent Member checked there were sufficient resources and Ian advised that things were improving now that the limited assurance reports were being sent to the Executives meeting.

Points covered:

4.1 - Two Limited Assurance Reports delayed.
4.2 - Two Limited Assurance Reports moved up to Substantial Assurance Reports.
4.4 - Two reports had been pushed back to the next financial year.
Appendix B - Report on standard progress reasonably positive.
Appendix C - Completed audits.
Appendix D - Compliance with KPI's and response times.

Standards of behaviour had received limited assurance. Only 24 out of approximately 16,000 replies on the Declaration of Interest were received. This would be followed up early in the financial year.

**Resolved – that:**

(a) The Audit Committee noted the Internal Audit Progress report.
(b) The report of Standards of Behaviour would be followed-up early in the financial year. IA

**AC: 18/077** **TRACKING REPORTS**

The Director of Corporate Governance introduced the report and stated that she was not happy with how reports were being tracked. This report would be reviewed and developed for the February 2019 Audit Committee NF

**Resolved – that:**

(a) The Audit Committee noted the report and the changes the Director of Corporate Governance wished to make to ensure that the tracking of reports was strengthened going forward.

**AC: 18/078** **BUSINESS CONTINUITY PROGRESS REPORT**

The report was introduced and the following comments made:

- A Group Chaired by Steve Curry, Chief Operating Officer would oversee the implementation of the actions within the report. A Strategic Group for Business Continuity was to be set up in January 2019. AH
- The Business Continuity Plan was tested in March 2018 when there had been heavy snowfalls and lessons were learnt from this. A lack of staff accommodation was noted. Staff often sorted out their own transport and accommodation needs and volunteers turned up to help with transport. It was suggested that in the future volunteers register to provide the transport service so we would get the balance right.
- It was found that when we do have disturbances due to flooding, or loss of electricity the business continuity plans

were by default practiced and the planning usually took place very well.
- Clinical Boards were now using templates for their Business Continuity Plans.
- 2 staff working on these areas are particularly good and other Health Authorities were copying our idea, which was a good thing
- Brexit – A plan was in place covering staff problem, re-ordering of specialised equipment, time-critical items etc.

**Resolved – that:**

(a) The Audit Committee discussed and noted the Business Continuity report.

**AC: 18/079** **LOSSES AND SPECIAL PAYMENTS**

The Deputy Financial Director introduced the report and made the following comments:

- The Losses and Special Payments panel met bi-annually to consider write-offs and special payments for the preceding 6 months. Details would be found in the minutes of the Losses and Special Payments Meeting. Job titles needed to be added in future appendices and a graphical representation would be good.
- There was nothing of notable value in the last six months but there was discussion regarding the £8.6m maternity equipment claim which needed to be kept on the books and the cost would be met by the Welsh Government. CL
- Ex-gratia payment was made to one household re. noise pollution and the Board hopes that this does not set a precedent and would be reviewed by Deputy Director of Finance. CL

**Resolved – that:**

(a) The Audit Committee noted the report on losses and special payments.

**AC: 18/080** **ITEMS FOR NOTING**

Clinical Negligence Claims – This was not in the Executive Nurse Directors diary and it is unclear on what was required.

**AC 18/081** **ITEMS TO BE DEFERRED TO BOARD/OTHER COMMITTEE**

No other items were deferred to the Board or other Committee

**AC 18/082** **ANY OTHER URGENT BUSINESS**

There was no other urgent business

**AC 18/083** | **DATE OF THE NEXT MEETING OF THE BOARD**

The next Audit Committee meeting would be held at **9.00am** on **26TH February 2019** in the Corporate Meeting Room, Headquarters, UHW

**ACTION LOG**
**FOLLOWING AUDIT COMMITTEE MEETING**
**DECEMBER 2018**

| REF | SUBJECT | AGREED ACTIONS | LEAD | DATE | \|STATUS/COMMENTS |
|---|---|---|---|---|---|
| **Actions Completed** | | | | | |
| **AC 18/079** | Losses and Special Payments | Job titles to be added to the appendices of future reports.<br><br>Review of ex-gratia payments made to ensure that no precedents have been set. | C Lewis<br><br>C Lewis | 23/04/19<br><br>26/0219 | Will be actioned when the next losses and special payments report is due to be considered by the Committee.<br><br>Verbal Update to be provided at the February meeting |
| **AC 18/077** | Tracking Report | The Director of Corporate Governance would bring back a tracking report to the Committee. | N Foreman | 26/02/19 | On agenda. |
| **AC 18/072** | Primary Care Planning Update | Agreement was made to review the allocated leads for management responsibilities | N Foreman | 26/0219 | Verbal Update to be provided at the February meeting |
| **AC 18/071** | Wales Audit Report on Medical Equipment | Investigate how other Health Boards deal with equipment <£5k inventory | T Haslam | 26/02/19 | Verbal Update to be provided at the February meeting |
| **AC 18/070**<br><br>**(***earlier minute ref. AC18/050***)** | Consultant Job Planning: Limited Assurance | This will be followed up by Internal Audit within the 2019/20 Internal Audit Plan (Quarter 1). | G Shortland | 30/06/19 | By June 2019 |
| **AC 8/058** | Post Payment Verification | In future reports provide more detail, explanation and comparison. | PPV Manager | 23/04/19 | Update scheduled for April 2019 |
| **AC 8/057** | Structured Assessment 2017 | Further update report to be received in 6 months | N Foreman | 26/02/19 | Outstanding actions to be picked up by WAO in the 2018 Structured Assessment.<br>**ACTION COMPLETE.** |

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|---|---|---|---|---|---|
| **AC 8/054** | WAO Report on Medical Equipment | Arrange for 3 IMs to meet Lead Executives and WAO to discuss. | D Ward | 25/09/18 | **ACTION COMPLETE.** |
| **AC 8/053** | Follow up Continuing Healthcare | Agreed to push back the timescale for further follow up | I Virgil | 25/09/18 | Included in the Internal Audit Plan for 2019/20.<br><br>**ACTION COMPLETE** |
| **AC 8/051** | Internal Audit Report | To ask COO why there had been delays in responses to Neuro IT and Renal IT systems. The audits had to be rescheduled and was not available for September Committee.<br><br>Ask COO to attend meeting to explain findings of paediatric/adult transition plans as sensitive issue.<br><br>Discuss reasonableness of Audit timescales with the Committee Chair. | Secretariat<br><br>Secretariat<br><br>I Virgil | 25/09/18 | There have been a number of reports where Clinical Boards have contested the findings and there has been further discussion between the Audit Team the COO and the CB to clarify the position while moving forward with the actions. This is related to a small number of reports. The Operations Team have been reminded to ensure there is timely response to reports going forward.<br><br>**ACTION COMPLETE.** |
| **Actions referred to other Committees/Board** | | | | | |
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|---|---|---|---|---|---|---|---|---|---|
| **REPORT TITLE:** | **Internal Audit Progress Report** | | | | | | | | |
| **MEETING:** | **Audit Committee** | | | | | | | **MEETING DATE:** | **26th February 2019** |
| **STATUS:** | **For Discussion** | | **For Assurance** | **x** | **For Approval** | **x** | **For Information** | | |
| **LEAD EXECUTIVE:** | **Director of Governance** | | | | | | | | |
| **REPORT AUTHOR (TITLE):** | **Acting Head of Internal Audit** | | | | | | | | |

**PURPOSE OF REPORT:**

**SITUATION**:

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

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

**REPORT:**

**BACKGROUND:**

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

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

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

The progress report highlights the conclusion and assurance ratings for audits finalised in that period.

Reports that are given reasonable assurance are summarised in the progress report with the reports given Limited Assurance included in full. There are two reports that have been given a Limited Assurance rating.

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

**ASSESSMENT:**
The progress report provides the Committee with a level of assurance 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 and assigned assurance ratings.

**RECOMMENDATION:**

The Audit Committee is asked to:

**Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
**Consider and Approve** updates to the Internal Audit Plan.

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

| Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sustainable development principle: 5 ways of working | Prevention | | Long term | x | Integration | x | Collaboration | x | Involvement | | |
| **EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:** | Not Applicable | | | | | | | | | | |

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

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

# Cardiff and Vale University Health Board

# Internal Audit Progress Report

# Audit Committee February 2019

# Private and Confidential

# NHS Wales Shared Services Partnership

# Audit and Assurance Service

## CONTENTS

## 1. INTRODUCTION

**1.1.** This progress report provides the Audit Committee with the current position regarding the work being undertaken by the Audit & Assurance Service as part of the delivery of the approved 2018/19 Internal Audit plan.

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

**1.3.** The plan for 2018/19 was agreed by the Audit Committee in April 2018 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

## 2. ASSIGNMENTS WITH DELAYED DELIVERY

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

| Audit | Current Position | Draft Rating | Reason |
|---|---|---|---|
| PCIC Interface incidents | Draft | Limited | Significant delays in agreement of report and management responses. Planned meetings with CB Management cancelled twice. |
| Medicine CB – Sickness Absence Management | Draft | Reasonable | Delay in completion of fieldwork due to resourcing issues. |
| Delayed Transfers of Care | Work in Progress | | Completion of fieldwork taking longer than planned. |
| Core Financial Systems | Work in Progress | | Commencement of audit delayed to Q4 at request of management. |
| Ward Nurse Staffing Levels | Work in Progress | | Completion of fieldwork taking longer than planned |
| e-advice | Work in Progress | | Delay in commencing fieldwork |
| Commissioning | Work in Progress | | Delay in commencing fieldwork |

## 3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

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

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

| FINALISED AUDIT REPORT | ASSURANCE RATING | |
|---|---|---|
| Claims Re-Imbursement | Substantial |  |
| Performance Reporting Data Quality – Non RTT | | |
| Renal IT System | Reasonable |  |
| Contract Compliance | | |
| CD&T CB – Bank, Agency & Overtime Spend | | |
| Estates Time Recording / Kronos System | | |
| Legislative / Regulatory Compliance | Limited |  |
| Information Governance - GDPR | | |
| Surgery CB – Medical Finance Governance | | |
| Medicine CB – Internal Medicine Follow-up | | |

## 4. DELIVERY OF INTERNAL AUDIT PLAN

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

To date six reports have been given Limited assurance as well a further audit that is at draft report stage. Whilst the current forecast year-end opinion is still reasonable assurance, any further Limited assurance reports from the remaining audits could have an impact on this.

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

**4.2.** Routine Follow-ups

A number of routine follow-up audits have been undertaken in the period but the results of these are still being collated. A full report on the outcome of the routine follow-ups will be included within the progress report presented to the April meeting of the Audit Committee.

**4.3.** Delivery of the 18/19 plan.

The Audit Committee has previously agreed the deferral of 3 audits from the current Internal Audit plan into the 2019/20 plan. These were the Continuing Healthcare Follow-up, Public Health Targets and Consultant Job Planning Follow-up.

During the current period, the Health Board has requested the deferral of a further five audits. The detail of these, along with the reasons for their requested deferral, are recorded within Appendix A. The proposed deferrals have been agreed by the relevant Executive Directors and the Audit Committee is therefore requested to approve the deferral of these audits into the 2019/20 plan.

The number of audits remaining within the current plan, and their spread across the assurance domains, is still sufficient to allow for the provision of the overall year-end assurance opinion for the Health Board.

The detail of the allocation of the completed audits across the assurance domains, along with those still to be undertaken and those deferred, is recorded within Appendix B.

**4.4.** Development of the 19/20 plan.

The development of the 2019/20 Internal Audit plan is progressing well. Meetings have been held with the majority of Executive Directors and also with the Clinical Board Directors of Operations.

A draft plan will be submitted to a meeting of the Executive Management Team during March for comment. An updated draft will then be presented to the April Audit Committee for formal approval.

**4.5.** Appendix C highlights the response times for responding to Internal Audit reports. Appendix D shows the Audit & Assurance Key Performance Indicators. Both of these highlight the need for the Health Board to improve its timeliness in responding and signing off Internal Audit reports.

## 5. FINAL REPORT SUMMARIES

### 5.1 Claims Re-Imbursement

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

The audit identified that the Health Board's claims reimbursement process is undertaken in compliance with Assessment Area 23 of the Welsh Risk Pool (WRP) Concerns and Compensation Claims Management Standard and the Organisational Claims Handling Policy and Procedure.

For the sample of reimbursed claims reviewed audit found that the above guidance and procedure had been followed.

### 5.2 Performance Reporting Data Quality – Non RTT

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

The Health Board has appropriate procedures in place for the collation and accurate reporting of performance data to the Board; this review highlights some extra provisions to strengthen this current process.

The audit has made note that there are a number of NHS Delivery Measures that have not been included within the Board Performance Report and also a disparity between the Performance Report and those measures reported operationally throughout the Health Board via the Tier 1 Scorecard process. This is partly justified by the need to report deliverables and metrics agreed in the IMTP but also to maintain consistency by avoiding frequent changes to the report so trends can be analysed. However, the audit notes the importance of uniform reporting

through the organisation, to the Board and externally to Welsh Government.

The data for inclusion within the Performance Report is gathered from various sources internally and externally to the Health Board that have been deemed appropriately validated.

The Performance Report is reviewed by each meeting of the Board, this review emphasises the need for reports to be presented in a format which is easy to appraise. However, the Performance Report in its current format has its limitations and has proven difficult to decipher.

## 5.3 Renal IT System

| 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 VitalData system is a well-managed system used in a coordinated way across Wales. The system architecture has a high level of resilience built in and support contracts are in place for both hardware and software. There is also a continuity plan for the system, however this has not been tested. Access to the system is granular and well controlled, with good controls over key data entry fields and extensive use of lists and there are a number of data quality reports in place.

There were areas of identified weaknesses, in particular the database and operating system software are out of date, unsupported, and contain known critical vulnerabilities. User access also had some issues with the current password length not complying with policy and there were users with access who have left the UHB. In addition although users appreciate the system there is no local forum for users to share knowledge and take ownership of the system.

## 5.4 Contract Compliance

| 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 has a range of documented Procurement and Contracting guidance in place for staff and Independent Members, and this is readily available via the Cardiff & Vale Intranet. Advice and guidance is also available from the Procurement Team, and this was recognised by the majority of staff as the first port of call if they required assistance or had any procurement queries.

There are well established processes and procedures in place for the ordering of goods and services, and robust monitoring processes are undertaken by the Procurement Team to identify non-compliant expenditure. Consequently our audit found that much of the Trust's expenditure was covered by a contract or Framework agreement.

However testing identified a significant number of instances where staff could not provide evidence that they had obtained quotations prior to raising purchase orders, and one instance where a full tender exercise should have been undertaken. The Trust cannot therefore demonstrate that all purchases achieve value for money or that suppliers are always able to compete for the provision of goods and services on a fair and equal basis.

## 5.5 CD&T CB – Bank, Agency & Overtime Spend

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

We found the use of bank, agency and overtime within the Clinical Board to be justified, with valid reasons for utilisation. At the time of the review the Clinical Board had decided to source all its agency workers through 'Medacs' which it considers to be the most efficient and cost-effective method.

All departmental delegated budget holders are provided with monthly reports from the Finance Team. Delegated budget holders present at the Directorate Performance Review meetings and the Finance Delivery Group meetings when required.

The Clinical Board does not have a documented Standard Operating Procedure detailing the process to follow for booking and authorising bank and agency staff and utilising overtime. We acknowledge that for our sample of departments, managers were clear on the process within their own departments. However, the Clinical Board may benefit from introducing clear guidelines and standard documentation to ensure that there is a standardised and consistent approach within the Clinical Board.

Our review of a sample of worked and paid overtime sessions identified instances of non-compliance with the requirement for a 30 minute unpaid break along with issues around the correct recording of additional hours worked by part time staff.

However, at the time of our review, we acknowledge that the costs associated with bank, agency and overtime were not excessive within the Clinical Board.

## 5.6 Estates Time Recording / Kronos System

| 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 pilot of the Kronos Workforce Ready (WFR) system has been running since July 2016 and was set up by the Estates Service Improvement Programme Team in conjunction with the system suppliers Kronos. A Business Case was prepared prior to running the pilot that set out the project objectives, expected costs and benefits and considered other options, but recommended piloting the Kronos system.

The audit has identified that controls are in place for the recording and management of Estates staff time, which represents an improvement

from the position at the time of the previous audit. However a number of the controls relate to manual processes operating alongside the Kronos system.

The pilot, which was expected to last 6 months, has now been running for over 2 years. However the system is still not fully functional with a number of key issues still to be resolved; the main issue being the failure to develop and implement an automatic interface between Kronos and ESR which is crucial to the successful implementation of the system and its rollout across the remainder of the Estates Department.

There has also been no regular monitoring or reporting of progress of the pilot to Estates Senior Management, and to date no evaluation of the suitability of the system for the Estates Department has been undertaken.

## CARDIFF AND VALE UHB INTERNAL AUDIT ASSIGNMENT STATUS SCHEDULE

| Planned output. | No | CRAF | Exec Director Lead | Plnd Qtr | Current progress | Assurance Rating | Audit Cttee |
|---|---|---|---|---|---|---|---|
| Annual Quality Statement | 18 | 5.1 | Nursing | Q1 | Final – Issued July 18 | Substantial | Sept |
| Ombudsman Reports | 20 | 5.6 | Nursing | Q1/2 | Final – Issued August 18 | Substantial | Sept |
| Dental CB – Theatre Cancellations | 38 | | COO/Clinical Board | Q1/2 | Final – Issued August 18 | Reasonable | Sept |
| Dental CB – Dental Nurse Provision | 39 | | COO/Clinical Board | Q1/2 | Final – Issued August 18 | Reasonable | Sept |
| Sustainability Reporting | 43 | 6.4 | Planning | Q1 | Final – Issued August 18 | Reasonable | Sept |
| Electronic Staff Record | 42 | | Workforce | Q1 | Final – Issued September 18 | Reasonable | Sept |
| Management of the Disciplinary process. | 41 | | Workforce | Q1 | Final – Issued September 18 | Reasonable | Sept |
| Charitable Funds | 15 | | Finance | Q1/2 | Final – Issued September 18 | Substantial | Sept |
| Carbon Reduction Commitment | 4 | | Planning | Q1/2 | Final – Issued October 18 | Reasonable | Dec |
| IT system follow up – Neuroscience It System | 23 | 6.8 | COO | Q1/2 | Final – Issued October 18 | Substantial | Dec |
| MH CB – Sickness Management | 35 | 6.2.1 | COO/Clinical Board | Q1/2 | Final – Issued October 18 | Limited | Dec |

| **Planned output.** | **No** | **CRAF** | **Exec Director Lead** | **Plnd Qtr** | **Current progress** | **Assurance Rating** | **Audit Cttee** |
|---|---|---|---|---|---|---|---|
| **Shaping Our Future Wellbeing – Capital Projects** | **3** | | **Planning** | **Q1/2** | **Final – Issued October 18** | **Reasonable** | **Dec** |
| **Standards of Behaviour ( DoI & G&H)** | **5** | **8.2** | **Corporate Governance** | **Q3** | **Final – Issued November 18** | **Limited** | **Dec** |
| **Cost Improvement Programme** | **16** | **6.7** | **Finance** | **Q2** | **Final – Issued November 18** | **Substantial** | **Dec** |
| **PCIC CB – District Nursing Rotas** | **30** | | **COO/Clinical Board** | **Q1/2** | **Final – Issued November 18** | **Reasonable** | **Dec** |
| **MH CB – Section 17 Leave** | **34** | **6.2.1** | **COO/Clinical Board** | **Q1/2** | **Final – Issued November 18** | **Reasonable** | **Dec** |
| **Cleaning Standards – Follow up** | **44** | **6.4.8** | **Planning** | **Q1/2** | **Final – Issued November 18** | **Reasonable** | **Dec** |
| Renal It System | 24 | 6.8 | COO | Q1/2 | Final – Issued December 18 | Reasonable | Feb |
| Claims Reimbursement | 2 | | Nursing | Q3 | Final – Issued January 19 | Substantial | Feb |
| Legislative / Regulatory Compliance | 4 | 8 | Corporate Governance | Q2/3 | Final – Issued January 19 | Limited | Feb |
| Performance Reporting data quality - Non RTT | 10 | 5.3 | Public Health | Q2 | Final – Issued February 19 | Substantial | Feb |
| Information Governance - GDPR | 25 | 8.1.5 | Public Health | Q3 | Final – Issued February 19 | Limited | Feb |
| Surgery CB – Medical Finance Governance | 31 | | COO/Clinical Board | Q1/2 | Final – Issued February 19 | Limited | Feb |
| Contract Compliance (added in to plan) | 48 | | Finance | Q2 | Final – Issued February 19 | Reasonable | Feb |

| Planned output. | No | CRAF | Exec Director Lead | Plnd Qtr | Current progress | Assurance Rating | Audit Cttee |
|---|---|---|---|---|---|---|---|
| Medicine CB – Internal Medicine Follow up | 49 | | COO/Clinical Board | Q3 | Final – Issued February 19 | Limited | Feb |
| CD&T CB – Bank, Agency & Overtime Spend | 36 | | COO/Clinical Board | Q1/2 | Final – Issued February 19 | Reasonable | Feb |
| Estates Time recording / KRONOS system | 46 | 6.4 | Planning | Q1 | Final – Issued February 19 | Reasonable | Feb |
| PCIC CB – PCIC Incident Reporting | 29 | | COO/Clinical Board | Q1/2 | Draft – Issued September 18 – Awaiting meeting with Execs to clear | Limited | April |
| Medicine CB – Absence Management | 32 | | COO/Clinical Board | Q1/2 | Draft – Issued February 19 | Reasonable | April |
| Delayed Transfers of Care | 13 | | COO | Q3 | Work in progress | | April |
| Commissioning | 11 | 2.1 | Public Health | Q2/3 | Work in progress | | April |
| UHB Core Financial Systems | 14 | 6.7 | Finance | Q3/4 | Work in progress | | April |
| Ward Nurse Staffing Levels | 21 | 6.2 | Nursing | Q3/4 | Work in progress | | April |
| e-advice | 26 | 6.8 | Therapies | Q2/3 | Work in progress | | April |
| Cyber Security | 27 | 6.8 | Therapies | Q3/4 | Work in progress | | April |
| e IT learning | 28 | 6.8 | Therapies | Q3 | Work in progress | | April |
| Specialist Clinical Board | 37 | | COO/Clinical Board | Q4 | Work in Progress | | April |

| Planned output. | No | CRAF | Exec Director Lead | Plnd Qtr | Current progress | Assurance Rating | Audit Cttee |
|---|---|---|---|---|---|---|---|
| Estates statutory compliance - Water | | 6.4.1 | Planning | Q2 | Work in Progress | | April |
| Capital project – Rookwood | | 6.4 | Planning | Q2/3 | Work in Progress | | April |
| Capital– Safeguarding work CRI | | 6.4 | Planning | Q2/3 | Work in Progress | | April |
| Risk Management / CRAF development /Risk registers | 3 | 8.2 | Corporate Governance | Q3/4 | Scheduled to start February 19 | | April |
| Strategic Planning/IMTP | 7 | 5 | Planning | Q3/4 | Scheduled to start February 19 | | April |
| MHRA Compliance | 22 | 8 | COO | Q3/4 | Scheduled to start February 19 | | April |
| Health & Care Standards | 1 | | Corporate Governance | Q4 | Scheduled to start March 19 | | Sept |
| Performance Reporting Data Quality RTT | 9 | 5.3 | Public Health | Q3 | Scheduled to start March 19 | | Sept |
| UHB Transformation Process | 12 | 10 | Public Health | Q3/4 | Scheduled to start March 19 | | Sept |
| ***Proposed deferred reviews*** | | | | | | | |
| *DOLS Follow-up* | *19* | *8.1.3* | *Medical* | *Q4* | *Deferral to 19/20 requested by Medical Director due to implementation of new process for standard authorisations in Feb / March 19. – To be agreed by AC* | | |
| *Private and Overseas patients* | *17* | | *Medical* | *Q2/3* | *Deferral to 19/20 requested by Medical Director due to potential effect of Brexit outcome. – To be agreed by AC* | | |

| Planned output. | No | CRAF | Exec Director Lead | Plnd Qtr | Current progress | Assurance Rating | Audit Cttee |
|---|---|---|---|---|---|---|---|
| *C&W CB – Paeds & Adults Transition Plans* | *33* | | *COO/Clinical Board* | *Q1* | *Work to be deferred. Despite many requests to management, scope not signed off.* | | |
| *Commercial Outlets (Deferred1718)* | *45* | *6.4* | *Director Planning* | *Q3* | *Dir of Planning proposed deferral to 19/20 due to work being undertaken by Finance staff – To be agreed by AC* | | |
| *Estates Service Improvement Team* | *47* | *6.4* | *Director Planning* | *Q1 - Q4* | *Dir of Planning proposed deferral to 19/20 due to changes in Estates structure – To be agreed by AC* | | |
| ***Previously agreed deferred reviews*** | | | | | | | |
| *Continuing Healthcare Follow up* | *6* | *5.1.13* | *COO* | *Q3/4* | *It was requested by the UHB and agreed by AC that this follow-up be deferred until the next audit year.* | | |
| *Public Health Targets* | *8* | *1.2* | *Public Health* | *Q1* | *Deferred to 19/20 - At request of Director of Public Health.* | | |
| *Consultant Job Planning Follow-up* | *40* | *6.2* | *Medical* | *Q3* | *It was requested by the UHB and agreed by AC that this follow-up be deferred until the next audit year.* | | |

| C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2018/19 (Draft reports highlighted in red italics) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Assurance domain** | **Audits** | | **Final & Draft Audit Assurance Rating** | | | | | **Audits to be completed** | **Deferred Audits** |
| | | | **Not rated** | **No** | **Limited** | **Reasonable** | **Substantial** | | |
| Corporate Governance, Risk and Regulatory Compliance | 6 | | | | ● Standards of Behaviour<br>● Legislative / regulatory Compliance | ● Contract Compliance | ● Claims Re-imbursement | ● H&CS<br>● Risk Management | |
| Financial Governance and Management | 4 | | | | | | ● Charitable Funds<br>● CIPs | ● Core Financials | ● Private & Overseas patients |
| Clinical Governance, Quality and Safety | 5 | | | | | | ● Annual Quality Statement<br>● Ombudsman Reports | ● Ward Nurse Staffing Levels<br>● MHRA Compliance | ● DoLS Follow-up |
| Strategic Planning, Performance Management and Reporting | 8 | | | | | | ● Performance Reporting Non RTT | ● Strat Plan IMTP<br>● Performance Reporting RTT<br>● Commissioning<br>● UHB Transformation<br>●DToC Reporting | ● CHC Follow-up<br>● Public Health Targets |
| Information Governance and Security | 6 | | | | ● Information Governance - GDPR | ● Neuroscience It System follow up<br>● Renal It system | | ● e-advice<br>● Cyber Security<br>● e IT Learning | |

| C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2018/19 (Draft reports highlighted in red italics) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Assurance domain** | **Audits** | | **Final & Draft Audit Assurance Rating** | | | | | **Audits to be completed** | **Deferred Audits** |
| | | | **Not rated** | **No** | **Limited** | **Reasonable** | **Substantial** | | |
| Operational Service and Functional Management | 12 | | | | ● Mental Health CB - Sickness Mgt.<br>● Surgery CB - Medical Staff Governance<br>● Medicine CB – Internal Medicine Follow-up<br>● *PCIC Interface Incidents (draft)* | ● Dental – Nurse Provision<br>● Dental – Theatre Sessions<br>● Mental Health CB – Section 17<br>●PCIC District Nursing rotas<br>● CD&T CB – Bank, Agency & OT Spend<br>● *Medicine CB – Absence Management (draft)* | | ● Specialist CB - Medical Staff Governance | ● C&W CB – Transition Plans |
| Workforce Management | 3 | | | | | ●Electronic Staff Record<br>●Management of the Disciplinary Process | | | ● Consultant Job Planning Follow-up |
| Capital and Estates Management | 10 | | | | | ● Capital Schemes – Future Wellbeing *(17/18)* (SSU)<br>● Environmental Sustainability Reporting<br>● Cleanliness Standards Follow up<br>● Carbon Reduction Commitment (SSU)<br>● Estates Time Recording System – Kronos | | ● Estates Statutory Compliance - Water<br>● Capital Project – Rookwood<br>● Capital – Safeguarding Work CRI | ● Commercial Outlets<br>● Service Improvement Team |

| INTERNAL AUDIT REPORT RESPONSE TIMES | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Audit | Rating | Status | Draft issued date | Responses & exec sign off required | Responses & Exec sign off received | Final issued | R/A/G | |
| Annual Quality Statement | Substantial | Final | 13/6/18 | 04/07/18 | 02/07/18 | 02/07/18 | G | |
| Ombudsman Reports | Substantial | Final | 23/8/18 | 13/09/18 | 23/08/18 | 24/08/18 | G | |
| Dental CB – Theatre Cancellations | Reasonable | Final | 07/08/18 | 28/08/18 | 22/08/18 | 30/08/18 | G | |
| Dental CB – Dental Nurse Provision | Reasonable | Final | 26/07/18 | 16/08/18 | 22/08/18 | 30/08/18 | A | |
| Sustainability Reporting | Reasonable | Final | 18/07/18 | 08/08/18 | 22/08/18 | 23/08/18 | A | |
| Electronic Staff Record | Reasonable | Final | 13/07/18 | 03/08/18 | 04/09/18 | 10/09/18 | A | |
| Management of the Disciplinary Process | Reasonable | Final | 13/07/18 | 03/08/18 | 04/09/18 | 10/09/18 | A | |
| Charitable Funds | Substantial | Final | 31/08/18 | 21/09/18 | 10/09/18 | 10/09/18 | G | |
| Carbon Reduction Commitment | Reasonable | Final | 29/08/19 | 19/09/18 | 24/10/18 | 25/10/18 | R | |
| Neuro IT System Follow-up | Substantial | Final | 21/10/18 | 03/10/18 | 04/10/18 | 04/10/18 | G | |
| Mental Health Sickness Absence | Limited | Final | 26/09/18 | 25/10/18 | 25/10/18 | 30/10/18 | G | |
| Shaping our Future Wellbeing - Capital | Reasonable | Final | 23/07/18 | 13/08/18 | 01/10/18 | 01/10/18 | R | |
| Standards of behaviour | Limited | Final | 06/11/18 | 21/11/18 | 13/11/18 | 15/11/18 | G | |
| Cost Improvement Programmes | Substantial | Final | 16/11/18 | 07/12/18 | 20/11/18 | 21/11/18 | G | |
| PCIC district nursing rotas | Reasonable | Final | 18/10/18 | 10/11/18 | 16/11/18 | 19/11/18 | A | |
| Mental Health CB - S17 Leave | Reasonable | Final | 26/10/18 | 16/11/18 | 12/11/18 | 16/11/18 | G | |
| Cleaning Standards Follow-up | Reasonable | Final | 24/8/18 | 14/9/18 | 21/11/18 | 21/11/18 | R | |
| Renal IT System | Reasonable | Final | 07/11/18 | 28/11/18 | 02/01/18 | 10/01/19 | R | |
| Claims Re-imbursement | Substantial | Final | 06/12/19 | 31/12/18 | 09/01/19 | 11/01/19 | A | |
| Legislative / Regulatory Compliance | Limited | Final | 18/12/19 | 11/01/19 | 18/01/19 | 18/01/19 | A | |
| Performance Reporting – Non RTT | Substantial | Final | 01/02/19 | 21/02/19 | 08/02/19 | 12/02/19 | G | |
| Information Governance - GDPR | Limited | Final | 07/12/18 | 01/01/19 | 12/02/19 | 12/02/19 | R | |
| Surgery CB – Medical Finance Gov | Limited | Final | 12/11/18 | 03/12/18 | 09/02/19 | 12/02/19 | R | |
| Contract Compliance | Reasonable | Final | 04/02/19 | 26/02/19 | 13/02/19 | 14/02/19 | G | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Medicine CB – Internal Med Follow-up | Limited | Final | 03/01/19 | 24/01/19 | 12/02/19 | 14/02/19 | A | |
| CD&T CB – Bank Agency & OT Spend | Reasonable | Final | 31/01/19 | 21/02/19 | 15/02/19 | 15/02/19 | G | |
| Estates Time Recording / KRONOS | Limited | Draft | 15/08/18 | 05/09/18 | 15/02/19 | 15/02/19 | R | |
| PCIC Interfaces Incidents | Limited | Draft | 26/09/18 | 25/10/18 | | | R | |
| Medicine CB – Absence Management | Reasonable | Draft | 08/02/19 | 01/03/19 | | | | |

| AUDIT & ASSURANCEKEY PERFORMANCE INDICATORS | | | | | | |
|---|---|---|---|---|---|---|
| **Indicator Reported to NWSSP Audit Committee** | **Status** | **Actual** | **Target** | **Red** | **Amber** | **Green** |
| Operational Audit Plan agreed for 2018/19 | **G** | April 2018 | By 30 June | Not agreed | Draft plan | Final plan |
| Total assignments reported (to at least draft report stage) against plan to date for 2018/19 | **A** | 85% 29 from 34 | 100% | v>20% | 10%<v< 20% | v<10% |
| Report turnaround: time from fieldwork completion to draft reporting [10 working days] | **A** | 86% 25 from 29 | 80% | v>20% | 10%<v< 20% | v<10% |
| Report turnaround: time taken for management response to draft report [15 working days] | **R** | 43% 12 from 28 | 80% | v>20% | 10%<v< 20% | v<10% |
| Report turnaround: time from management response to issue of final report [10 working days] | **G** | 100% 28 from 28 | 80% | v>20% | 10%<v< 20% | v<10% |


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# Cardiff and Vale University Health Board

## Legislative / Regulatory Compliance

## Final Internal Audit Report

## 2018/19

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
| **Review reference:** | C&v-1819-04 |
| **Report status:** | Final Internal Audit Report |
| **Fieldwork commencement:** | 11th October 2018 |
| **Fieldwork completion:** | 10th December 2018 |
| **Draft report issued:** | 18th December 2018 |
| **Management response received:** | 18th January 2019 |
| **Final report issued:** | 18th January 2019 |
| **Auditor/s:** | Elizabeth Vincent, Senior Internal Auditor<br>Cara Vernon, Auditor |
| **Executive sign off:** | Nicola Forman, Director of Governance |
| **Distribution:** | Nicola Forman, Director of Governance<br>Sian Rowlands, Head of Corporate Risk & Governance |
| **Committee:** | Audit Committee |

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

## 1. Introduction and Background

The review of the management of Legislative and Regulatory Compliance was completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board (UHB).

The statutory obligations of the UHB are wide ranging and complex; the UHB must comply with general law as well as NHS specific legislation. In addition, the UHB is also subject to accreditation and review by a number of independent inspection and regulatory bodies.

It is therefore important that the UHB has robust processes in place to ensure that it is complying with all these statutory obligations and any issues are appropriately identified, escalated and addressed in a timely manner.

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

## 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 legislative and regulatory compliance, in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of systems objectives are managed appropriately.

The purpose of the review was to establish if effective processes are in place to ensure that the Health Board complies with all licencing, statutory and regulatory requirements and any associated risks or issues are effectively identified and addressed.

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

- Effective processes are in place within the Health Board for establishing compliance requirements relating to licenced, statutory and regulated activities;
- Appropriate actions are effectively carried out by the relevant services /departments to ensure that the required compliance is achieved;
- Compliance requirements and the level of achievement are appropriately monitored and recorded at a corporate level within the Health Board;
- The outcomes from the monitoring of compliance requirements and other internal/external reviews are periodically reported to an appropriate UHB committee; and
- Risks relating to licenced and regulated activities are appropriately assessed and recorded on the appropriate Clinical Board / Health Board Risk Registers.

## 3. Associated Risks

The potential risks considered in the review were as follows:

- Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service; and
- Reputational and financial loss due to non-compliance with the requirements of regulated activities

## 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 Legislative / Regulatory Compliance is **Limited** A**ssurance**.

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 findings from the current review have identified that the processes in place to ensure that the Health Board is compliant with all licencing, statutory and regulatory requirements are inadequate. The Health Board's Regulatory and Review Bodies Tracking Report (the 'Tracking Report') was incomplete and did not have the most recent information shown on it. The Corporate Team did not have a comprehensive list of all the required regulators so were unable to establish if all the Regulatory bodies are being captured on the register.

Weaknesses were also identified during the testing of processes within departments, actions that had been categorised as completed on the register were not always supported by relevant evidence. The Corporate

Team did not hold this information and the departments were unable to provide this information when requested.

Whilst the monitoring of the regulatory reports are managed to a reasonable standard within Health and Safety, improvements are required to the process for reviewing South Wales Fire Services (SWFS) reports at the Departmental Fire Safety Managers (DFSM) meeting.

The Tracking Report Register was presented to the Audit Committee in September 2018 without a covering paper and the layout and the formatting of the report made it difficult to read.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Effective Processes in place | | ✓ | | |
| **2** | Appropriate Actions in place | | | ✓ | |
| **3** | Compliance Requirements | | ✓ | | |
| **4** | Monitor of Compliance at Committees | | ✓ | | |
| **5** | Risks relating to Legislative Compliance | | | ✓ | |

** 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 5 issues that are classified as weakness in the system control/design for Legislative / Regulatory Compliance.

### Operation of System/Controls

The findings from the review have highlighted 2 issues that are classified as weakness in the operation of the designed system/control for Legislative / Regulatory Compliance.

## 6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

**Objective 1: Effective processes are in place within the Health Board for establishing compliance requirements relating to licensed, statutory and regulated activities.**

The following significant finding were noted:

- The current processes in place corporately for identifying the activities associated with statutory, regulatory and licencing bodies are inadequate. The processes used for identifying relevant activities and reports do not currently ensure that all areas are included and all required information is recorded.
- A benchmarking exercise was carried out by comparing the UHB Tracking Report to Velindre's legislative compliance register, to establish if the regulatory bodies identified were the same. There were a large number of differences between the two with the UHB having considerably less regulatory bodies shown on its Report.

**Objective 2: Appropriate actions are effectively carried out by the relevant services/departments to ensure that the required compliance is achieved.**

The following areas of good practice were noted:

- All reports from the Health and Safety Executive (HSE), SWFS and Environmental Health (EHO) are shared at the Operational Health and Safety Group (OHSG) that meet on a quarterly basis.
- The agenda and minutes from the OHSG meetings were reviewed for the period September 2017 - May 2018. There is a standard agenda in place, which includes feedback from the H&S Committee and Clinical Service Boards. An enforcement agencies correspondence report is presented to the group along with the Fire Safety Management and Enforcement Report. In addition the Health and Safety Priority Action Plan is also monitored at this group.

The following significant findings were noted:

- A sample of completed activities for South Wales Fire Service (SWFS) was chosen from the Tracking Report and evidence to support their completion was requested. There were instances where the evidence could not be provided and actions on some of the reports had not been completed.
- Management actions that are identified from a SWFS report are monitored at the Deputy Fire Safety Manager's (DSFM) bimonthly meeting. Attending figures identified that the attendance levels are low and the same members of staff are always present. Key areas who have the most management actions are not attending therefore we are

unable to provide assurance that the management actions are being appropriately scrutinised.

**Objective 3: Compliance requirements and the level of achievement are appropriately monitored and recorded at a corporate level within the Health Board.**

The following significant findings were noted:

- The Tracking Report for the UHB has all the required headings however most of the columns under these headings are incomplete. It was difficult to establish if the information shown on the register was the most current as the frequency of the site inspections was not always provided.

  Further analysis of the Report identified that a number of the recorded items date back to 2015 and may not still be current. We also identified through our testing exercise that some of entries for SWFS and HSE have been completed but this has not been reflected on the register.

  We also established at the time of the audit that the information shown on the register was incomplete for the regulators we reviewed.

**Objective 4: The outcomes from the monitoring of compliance requirements and other internal/external reviews are periodically reported to an appropriate UHB committee.**

The following area of good practice were noted:

- The Tracking Report was presented at the September 2018 Audit committee.

The following significant findings were noted:

- The Tracking Report that was presented to the Audit Committee was submitted without a covering paper. The formatting and layout of the report also made it impossible for the Audit Committee to read.

**Objective 5: Risks relating to licensed and regulated activities are appropriately assessed and recorded on the appropriate Clinical Board/Health Board Risk Registers.**

The following good practice has been noted;

- Relevant risks are being recorded on departmental and Clinical Board risk registers and key risks relating to licensed, statutory and regulated activities are listed on the Health Board's Corporate Risk and Assurance Framework. Therefore assurance can be provided that the risks associated with legislation are appropriately assessed and recorded.

There were no significant findings noted under this objective.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

| Priority | H | M | L | Total |
|---|---|---|---|---|
| **Number of recommendations** | **4** | **3** | **0** | **7** |

| Finding 1 - Ineffective Corporate process for identifying compliance requirements (Control design) | Risk |
|---|---|
| The current processes that are in place corporately for identifying the activities associated with statutory, regulatory and licencing bodies need strengthening.<br><br>The Corporate Administration Officer, who is responsible for maintaining the tracking report, uses the Chief Executive post log as the source document for obtaining the information. However examples have been identified when documentation relating to statutory, regulatory and licencing bodies has not been received via the Chief Executive's office. Therefore reliance can't be placed on this method to collate all the necessary information.<br><br>The Officer also sends an email twice a year to a list of contacts requesting further information prior to each Audit Committee. However the list of contacts is not subject to any review or updating. We analysed the list and found that 2 of the 21 names recorded are no longer found on outlook. No email addresses, post details or departments are recorded for the named contacts. Most significantly there is also no record of which statutory, regulatory or licenced activity each person is responsible for.<br><br>The standard email that is sent by the Corporate Administration Officer asks for some of the information that is required to complete the register but not all, therefore incomplete information is received. A copy of the actual report from the respective regulator is not requested as supporting evidence. | Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service.<br><br>Reputational and financial loss due to non-compliance with the requirements of regulated activities. |

| Recommendation | Priority level |
|---|---|
| The Corporate Governance Team should re-evaluate the processes in place for identifying the activities associated with statutory, regulatory and licencing bodies so that there are robust systems in place to capture this information more effectively and completely. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Agreed this is an essential responsibility of the Corporate Governance Team which to date has not been undertaken effectively.<br>This piece of work needs to be undertaken as a matter of urgency due to the risks it imposes with non-compliance with statutory and regulatory activities by not having adequate processes in place. | Head of Corporate Governance<br>End of February 2019 |

| Finding 2 – Incomplete Tracking Report (Operating effectiveness) | Risk |
|---|---|
| As a benchmark, the Health Board's Tracking Report (for the period ending 31st August 2018) was compared against Velindre NHS Trust's Legislative Compliance Register to establish if the content was comprehensive and included similar, expected activities.<br>The Velindre Compliance Register listed 30 activities of which only 11 could be found on the Health Board's Tracking Report. From the missing 19 we felt that at least 7 were relevant to the Health Board and should therefore be included on its Tracking Report.<br>Due to the high number of inconsistencies between both registers we feel that | Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service.<br>Reputational and financial loss due to non-compliance with the requirements of regulated activities. |

| | |
|---|---|
| the Health Board's Tracking Report is incomplete and may not be capturing all the relevant regulators. | |
| **Recommendation** | **Priority level** |
| A full list of Regulators that are relevant to the UHB needs to be established to ensure that the register is capturing all the required information. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Agreed this should be in place and the fact that it is not places the organisation at risk. | Head of Corporate Governance<br>End of February 2019 |

| **Finding 3 - Sampled activities not recorded accurately on Tracking Report (Control design)** | **Risk** |
|---|---|
| The information shown on the Regulatory and Review Bodies Tracking Report for the period ending 31st August 2018 for the sampled areas was inaccurate and not up to date.<br>The last entry shown on the register for a SWFS notice was January 2018, however we found that a further 11 notices have been issued up to August 2018; 6 at UHW, 3 at CRI and 2 at Llandough. Also a number of the entries shown on the register for SWFS had actually been completed but this had not been accurately reflected on the register.<br>The Tracking Report only included details of three reports for the Health and | Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service.<br>Reputational and financial loss due to non-compliance with the requirements of regulated activities. |

| | |
|---|---|
| Safety Executive (HSE) that dated back as far as 2015/ 2016. Two of these have been completed and should no longer feature on the Tracking Report; the third entry is still ongoing and is being discussed at the H&S Committee. The true number of reports issued up to August 2018 for the HSE and Environmental Health is ten; none of these are shown on the report.<br><br>In addition the HTA report that was issued in September 2017, which identified a number of critical non conformities is still shown on the Tracking Report. As part of the 2017/18 Audit Plan, an internal audit review of the progress against the HTA inspection was carried out, which confirmed that the majority of these issues had been addressed as at March 2018. This information was not reflected on the Tracking Report which further highlights that the information shown is out of date. | |
| **Recommendation** | **Priority level** |
| The Corporate Governance Team should ensure that all the relevant information that is required for the completion of the Tracking Report is obtained and up to date. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Agreed the information should be up to date and accurate | Head of Corporate Governance<br>End of February 2019 |

| Finding 4 - Audit Committee Paper (Control design) | Risk |
|---|---|
| The Tracking Report was presented to the Health Board's Audit Committee in September 2018 and is usually reported to them every six months. On this occasion the register was submitted without a covering paper which should introduce and explain its purpose to the Audit Committee.<br><br>In addition the information provided was insufficient due to the numerous incomplete sections shown on the register. The formatting and layout of the report also made it impossible to read.<br><br>Due to these weakness the Audit Committee was unable to effectively review the Tracking Report and provide assurance to the Board that the register is satisfactory. | Lack of assurance provided to the Audit Committee. |
| **Recommendation** | **Priority level** |
| The Corporate Governance department must ensure that the information provided to the Audit Committee is supported by a covering paper, is legible and contains a comprehensive list of the compliance requirements relating to licensed, statutory and regulated activities. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| It has already been agreed at the last Audit Committee that this report would be reviewed to ensure that it provided the Committee with a comprehensive list of compliance requirements relating to the statutory and regulated activities | Head of Corporate Governance<br><br>February 2019 Audit Committee |

| Finding 5 - SWFS notices (Control design) | Risk |
|---|---|
| A sample of eight notices for the South Wales Fire Service (SWFS) was chosen from the Tracking Report. All 8 were recorded as complete and evidence to support their completion was requested from the Senior Fire Safety Officer.<br><br>The following issues were identified;<br>• 1/8 no evidence was provided to support its completion. The Senior Fire Safety Officer felt that the original findings from SWFS were unjust and both management actions had been dismissed by him.<br>• 1/8 unable to provide evidence to support that the work had been completed. The work was carried out by a private company which would have been requested by the Clinical Board or Estates. Completion of works carried out by Estates that relates to enforcement notices are not fed back to the Senior Fire Safety Officer.<br>• 2/8 both notices from SWFS had three actions identified. Evidence could only be found to support the completion of three out the six actions. | Required actions may not be completed. |
| **Recommendation** | **Priority level** |
| The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Agreed | Head of Health and Safety<br>February 2019 Audit Committee |

| Finding 6 - Process in place to establish compliance is achieved (Operating effectiveness) | Risk |
|---|---|
| A meeting with the Senior Fire Safety Officer and further testing identified that the current processes in place to ensure compliance is achieved for the SWFS notices could be improved.<br>All actions identified in the UHB fire risk assessment are split into three categories; management, corporate and estates. The management actions are managed by the Departmental Fire Safety Managers (DFSM) from each Clinical Board. Corporate actions are the responsibility of the Fire Safety Department and Estates actions go via the Estates department.<br>The management actions are monitored at the DFSM bimonthly meeting. Copies of the DFSM meetings were obtained to ensure that the required people are attending each meeting and their frequency. Analysis of the attendance figures identified that the attendance levels are low and it is the same members of staff who are always present. Key areas who have the most management actions are not attending therefore we are unable to provide assurance that the management actions are being appropriately scrutinised. | Required actions may not be completed. |
| **Recommendation** | **Priority level** |
| The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Agreed | Head of Health and Safety<br>February 2019 |

| Finding 7 - Process in place corporately for identifying re-inspections (Control design) | Risk |
|---|---|
| The process in place at a corporate level for identifying when compliance against the listed activities is due to expire or re-inspection is due is inadequate.<br>The Tracking Report includes a column headed 'Date next scheduled visit/renewal of Licence/ Accreditation' however this is incomplete in most instances. The Report does not include the standard frequency of when each visit should take place which would be useful and should be added.<br>Although the standard email that is sent out by the Corporate Administration Officer asks when the next visit/ review is due to take place, this is not always answered. This however is not pursed by the Corporate Team with a follow up email or telephone conversation. | Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service.<br>Reputational and financial loss due to non-compliance with the requirements of regulated activities. |
| **Recommendation** | **Priority level** |
| The Corporate Team should re-evaluate the Report to ensure that all the necessary information required to maintain a comprehensive list is in place.<br>The Corporate Team should also review the standard email that is sent out to ensure that all the required information is requested. They should also pursue those who have not provided the relevant information. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Recommendation agreed | Head of Corporate Governance February 2019 |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

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

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

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

### Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>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 & Vale University Health Board

# Information Governance: General Data Protection Regulation (GDPR)

## Final Internal Audit Report

## 2018/19

## Private and Confidential

## NHS Wales Shared Services Partnership

## Audit and Assurance Service

**Contents** **Page**



| | |
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| | |
|---|---|
| **Executive sign off:** | Sharon Hopkins, Executive Director of Transformation, Improvement & Informatics |
| **Distribution:** | James Webb, Information Governance Manager |
| **Committee:** | Audit Committee |

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

## 1. Introduction and Background

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

The General Data Protection Regulation (GDPR) was adopted on 27 April 2016. It took effect from 25 May 2018 and is immediately enforceable as law in all member states of the European Union (EU).

The primary objectives of the new legal framework are to institute citizens' rights in controlling their personal data and to simplify the regulatory environment through a unified regulation within the EU. Many principles of the GDPR are broadly the same as the existing Data Protection Act (DPA). One of the most significant changes is the increased penalties. Under the new regulations, penalties will reach an upper limit of €20m or 4% of annual turnover, whichever is higher.

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

## 2. Scope and Objectives

The overall objective of the audit was to provide assurance to the Health Board that arrangements are in place and managed appropriately within its wards, departments and directorates to ensure compliance with the requirements of the GDPR.

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

- appropriate action is being taken to ensure that management and staff are aware of the GDPR and the impact it is likely to have;
- local governance controls and measures have been implemented; and
- a register of information assets is maintained and identifies the source, responsibility and sharing arrangements for each asset.

## 3. Associated Risks

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

I. insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation;

II. controls not operating resulting in non-compliance; and

III. reputational damage and/or financial loss.

## 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 GDPR 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 UHB started making preparations for GDPR in advance of its implementation, with training provided to the staff group deemed to be Information Asset Owners (IAO). However the loss of staff within the Information Governance (IG) team and the absence of the IG Manager meant that this work did not continue smoothly. Guidance for staff on the website has not been updated and contains incorrect information and procedures have not been updated to reflect GDPR requirements. Within Clinical Boards there has not been a consistent mechanism for ensuring appropriate actions are undertaken to enable compliance with GDPR and there is a lack of visibility from the IG team into Clinical Board processes.

In general, staff awareness of IG and GDPR is reasonable, however there are some areas where this awareness is not complete and may lead to non-compliance, this is particularly the case for subject access requests and breach reporting.

The UHB has a Privacy Impact Assessment (PIA) process in place, along with a staff Privacy Notice, and service user Privacy Notice, however service user information regarding GDPR is often not on display.

There is an Information Asset Register (IAR) process in place and the majority of areas have started to develop these, however this is not the case for all departments and there is a degree of inconsistency and incompleteness for those departments who have created an IAR. The processes within the UHB do not fully identify information flows or the basis for processing.

In summary, although there are areas of good practice, the extent to which guidance is outdated, the lack of full awareness and the non-compliance areas means that the UHB has no process to provide assurance over compliance and limited mechanisms to identify non-compliance before a reportable breach occurs.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Central Actions | | ✓ | | |
| **2** | Local Governance | | | ✓ | |
| **3** | Information Asset Registers | | ✓ | | |

** 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 GDPR.

### Operation of System/Controls

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

## 6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

**Objective 1: Appropriate action is being taken to ensure that management and staff are aware of the GDPR and the impact it is likely to have.**

The following areas of good practice were noted:

- an update of actions taken to prepare for GDPR went to the IT Committee group in May18 with detail on further work needed;
- the requirements for GDPR compliance were identified and actions fed into the ICO action plan;
- training sessions were provided for IAOs (Directorate Managers); and
- monitoring of the GDPR is undertaken by the Information Technology and Governance Sub Committee.

The following significant findings were identified:

- There was no GDPR action group or task and finish group or similar set up to drive and ensure Clinical Boards undertook the appropriate actions. The IG team went to all Directorates and gave a presentation on GDPR and the requirements etc. However there has been no checking to ensure actions have been taken and that Clinical Boards are ensuring compliance, and there is currently limited visibility from the IG team to Clinical Boards.
- Reviewing the processes within Clinical Boards indicated that most of these do not have a structure to identify the required actions to be undertaken to ensure compliance with GDPR and no process to ensure that compliance is achieved. These processes are of an ad-hoc nature and vary across Directorates and Clinical Boards.
- The staff resource within the IG team has not been sufficient to ensure appropriate preparation for GDPR within the organisation. The lack of continuity at the manager level and the lack of staff resource has meant that issues raised by Clinical Boards have not been dealt with promptly and the training provided across the UHB not been complete.
- The current procedure for subject access requests on the UHB web site is still the old one and contains incorrect information.
- Guidance for staff on the UHB intranet is out of date and incorrect, with the following issues identified:

- there is a note re GDPR and an associated link stating the GDPR has 6 principles. However the GDPR contains 7 principles.
- the IG start page has more references to the Data Protection Act (DPA) than GDPR and also has the absent IG Manager mail as the contact. (this mailbox is full)
- The IG page links to a sub page on the data protection act. This page hasn't been updated to reflect GDPR and still refers to 8 DPA principles. In addition the link to the DPA on the ICO site is dead (as it is no longer valid) This is also true of other links to ICO information e.g. the definition of personal data.

**Objective 2: local governance controls and measures have been implemented to enable compliance with the GDPR.**

The following areas of good practice was noted:

- staff awareness has been raised by emails and reminders sent to staff, and inclusion in some Directorate newsletters;
- some Directorates have undertaken actions to improve the compliance position;
- IG breaches are understood and reported on Datix;
- relevant staff aware of PIAs and these are being completed;
- PCIC have an IG group, this has highlighted areas where work needs to be done to comply with GDPR, and is auctioning these;
- roles and responsibilities for IG / GDPR are well defined in PCIC;
- PCIC have provided training on GDPR to their staff and raised awareness;
- Dental CB provide training on IG on a regular basis;
- Medical records and Dental Clinical Board keep a record of access requests to track compliance; and
- in general awareness of GDPR is indicated by staff raising relevant queries and reporting breaches.

The following significant findings were identified:

- One of the key vehicles for raising awareness of GDPR and enabling compliance is the IG module within mandatory training. However compliance rates for the UHB are not high, with an average of 68.5%.

(maximum of 84% for Dental, minimum of 59% for both Capital, Estates and Facilities and Surgical Services).

- Although training was provided to Directorate Managers (as these were the group defined as IAOs), this was prior to GDPR being active and there has been limited follow up training provided and limited detail on specific actions to be undertaken. In addition not all staff in roles dealing with information have had relevant training, in particular staff within Dermatology have not had training but are currently undertaking the IAO role.
- Although in general staff are aware of what constitutes an IG breach and are aware of the need to report in Datix, the knowledge of the revised timescale under GDPR is not complete and there is a risk that a breach may not be entered on Datix immediately ( particularly on Friday / weekends). This potential delay in reporting could lead to a risk that the UHB will not comply with the 72 hour reporting window defined within GDPR.
- There is currently a lack of clarity regarding the conflicting requirements of GDPR, Welsh Government retention guidelines and UHB practice due to instructions following "scandals" such as the infected blood scandal and the abuse scandal. Due to this the UHB is retaining records longer than the period stated within WG guidelines.
- The processes / guidance for staff dealing with transfers of information to non EEA states is not complete. Staff do not always understand the need for gaining explicit consent for this and thus may not do so.

**Objective 3: A register of information assets is maintained and identifies the source, responsibility and sharing arrangements for each asset.**

The following areas of good practice were noted:

- IARs in place for many areas including: central IT systems; PCIC; Child Health; Health Records; Therapies; Dental.

The following significant findings were identified:

- There is no IAR in place and no work undertake to develop one for Dermatology or Internal Medicine. In addition the IARs for some other areas are incomplete as they do not go into detail regarding what is held at each locality. Furthermore, from reviewing all the IARs there are inconsistencies in the collection and recording of information on them

- entering of UHB wide systems on some but not others. There is a lack of clarity over who is responsible for recording these;
- identification of IAO is inconsistent; and
- differing templates are being used.

- The IAR process does not pick up all items that would allow the full benefits to be gained and ensure full compliance with GDPR:
  - information flows are not being recorded on the IARs; and
  - the basis for processing is not being considered.

## 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** | **8** | **1** | **12** |

| Finding 1– GDPR Coordination (Operating effectiveness) | Risk |
|---|---|
| There was no GDPR action group or task and finish group or similar set up to drive and ensure Clinical Boards undertook the appropriate actions.<br><br>The IG team went to all Directorates and gave a presentation on GDPR and the requirements etc. However there has been no checking to make sure actions have been taken and that Clinical Boards are ensuring compliance, and there is currently limited visibility from the IG team to Clinical Boards.<br><br>Reviewing the processes within Clinical Boards indicated that most of these do not have a structure to identify the required actions to be undertaken to ensure compliance with GDPR and no process to ensure that compliance is achieved. These processes are of an ad-hoc nature and vary across Directorates and Clinical Boards.<br><br>Accordingly the UHB has no process to provide assurance over compliance and limited mechanisms to identify non-compliance before a reportable breach occurs. | Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation. |
| **Recommendation** | **Priority level** |
| The UHB should consider establishing a GDPR group with representation from all clinical boards. The function of the group should be to ensure appropriate compliance actions are taken and to provide assurance that the UHB has good processes to ensure compliance with the GDPR. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |

| | |
|---|---|
| The UHB has adapted the all Wales IG policy. As part of the process to formal adoption, consultation and impact assessment will be taking place through which we anticipate identification of all clinical board requirements and prioritised action.<br><br>The UHB sees placing responsibility and accountability as close as possible to the operational front line as the key to having an empowered and engaged workforce. Thus we see that the role of the corporate IG department is to design delivery of compliance and to provide specialist advice, rather than co-ordinate and deliver. It is accepted that as resources and expertise accumulate in line with expectation, there is more the central team can do on communication and engagement including the creation of a virtual mutually supporting networking of IAOs / IAAs. As recommended this will include setting up a GDPR group for a year. | Head of IG - Improvement approach with engagement around IG policy to take place up to end of Q1 2019/20 |

| **Finding 2– IG Team Resource (Operating effectiveness)** | **Risk** |
|---|---|
| The staff resource within the IG team has not been sufficient to ensure appropriate preparation for GDPR within the organisation. The Information Governance Manager has been absent since March, and the post covered by 2 consecutive managers. The team itself consists of only 4 additional staff, 2 of which are recent appointments.<br><br>The lack of continuity at the manager level and the lack of staff resource has meant that issues raised by Clinical Boards have not been dealt with promptly and the training provided across the UHB not been complete. | Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation. |

| Recommendation | Priority level |
|---|---|
| The resource requirement for the Information Governance team should be fully assessed and resource provided appropriately. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| In the context of the UK wide economy growing at a lower rate than: patient expectation, demand and health care cost inflation, the UHB has had to take business decisions in order to deliver a financially balanced plan. We recognise these have had significant consequences on many of our staff and resulted in high levels of sickness which have only made the position harder for all.<br><br>We fully appreciate that a once in a generational change to IG legislation coincided with difficult financial circumstances has presented us with a challenge, but we would contend that this was a short sharp shock to the system which is now being adopted into routine ways of working as knowledge and awareness builds from experiential learning.<br><br>As such we anticipate that by the end of Q1 2019/20 we will have increased the number of whole time equivalents in place and working by a whole time equivalent, taking the operational staffing levels to 4.8 wte, which will continue to be complimented by specialist advice from both Welsh Health Legal and Risk and a local legal firm. To confirm the financial resource for this external support is available within the UHB's budget. | Head of IG – Q1 2019/2020 |

| Finding 3– Subject Access Requests (Operating effectiveness) | Risk |
|---|---|
| The current procedure for subject access requests on the UHB web site is still the old one and contains incorrect information as it states both the old 40 day timescale, the fee and that access requests must be made in writing and using the UHB form. However the GDPR and ICO guidance is clear that requests may be verbal and organisations 'may not insist on the use of a particular means of delivery for a SAR'. In addition the GDPR timescale is 30 days and no fee can be charged.<br><br>This means that the UHB does not have an appropriate procedure in place, the guidance to staff and patients is wrong, and consequently staff are not complying as they are insisting requests go to medical records in writing. | Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation. |
| **Recommendation** | **Priority level** |
| A revised Subject Access Procedure should be completed, placed on the intranet and flagged to all staff. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Accepted | Head of IG – March 2019 |

| Finding 4– Guidance for Staff (Operating effectiveness) | Risk |
|---|---|
| Guidance for staff on the UHB intranet is out of date and incorrect, with the following issues identified:<br>- there is a note re GDPR and an associated link stating the GDPR has 6 principles. However the GDPR contains 7 principles.<br>-the IG start page has more references to the DPA than GDPR and also has the absent IG Manager mail as the contact. (this mailbox is full)<br>- The IG page links to a sub page on the data protection act. This page hasn't been updated to reflect GDPR and still refers to 8 DPA principles. In addition the link to the DPA on the ICO site is dead (as it is no longer valid) This is also true of other links to ICO information eg the definition of personal data.<br>One reason for the out of date information is that the only person in the IG team with access to change the information is the absent information governance manager. However this means that there is no accurate information easily available to staff through the IG pages. | Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation. |
| **Recommendation** | **Priority level** |
| The IG webpages should be updated to ensure they present current, accurate information. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The contact details will be updated shortly. | Head of IG – Q2 2019/20 |

| | |
|---|---|
| As noted above the department has been short staffed and there has needed to be a prioritisation between designing and mitigating significant risks to non-compliance and making general information available. The UHB has engaged widely on the DPA 2018 and is intending to use the consultation on the IG policy as a further vehicle for promoting awareness and setting out expectations.<br><br>As identified above we anticipate that a further whole time equivalent will be available and contributing to delivery of the UHB's plan in Q1 2019/20 and that at this time we can speed up delivery of our comprehensive IG action plan. | |

| **Finding 5– Mandatory Training (Operating effectiveness)** | **Risk** |
|---|---|
| One of the key vehicles for raising awareness of GDPR and enabling compliance is the IG module within mandatory training. However compliance rates for the UHB are not high, with an average of 68.5%. (maximum of 84% for Dental, minimum of 59% for both Capital, Estates and Facilities and Surgical Services) | Controls not operating resulting in non-compliance. |
| **Recommendation** | **Priority level** |
| The UHB should seek to ensure all staff complete the IG training module. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Accept – The UHB is engaged nationally in the development of the e-learning package and has licenses for its use. We intend to make use of this national initiative in line with its roll out plan. | Head of IG / WOD – National implementation |

| Finding 6– Training Provision(Operating effectiveness) | Risk |
|---|---|
| Although training was provided to Directorate Managers (as these were the group defined as IAOs), this was prior to GDPR being active and there has been limited follow up training provided and limited detail on specific actions to be undertaken.<br>In addition not all staff in roles dealing with information have had relevant training, in particular staff within Dermatology have not had training but are currently undertaking the IAO role. | Controls not operating resulting in non-compliance. |
| **Recommendation** | **Priority level** |
| Training on GDPR should be enhanced and provided to all staff acting in an IAO or IAA role.<br>Further information should be passed to Directorates on the specific actions to be undertaken following GDPR. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Training is via the mandatory training route described in recommendation 5.<br>The UHB will take actions to ensure we have asset registers and awareness of GDPR within dermatology and across the medicine clinical board as an early priority.<br>Within clinical boards there will be further emphasis and engagement on the responsibilities and requirements for IAO/IAA roles, in order to enable | March -2019 General Manager Medicine & Dermatology / IAO - Dermatology |

| | |
|---|---|
| appropriate senior staff to be allocated/trained, following implementation of enhanced training programme<br>"Dojo" training which is designed to help staff understand cyber security threats is available on ESR. | |

| **Finding 7–IARs (Operating effectiveness)** | **Risk** |
|---|---|
| There is no IAR in place and no work undertake to develop one for Dermatology or Internal Medicine.<br>In addition the IARs for some other areas are incomplete as they do not go into detail regarding what is held at each locality.<br>furthermore, from reviewing all the IARs there are inconsistencies in the collection and recording of information on them<br>- entering of UHB wide systems on some but not others. There is a lack of clarity over who is responsible for recording these.<br>- identification of IOA is inconsistent.<br>- differing templates are being used. | insufficient preparation for the new GDPR resulting in non-compliance<br>Controls not operating resulting in non-compliance. |
| **Recommendation** | **Priority level** |
| All areas should be asked to complete an IAR or feed into an IAR.<br>Further guidance should be issued over what information to collect and how to record it using the standard template. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| All areas have been asked on numerous occasions to complete asset registers and this was being reported into UHB committees. We acknowledge that the readiness is varied across service areas, which is a reflection on the operational challenges and the wider level of performance with other deliverables and risks requiring prioritisation.<br><br>The UHB will take actions to ensure we have asset registers and awareness of GDPR within dermatology and across the medicine clinical board as an early priority. | Medicine Clinical Directors, Directorate Managers and IAOs Q2 2019/20 |

| Finding 8–Breach Reporting (Operating effectiveness) | Risk |
|---|---|
| Although in general staff are aware of what constitutes an IG breach and are aware of the need to report in Datix, the knowledge of the revised timescale under GDPR is not complete and there is a risk that a breach may not be entered on Datix immediately ( particularly on Friday / weekends). This potential delay in reporting could lead to a risk that the UHB will not comply with the 72 hour reporting window defined within GDPR. | Controls not operating resulting in non-compliance. |
| **Recommendation** | **Priority level** |
| A reminder should be sent to all staff to ensure that all IG breaches are entered onto Datix immediately. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| Acknowledged – further engagement is planned via the requirement to consult and impact assess the IG policy | Head of IG Q2 2019/20 |

| Finding 9– Retention of Records (Operating effectiveness) | Risk |
|---|---|
| There is currently a lack of clarity regarding the conflicting requirements of GDPR, Welsh Government retention guidelines and UHB practice due to instructions following "scandals" such as the infected blood scandal and the abuse scandal.<br><br>Currently the UHB is retaining records longer than the period stated within WG guidelines. As the GDPR states that records should only be kept "as long as necessary" this may mean non-compliance.<br><br>Guidance for retention of child health records states to keep until the 25th birthday then destroy, however due to recent "scandals" such as infected blood / abuse etc. they have been told not to destroy until the record has been looked at to ensure nothing needs to be kept. Due to the lack of clinical resource these records are not being reviewed, and accordingly not destroyed and so they are retaining records longer than guidance states. | Controls not operating resulting in non-compliance |
| **Recommendation** | **Priority level** |
| This issue should be raised with WG to confirm that the requirement to keep overrides the stated retention guidelines. This issue should be entered onto the UHB risk registers. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardians) groups.<br>Given the advent of digital and the opportunities presented by 'big data' analysis the proposal is that digital records containing the core clinical record will be kept for 100 years. The UHB is an advocate of this position<br>The paper record is being retained on instruction of the NHS Wales Chief Executive for the reasons stated in the findings. | No action required |

| Finding 10– IAR Completeness (Operating effectiveness) | Risk |
|---|---|
| The IAR process does not pick up all items that would allow the full benefits to be gained and ensure full compliance with GDPR:<br>- Information flows are not being recorded on the IARs.<br>- The basis for processing is not being considered. | Controls not operating resulting in non-compliance. |
| **Recommendation** | **Priority level** |
| The IAR process should pick up information flows and also consider the basis for processing. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| In line with the approach taken across NHS Wales which has been discussed openly with the ICO's office a phased approach to the development of IARs has been adopted. Presently the UHB is in the process of mapping flows, with the initial focus having been on mapping new flows, those concerning R&D (potentially higher risk) and those into NWIS.<br>The legal basis for processing in the majority of cases is patient care as set out in our privacy notice.<br>The UHB is using the requirement to get the documentation right for all new flows as a tool for increasing knowledge of what is required. | Operationally: IAOs as laid out in the IG policy<br>Corporately: SIRO & DPO<br>Q2 2019/20 |

| Finding 11–Non EEA Information Transfers (Operating effectiveness) | Risk |
|---|---|
| The processes / guidance for staff dealing with transfers of information to non EEA states is not complete. Staffs do not always understand the need for gaining explicit consent for this and thus may not do so. | Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation. |
| **Recommendation** | **Priority level** |
| The UHB should make clear the requirement to gain explicit consent for these transfers. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| As above – there is no requirement for consent where the data processing by a non EEA 3rd party has a EEA 'kitemark'. Information around this is being shared and informed by work reporting into IG MAG | Head of IG – continuation of existing practice |

| Finding 12– Service User information (Operating effectiveness) | Risk |
|---|---|
| Although information (posters) for patients were sent out to all Directorates, these have not been put up in all cases. | Controls not operating resulting in non-compliance. |
| **Recommendation** | **Priority level** |
| Directorates should be reminded to display the GDPR information. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Accept – SIRO will write to Directorate Managers & CDs to remind them of this requirement. | SIRO – end of February |

## 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.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>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

# Surgery Clinical Board – Medical Finance Governance

# Final Internal Audit Report

# 2018/19

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
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| **Auditor/s:** | Lucy Jugessur, Principal Internal Auditor |
| | Ian Virgil, Assistant Head of Internal Audit |
| **Executive sign off:** | Steve Curry, Chief Operating Officer |
| **Distribution:** | Mike Bond, Director of Operations |
| | Guy Blackshaw, Clinical Director, General Surgery |
| | Denis Williams, Directorate Manager, Ophthalmology |
| **Committee:** | Audit Committee |

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

## 1. Introduction and Background

The review of Medical Finance Governance within the Surgery Clinical Board was completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board.

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

## 2. Scope and Objectives

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

The purpose of the review was to establish if there are effective governance arrangements in place within the Clinical Board to ensure that Medical staff time and costs are appropriately monitored and controlled.

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

- There are appropriate local procedures and processes in place for the management of medical staff time that are in line with the relevant Health Board policies and procedures and Welsh Government (WG) guidance;
- Consultant staff are appropriately working the required core contracted hours as stated within their current job plans and flexible sessions are appropriately managed;
- The activity undertaken by consultant staff as part of the core hours stated within their job plans is in line with the requirements of the service and needs of the organisation;
- Additional sessions worked by consultants and other medical staff are justified, subject to appropriate authorisation and are worked in addition to their core contracted hours;
- Payments for additional sessions are based on appropriately verified and authorised claims and are made at the correct rate in accordance with Agenda for Change (A4C) and WG guidance; and
- Requests for locum medical staff are made following an effective assessment of need and are appropriately authorised and correctly paid.

The scope of the review did not include the consultant job planning process as this was subject to a recent, separate review by Internal Audit.

Testing for the review was undertaken within the Ophthalmology and General Surgery Directorates.

## 3. Associated Risks

The potential risks considered in this review were as follows:

- Delays in patient treatment / non-achievement of objectives or targets;
- Inappropriate / ineffective medical staff activity; and
- Unnecessary / inappropriate expenditure.

## OPINION AND KEY FINDINGS

## 4. Overall Assurance Opinion

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

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Surgery CB – Medical Finance Governance is **Limited assurance**.

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

The current review has identified that the processes in place for managing Medical Finance Governance are not being consistently applied across the two sampled Directorates.

The majority of significant issues were identified within the General Surgery Directorate and this is the main reason for the current limited assurance rating. A number of Consultant's job plans were out of date and one consultant had no job plan in place at all. Clinics and theatres had been cancelled for one Consultant without appropriate reasons being recorded. Furthermore, sessions are being cancelled within the colorectal service due to a lack of cover between the colorectal consultants. There

was also a lack of paperwork available within the Directorate to evidence appropriate authorisation when requesting Locum Consultants.

Fewer issues were noted within Ophthalmology where it was identified that consultants are appropriately working their core contracted clinic and theatre sessions. Additional Waiting List Initiative (WLI) sessions are appropriately authorised and paid although displaced SPA sessions are not always being adequately recorded or agreed. Appropriate documentation is completed when requesting Locum Consultants although the extension of one Locum Consultant cover request was completed retrospectively.

It was also noted that neither Directorate has any documented procedure notes in place outlining the processes to be undertaken.

The review did identify that, within both Directorates, core consultant time and additional sessions are being effectively planned around the requirements of the services.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Appropriate local procedures and processes | | | ✓ | |
| **2** | Consultant staff are working required core contracted hours | | ✓ | | |
| **3** | Activity undertaken by consultant staff is in line with requirements of the service | | | | ✓ |
| **4** | Additional sessions worked by consultants and other medical staff | | ✓ | | |
| **5** | Payments for additional sessions are based on appropriately verified and authorised claims | | | ✓ | |
| **6** | Requests for locum medical staff | | ✓ | | |

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

### Design of Systems/Controls

The findings from the review has highlighted one issue that is classified as weakness in the system control/design for Surgery CB – Medical Finance Governance.

### 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 Surgery CB – Medical Finance Governance.

## 6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

**Objective 1: There are appropriate local procedures and processes in place for the management of medical staff time that are in line with relevant Health Board policies and procedures and Welsh Government (WG) guidance.**

The following areas of good practice were noted:

- It was evident that there are processes in place for the management of medical staff time within both the General Surgery and Ophthalmology Directorates.
- Within the Ophthalmology Directorate there are timetables for each of the Consultants detailing where they are working on each day.

The following significant findings were noted:

- There are no documented procedure notes in place within the General Surgery or Ophthalmology Directorates for the management of medical staff time.

**Objective 2: Consultant staff are appropriately working the required core contracted hours as stated within their current job plans and flexible sessions are appropriately managed**

The following areas of good practice were noted:

- There are timetables in place for each of the Ophthalmology Consultants that detail the times and days that they are working clinic, theatre and SPA sessions. The Audit review confirmed that Consultants are working their contracted hours and all clinic and theatre sessions are undertaken apart from when the Consultants are on annual leave, study leave, bank holiday or Audit.
- Nine of the 10 General Surgery Directorate consultants reviewed had appropriately completed their required clinic sessions apart

from occasions when they were on annual leave, study leave or on-call; and

- There is a spreadsheet maintained for the Colorectal General Surgery Consultants confirming the sessions that the Consultants are working. There are 8 Colorectal Consultants who undertake lists over the 5 days.

The following significant findings were noted:

- Job plans were not up to date for all the General Surgery Consultants selected and 1 Consultant did not have any job plan in place;
- One General Surgery consultant had not carried out all required clinic and theatre sessions during the period under review; and
- Colorectal Consultants were not always covering the other Colorectal Consultants theatre sessions if they were on annual leave or study leave.

**Objective 3: The activity undertaken by consultant staff as part of the core hours stated within their job plans is in line with the requirements of the service and needs of the organisation**

The following areas of good practice were noted:

- The requirement for consultant sessions are derived from the Ophthalmology IMTP that details the needs of the services which have been agreed from the plans within the service. Within the IMTP it confirmed that there would be 48 Waiting List additional sessions undertaken for this financial year.
- The requirements of the service are agreed and stated within the General Surgery IMTP. The past years activity is reviewed including the number of referrals, number of people treated and the number of patients left on the list at the end of the year and how much activity would be required. The waiting list initiative is considered as well to assess how many extra WLI sessions will be required.

There were no significant findings noted.

**Objective 4: Additional sessions worked by consultants and other medical staff are justified, subject to appropriate authorisation and are worked in addition to their core contracted hours**

The following areas of good practice were noted:

- The additional sessions within Ophthalmology and General Surgery have occurred due to the demands of the service. The Directorate IMTPs confirm the number of WLI sessions required and within which specialities. There are weekly RTT meetings held and the performance for the Clinical Board is reported within this forum. An

additional sessions report is sent to Finance confirming the sessions worked, who completed them, how many patients were seen and the reason for the sessions.

Additional areas of note:

- Audit was advised by the Ophthalmology Service Manager that there are also additional sessions undertaken by CESP consultants and the patients are vetted by the lead Consultant for CESP. Audit were advised that the patients reviewed are based on longest waiting times. CESP activity is not recorded through WLI payments as it is a separate company to whom the payments are paid. The CESP Consultants were outside the scope of the current Audit.

The following significant findings were noted:

- Within Ophthalmology a number of waiting list initiative sessions were carried out when the consultants were due to undertake SPA sessions. The claim forms did not detail when the SPAs had been rescheduled.
- Additional sessions were undertaken in May within General Surgery but the claim forms were not annotated to confirm when the displaced sessions that were due to be undertaken were rescheduled.

**Objective 5: Payments for additional sessions are based on appropriately verified and authorised claims and are made at the correct rate in accordance with Agenda for Change (A4C) and WG guidance**

The following areas of good practice were noted:

- There are specific rates in place for Consultants additional sessions and these are agreed throughout the whole of Wales.
- Audit reviewed Ophthalmology Waiting List Initiative claim forms and they were authorised by the Directorate Manager of Ophthalmology and ENT. All had received the standard payment of £579.
- Audit reviewed the two additional sessions worked during May for General Surgery and both had received the standard payment of £579 and both claims had been authorised by the Director of Operations.

There were no significant findings noted.

**Objective 6: Requests for locum medical staff are made following an effective assessment of need and appropriately authorised and correctly paid**

The following areas of good practice were noted:

- The timesheets for Locums working within Ophthalmology were available and they had been approved by the Service Manager.
- The rotas are reviewed to identify where there are gaps and junior medical staff will undertake on call sessions where there are gaps within General Surgery. In cases where the junior medical staff are unable to cover the shift, Medacs will be contacted to request Locum Consultants.

The following significant findings were noted:

- The Ad-hoc Locum cover request form for an Ophthalmology Locum Consultant was completed retrospectively.
- General Surgery did not follow the correct process to obtain a Locum Consultant.

## 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** | **3** | **0** | **6** |

| Finding 1 - General Surgery Consultants working required hours (Operating effectiveness) | Risk |
|---|---|
| Audit reviewed a sample of 10 General Surgery Consultants to establish if they were working the required Direct Clinical Care Sessions. The following findings were noted from the testing of sessions worked during May 2018:<br>• One Consultant only undertook 1 of the 4 clinics that he was due to carry out during May, with 2 being cancelled due to meetings. The same Consultant was due to undertake 8 theatre sessions but 4 were cancelled. However, there was no evidence or reason provided for the cancellations. This point was discussed with the Clinical Director for General Surgery and he confirmed that this Consultant is a mentor. Audit were advised that the Consultant was mentoring on these dates and the theatre sessions were undertaken by the mentee. However, it was not recorded on Theatreman that the Consultant was mentoring for those theatre sessions;<br>• Three of the Consultants reviewed were Colorectal Consultants. There are 8 Colorectal Consultants who undertake theatre lists over the 5 days and therefore if a Consultant is unable to carry out a session they should ensure that there is cover for that session. However the following was noted:<br>  • It was identified that 1 of the Consultants was on leave for 1 session, study leave for 1 session and on call for 1 session during May and none of the other Colorectal Consultants undertook the theatre lists. In addition, the Consultant was due to do a theatre list on the 23 May 2018 but it was cancelled and there was no reason provided.<br>  • Another of the Consultants had 2 theatre sessions cancelled due to the Consultant having study leave for 1 session and annual leave for 1 session, again none of the other Colorectal Consultants undertook the | Inappropriate / ineffective medical staff activity. |

| | |
|---|---|
| theatre lists.<br>• A 3rd Consultant had 2 theatre sessions cancelled due to the Consultant being on military leave and none of the other Colorectal Consultants undertook the theatre list. | |
| **Recommendation** | **Priority level** |
| The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres.<br>Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| • A new system to accurately record consultant activity in theatre is being developed with a clear desktop procedure.<br>• Through job planning each consultants expected activity will be agreed in weeks and monitored accordingly by the Directorate<br>• Expectation around backfill sessions will be agreed and signed by consultants and a system to monitor this will be managed by the Directorate team<br>• Systems will be put in place by end of March 2019 | Directorate/Speciality Manager for General Surgery in conjunction with Clinical Director<br>End March 2019 |

| Finding 2 – Additional Sessions (Operating effectiveness) | Risk |
|---|---|
| The Waiting List Initiative Policy confirms that "WLI work may be accommodated through the temporary displacement of SPA job plan commitments…The nature of the displaced SPA activity and when this will be rescheduled must be agreed and recorded on the WLI claim form."<br><br>The Waiting List Initiative Forms for Ophthalmology in May were reviewed and all had been authorised by the Directorate Manager. It was however identified that six of the eight Waiting List Initiative additional sessions were undertaken when the Consultant was timetabled to do an SPA session. It was evident from reviewing the WLI claim forms that there was no record confirming if the SPAs had been displaced and rescheduled and therefore no record of agreement.<br><br>There were only 2 instances of additional sessions worked by General Surgery Consultants in May. The job plan of the Consultant that undertook the extra sessions confirmed that they were planned to do a pre-op ward round and multi-disciplinary team at the time of the additional sessions. There was no recorded detail or agreement to confirm that these sessions were rescheduled. | Unnecessary / inappropriate expenditure. |
| **Recommendation** | **Priority level** |
| The Directorates should ensure that any displaced SPA sessions are appropriately recorded and agreed on the WLI form, in accordance with the policy. | **High** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| • Systems will be put in place to ensure that the governance for displaced SPA will be aligned to health board policy and audited within Directorates.<br>• Job plans will have clear timetables to ensure it is simple to follow WLI against working week<br>• Key responsible officers will be allocated to this task | Directorate/Specialty managers in conjunction with Clinical Directors |

| Finding 3 – Requests for General Surgery Locum Consultants (Operating effectiveness) | Risk |
|---|---|
| During the period of review there had only been 2 occasions where Locum Consultants were required within General Surgery. It was identified that the request for the locum cover was made via an Email to Medacs from the Directorate Administrator.<br>Audit was advised that the CV of the Locum would have been reviewed by the Clinical Director and the Professional Clinical Lead.<br>However, there was no paperwork in place within the Directorate to authorise the request for the Locum Consultant or any documentation approving the Locum Consultant provided by Medacs.<br>The Medical Personnel department have confirmed that whilst it is adequate for Locum Consultants to be requested via Email, the actual approval process should have been performed within the Directorate and evidence of the approval should be maintained there. | Unnecessary / inappropriate expenditure. |

| Recommendation | Priority level |
|---|---|
| General Surgery should ensure that they follow the correct procedure for recruiting and authorising Locum Consultants. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| • Ensure CD signs off paperwork for locum highlighting rationale for locum<br>• Create SOP/DTP so all staff can follow clear process<br>• Review paperwork to ensure it is up to date<br>These actions will be put in place by end of March 2019 | Directorate/Speciality manager in conjunction with CD<br>End March 2019 |

| Finding 4 - Desk top procedures (Control design) | Risk |
|---|---|
| There are processes in place for managing Consultant medical staff time and costs within both of the Directorates reviewed. However, the processes are not recorded on any local documented procedure notes within either of the Directorates.<br>The lack of documented procedure notes creates the risk that the processes may not be consistently carried out or may not be completed at all during periods of staff absence or turnover. | Delays in patient treatment / non-achievement of objectives or targets. |

| Recommendation | Priority level |
|---|---|
| Management should produce desk top procedures to ensure that Consultants medical staff time and costs are being managed appropriately and consistently. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| • Standardised procedure notes to be created and shared with key personnel (March 2019) | Directorate/Speciality Manager<br>End March 2019 |

| Finding 5 - Job Plans for General Surgery Consultants (Operating effectiveness) | Risk |
|---|---|
| Audit tested a sample of 10 General Surgery Consultants to establish if they were appropriately working their contracted sessions in clinics and theatres as recorded on their individual job plans.<br>It was identified that the job plans for five of the Consultants were out of date as their recorded working patterns for theatres were not in line with the actual theatre sessions that they were required to deliver.<br>In addition, there was another of the Consultants who had no job plan in place at all.<br>The issue of out of date and / or missing job plans has been previously raised as part of a specific Internal Audit review of Consultant job planning that was completed in May 2018. Actions to address the findings from the previous review are currently being progressed via the Medical Director's office and | Inappropriate / ineffective medical staff activity. |

| | |
|---|---|
| Clinical Boards.<br><br>The issue has been raised here due to the impact it had on Audit's ability to test if the sampled consultants were working the correct sessions. The difficulty created by the lack of up to date job plans was partly mitigated by the information on current consultant clinical and theatre sessions held by the Directorate team. This is reflected in the current priority rating for this finding. | |
| **Recommendation** | **Priority level** |
| In conjunction with the actions already being taken following the Consultant Job Planning Audit, the Directorate should ensure that all consultants have an up to date, agreed job plan in place that accurately reflects the current required sessions. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| • All job plans will be completed and recorded appropriately (March 2019) | Clinical Director<br><br>End March 2019 |

| Finding 6 - Ophthalmology Locum cover (Operating effectiveness) | Risk |
|---|---|
| There were 2 Ophthalmology Locum covers during the period Audit reviewed. An extension of one of the Locum Consultants was required. The extension was for the period 2 April - 13 July 2018, however, the Locum request document was dated the 2 July 2018. The request form should be completed prior to an extension for the locum cover.<br><br>This point was discussed with the Directorate and Audit were advised that there had been a verbal approval of the extension but there was a delay in the paperwork being processed to Medacs. | Unnecessary / inappropriate expenditure. |
| **Recommendation** | **Priority level** |
| Management should ensure that request for Locum cover documentation is fully completed prior to the cover required. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| **Clinical Board Response**<br>• SOP/DTP will be developed and standardised for all Directorates to record adherence to agree protocols (March 2019) | Directorate Manager/Deputy Director of Operations<br><br>End March 2019 |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

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

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

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

### Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

## Cardiff and Vale University Health Board

# Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up

## Final Internal Audit Report

## 2018/19

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
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| **Auditor/s:** | Ian Virgill, Kimberley Rowe |
| **Executive sign off:** | Steve Curry, Chief Operating Officer |
| **Distribution:** | Geraldine Johnston, Director of Operations<br>David Allison, General Manager |
| **Committee:** | Audit Committee |

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

## 1. Introduction and Background

The follow-up review of Internal Medicine – Mandatory Training and PADRs was completed in line with the Internal Audit Plan.

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

The original Internal Medicine report was finalised in November 2017 and highlighted a total of 6 issues which resulted in an overall assurance rating of limited assurance.

## 2. Scope and Objectives

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

The purpose of the follow up review is to establish if the previously agreed management actions have been implemented, in order to ensure that all staff members comply with statutory and mandatory requirements and annual PADRs are effectively planned and completed.

In following up the agreed actions the main areas that the review will seek to provide assurance on are:

- The Directorate have developed a Project Outline Document to support ward areas to complete PADR, along with a trajectory of expected completions and mandatory training fields;
- Bi-weekly operational meetings are taking place with a standing agenda item for PADR compliance;
- There is an assigned member of the Directorate team responsible for improving the mandatory training position;
- Key reports from ESR to be circulate and remain on the Performance Review agenda;
- The staff database within the Directorate office is to be regularly maintained and agree with ESR data;
- All staff are appropriately using ESR and hierarchies are correct for their area; and
- PADRs to be uploaded in ESR.

## 3. Associated Risks

The potential risks considered in this review are as follows:

- Staff members are not appropriately trained;
- Staff performance isn't effectively assessed and addressed; and

- Non-compliance with PADR or training requirements isn't identified or addressed.

## OPINION AND KEY FINDINGS

### 4. Overall Assurance Opinion

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

| | | |
|---|---|---|
| **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 sampled wards tested during the original review and follow-up have shown some improvement in compliance levels for both PADRs and Statutory and Mandatory Training. However, there is a lack of evidence to confirm that the improvements are a result of appropriate implementation of the agreed management actions. This has contributed to the conclusion that no actions are fully complete; with 3 actions being part complete (2 High, 1 Low), 2 actions not complete (1 High, 1 Medium) and the remaining medium priority action no longer applicable. There is therefore a lack of assurance that the controls in place are sufficient to ensure that the improvement in compliance levels will continue and be sustained in the future.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Internal Medicine – Mandatory Training and PADRs has remained as **Limited Assurance**. Management will however need to ensure that the outstanding actions are fully implemented.

## 5. Summary of Audit Findings

Follow up work was undertaken to confirm the progress that the Health Board has made against the agreed management responses from the original audit, as detailed within Appendix A.

| Priority rating | No of management responses to be implemented | Fully actioned | Partially actioned | Not actioned | Not Applicable |
|---|---|---|---|---|---|
| High | 3 | 0 | 2 | 1 | 0 |
| Medium | 2 | 0 | 0 | 1 | 1 |
| Low | 1 | 0 | 1 | 0 | 0 |
| **Total** | **6** | **0** | **3** | **2** | **1** |

In summary, progress against the six management responses that required implementation is as follows:

- No evidence has been provided of the Project Outline Document – the Directorate Manager (who has changed since the previous audit) is not aware of such a document. There was also no evidence provided to support a trajectory of PADR completions or monitoring at Bi-weekly operational meetings. Despite this, sample testing proved an improvement in the completion of PADRs, although for 40% of the staff sampled there was still no evidence that a PADR had been completed in the last 12 months;
- Sample testing supported an improved position on completion of statutory and mandatory training modules. However it is noted that evidence to confirm 100% compliance with the required training was only available for 41% of the sampled staff;
- The Directorate Performance reviews have not consistently been taking place. The only minutes available for audit were from the meeting on 26 July 18. There is no evidence within the minutes that PADR and training compliances are presented and discussed;
- Copies of previous PADRs continue not to be retained on employee files and are not uploaded to the ESR system; and
- All line managers evidenced that they had access to ESR, however, hierarchies are delayed being updated when staff are moved from different departments or there is a new Senior Nurse in the hierarchy. This was found to be a particular issue on Ward B7.

| Finding 1 - Completion of PADRs (Operating effectiveness) | Risk |
|---|---|
| Audit selected ten staff from each of three sampled Internal Medicine wards (C7 at UHW, East 4 at UHL and B7 at UHW) to establish if a PADR has been carried out within the last twelve months. Audit then checked if the PADRs had been fully and correctly completed with the PADR signed off as approved by both reviewee and reviewer with personal objectives set alongside a personal development plan. The findings for each ward were as follows:<br><br>**Ward C7 Medical UHW**<br>• 9 of the 10 employees sampled had not had a PADR completed within the last 12 months.<br>• The one PADR completed within twelve months was completed using the old format.<br>• Staff are completing PADRs on a training day, individual objectives and personal development plans were completed in groups and were not specific to each individual.<br><br>**Ward East 4 UHL**<br>• 1 out of 10 employees sampled had not had a PADR completed within the last 12 months.<br>• 5 of 9 PADRs were completed using the old format.<br>• 4 of 4 PADRs completed using the current format were not completed correctly, only organisational objectives were given no personal objectives or a personal development plan. | Staff performance isn't effectively assessed and addressed. |

| | |
|---|---|
| **Ward B7 Respiratory UHW**<br>• 5 out of 10 employees sampled had not had a PADR conducted in the last 12 months.<br>• 1 of the 5 PADRs completed was not dated with a review date.<br>• 1 of the 5 PADRs completed did not set any personal objectives or create a personal development plan.<br>• 5 of the 5 PADRs completed within the last 12 months were not signed by the employee.<br>• 3 of the 5 PADRs completed within the last 12 months were not signed by the reviewer/manager. | |
| **Recommendation** | **Priority level** |
| Management should ensure that all staff within Internal Medicine undertake a PADR, which is completed in full with both organisational and personal objectives agreed by the reviewing manager and employee. Management should create a personal development plan for each employee to help achieve each objective set.<br>Management must ensure that when completing the annual review with staff they are completing the latest and most up to date version of the PADR format. | **High** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| The Directorate has developed a Project Outline Document to support ward areas to complete PADR. This POD included timelines. | December 2017 Jane Murphy / Dave Pitchforth |
| The directorate has provided a trajectory of expected completion of PADRs. | March 2018 Jane Murphy / Dave Pitchforth |
| The directorate will share best practice to ensure learning. | November 2017 Jane Murphy / Dave Pitchforth |
| Bi-weekly operational meetings will now include PARD compliance as a standing agenda item. | December 2017 |
| Implementation of Tier 1 target meetings chaired by Lead Nurse, this will include a robust discussion of actions required. Senior Nurses will support this robustly. | December 2017 and ongoing |
| *__Note –__the Directorate Team feels that the actual current position with regard to PADR compliance, since completion of the audit, is now more positive than the results of the sample testing within the report indicate. | |

| Current Position |
|---|
| <u>Part Complete</u><br><br>No evidence has been provided of the Project Outline Document – the Directorate Manager (who has changed since the previous audit) is not aware of such a document. There was also no evidence provided to support a trajectory of PADR completions or monitoring at Bi-weekly operational meetings.<br><br>Despite this, sample testing proved an improvement in the completion of PADRs:<br>• 60% of sampled staff had an evidenced PADR in the past 12 months. (C7=3/5, E4 = 5/5, B7 1/5); |

| |
|---|
| • 89% of the available PADRs were fully and correctly carried out (1/9 incorrect). With all PADRs containing a personal development plan;<br>• All PADRs were signed by the reviewer, but only 78% were signed by the reviewee (7/9);<br>• All PADRs evidenced were completed using the relevant form format; and<br>• PADRs were completed individually and not as a group. |

| Updated Management Response | Updated Responsible Officer / Deadline |
|---|---|
| All PADRs are signed by the employee prior to them leaving the room at the end of their PADR or employee to sign and return within 7 days of PADR completion. | Ward Sisters/Charge Nurses<br>June 2019 |

| Finding 2 - Mandatory Training Level of Compliance (Operating effectiveness) | Risk |
|---|---|
| There are currently 13 core training modules expected to be completed by C&V staff members. Audit tested 5 Directorate support staff and 10 staff from each of the three sampled wards to establish their level of compliance with the required mandatory training. The findings for each area were as follows:<br><br>**Directorate Support**<br>• No member of staff sampled was 100% compliant on their statutory / mandatory training;<br>• Out of a total of 65 core modules that should have been completed, two modules completed had surpassed the expiry date and 23 had not been completed;<br>• Individual Compliance rates ranged from 30.77% to 84.62%; and | Staff members are not appropriately trained. |

| | |
|---|---|
| • Overall compliance for the area based on the employees sampled was 61.54%.<br><br>**Ward East 4 UHL**<br><br>• No member of staff sampled was 100% compliant on their Statutory / Mandatory Training;<br>• Out of a total of 130 core modules that should have been completed, ten modules completed had surpassed the expiry date and 60 modules had not been completed;<br>• Individual Compliance rates ranged from 7.69% to 92.31%; and<br>• Overall compliance for the ward based on employees sampled was 46.15%.<br><br>**Ward B7 Respiratory Unit UHW**<br><br>• 9 out of 10 members of staff were not 100% compliant on their Statutory/Mandatory Training;<br>• Out of a total of 130 core modules that should have been completed, 11 modules completed had surpassed the expiry date and 43 modules had not been completed;<br>• Individual compliance rates ranged from 15.38% to 100%; and<br>• Overall compliance for the ward based on employees sampled was 66.15%.<br><br>**C7 Medical UHW**<br><br>Audit were unable to check the compliance matrix for the staff located in the ward as they were not included in the hierarchy on ESR. Personal files were checked for certificates but only one employee had any certificates to prove completion of training modules. | |

| | |
|---|---|
| The audit notes that LED and Workforce's compliance rates only reflect 10 modules with a plan to report on all 13 from April 2018. | |
| **Recommendation** | **Priority level** |
| Management should ensure that all members of staff within the directorate are fully compliant and up to date with their mandatory training.<br>If staff members believe that ESR is not tracking when a module is completed, staff should print out the certificate available to provide proof and store it within their personal file. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The Directorate has assigned a member of the team to improve the mandatory training position.<br>All colleagues have been reminded of their requirements.<br>Signposting to where to access the training was provided.<br>If required 'timeout' for colleagues will be provided.<br>POD referenced above includes mandatory training fields – see above | March 2018 (Sarah Edwards Deputy DM, Jane Murphy / Dave Pitchforth)<br><br>December 2017 (development of POD) |
| **Current Position** | |
| Part Complete<br>As above, no evidence has been provided for the referenced POD.<br>Sample testing supported an improved position on completion of statutory and mandatory training modules: | |

- 17/20 sampled employees compliance matrices were available using the line managers ESR. The remaining 3 employees (Ward B7) were not listed within the line manager hierarchy;
- Overall, 41% of staff with an available compliance matrix were 100% compliant – this is an improved position to the prior review; and
- Of the available compliance matrices, a total of 78% modules have been completed (this figure has been adjusted to reflect the unavailability of the Mental Capacity Act training due to ESR issues (6/204 modules had expired and 33/204 had not been completed)

| Updated Management Response | Updated Responsible Officer / Deadline |
|---|---|
| Improved compliance for 85% of staff with completion of 100% mandatory and statutory training modules (44% improvement over 6 months). Staff to be allocated onto study leave planner and compliance monitored monthly via ESR and discussed with ward managers at 121s. | Ward Sisters/Charge nurses<br>September 2019 |

| Finding 3 - Monitoring and Reporting (Operating effectiveness) | Risk |
|---|---|
| Audit were supplied with the previous three Performance Review meeting minutes for the Internal Medicine Directorate. From review of the minutes it was clear that PADR compliance is not always reported, the minutes also showed that Statutory & Mandatory training compliance rates have not been reported in the previous three meetings.<br>From the Performance Review meeting dated 21/09/2017, it is minuted that PADRs were discussed within the meeting with the current compliance percentage supplied, the minutes show that the percentage figure was obtained | Non-compliance with PADR or training requirements isn't identified or addressed. |

| | |
|---|---|
| from the database held within the directorate office, this database is currently out-dated as outlined in the issue 'Directorate Database' below. Statutory & Mandatory training was not discussed during the meeting due to the directorate 'waiting on data in relation to training'.<br><br>For the Directorate Performance Review dated 01/05/2017 PADR compliance rate was discussed within the meeting, however there was no reference to Statutory & Mandatory training or the compliance rate at the time.<br><br>For the Directorate Performance Review dated 29/11/2016 both PADR and Statutory & Mandatory training were not discussed during the review based on the minutes.<br><br>Based on the latest report from the Directorate Performance review for Internal Medicine the current PADR compliance rate is at 41.47%. | |
| **Recommendation** | **Priority level** |
| Management should ensure that workforce runs monthly reports that highlight the current PADR compliance rate and also separate reports highlighting the current compliance rate for Statutory & Mandatory Training. These reports should be fed back and reported on during the Directorate Performance Review as and when they are held. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Key links with ESR team will be established and core reports determined, including circulation and frequency, this will ensure that any data discrepancies are highlighted to ensure accurate reporting. Accurate reporting of figures can be provided by Directorate team in due course. | Cari Randall, January 2018 |

| | |
|---|---|
| Issues to remain on Performance review agenda<br>Operational meeting and Tier 1 meeting referenced above will review nursing position at ward level readily.<br>Ongoing training by Lead and Senior Nurse to support ward sisters to be able to undertake the process and ensure all reporting hierarchies are correct for reporting. | MCB November 2017<br>Jane Murphy December 2017 and ongoing<br>Jane Murphy December 2017 and ongoing |

| **Current Position** |
|---|
| Not Complete<br>The Directorate Performance reviews have not consistently been taking place. The only minutes available for audit were from the meeting on 26 July 18. There is no evidence within the minutes that PADR and training compliances are presented and discussed. |

| **Updated Management Response** | **Updated Responsible Officer / Deadline** |
|---|---|
| Monthly Performance Meetings with the MCB to be undertaken monthly (avoid cancellation) and PADR compliance reported and discussed, and progress monitored against 6 month improvement trajectory. | General Manager, Integrated Medicine Directorate<br>March 2019 |

| Finding 4 - Retention & review of PADRs (Operating effectiveness) | Risk |
|---|---|
| The personal files for the sampled staff were reviewed to establish if copies of PADRs from the previous year were retained in order to evidence effective monitoring of progress against previously agreed actions. The findings for each area were as follows:<br>**Ward C7 Medical UHW**<br>• Only two of the ten employees sampled had previous years PADRs stored within their personal files which were both signed and completed.<br>• No individuals sampled have completed a PADR in the current period.<br>• PADR dates are not currently being uploaded onto ESR.<br>**Ward East 4 UHL**<br>• Signed and completed paper copies of previous years PADR forms are stored within the individual's personal files within the ward office and viewed by audit, with the exception of one employee where no PADR completed during the period and another who was new to the organisation.<br>• Audit found that five of the PADRs for the current year did not have personal objectives or personal development plans in place so were unable to determine if any tracking and monitoring had taken place on a year on year basis.<br>• PADR dates are not currently being uploaded onto ESR.<br>**Ward B7 Respiratory UHW**<br>• Four of the ten employees sampled were new to the Health Board and were not expected to have a PADR held in the personal file. Five out of the six | Staff performance isn't effectively assessed and addressed. |

| | |
|---|---|
| remaining employees did not have the previous year's PADR held within the personal file. | |
| **Recommendation** | **Priority level** |
| Management should ensure that any completed PADRs are retained in employees personal files and recorded onto ESR as evidence the PADR has been completed. PADRs should be retained to support the reviewer when establishing progress against agreed objectives during the year and on a year on year basis. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The Directorate has developed a POD to support ward areas to complete PADR. See above | December 2017 Jane Murphy / Dave Pitchforth |
| The directorate has provided a trajectory of expected completion of PADRs. | March 2018 Jane Murphy / Dave Pitchforth |
| The directorate will share best practice to ensure learning. | November 2017 Jane Murphy / Dave Pitchforth |
| **Current Position** | |
| Not Complete<br>Sample testing showed:<br>• 2/15 staff sampled were not in employment in the previous year so have not been included in this test.<br>• 2/13 employees had copies of their previous years' PADR. However, 1 of these employees had not had a current year appraisal therefore tracking could not be monitored.<br>• 11/13 employees sample did not have previous PADRs stored within their personal files; and | |

- Whilst ESR contains a record of PADR completion, evidence of these PADRs is not uploaded.

| Updated Management Response | Updated Responsible Officer / Deadline |
|---|---|
| Copies of all completed PADRs must be placed in personal files.<br>Record of a completed PADR must be recorded on ESR. | Ward Sisters/Charge Nurses<br>April 2019 |

| Finding 5 - Directorate Database (Operating effectiveness) | Risk |
|---|---|
| The directorate office has an Excel document in place containing all staff within the directorate which records the dates of the most recent PADRs and the dates each statutory training module was completed.<br>Audit found that the database was not kept up to date and did not contain new staff members, with old staff members for the directorate still held on the database. Also dates recorded for the mandatory training and PADRs were not reflecting the most recent completion dates. | Non-compliance with PADR or training requirements isn't identified or addressed. |
| **Recommendation** | **Priority level** |
| Management must ensure that the staff database is regularly maintained, with the deletion of staff that have left the directorate and the inclusion of new employees. Management must look to tie in the mandatory training dates with the ESR matrices to ensure they tie back to LED. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| Role to be included in job description of Directorate Team | Cari Randall March 2018 |

| Current Position |
|---|
| No Longer Applicable<br>No database is maintained by the directorate office. They are now reliant on reports from ESR therefore consistent figures are being used and reported. |

| Finding 6 - ESR (Operating effectiveness) | Risk |
|---|---|
| As part of the review the following issues were identified in relation to the use of ESR:<br>• During the review Audit became aware that Internal Medicine were only placed on ESR as of the 1st July 2017. Since the introduction of the directorate onto ESR the ward managers and directorate office staff visited had stated that no training had been supplied by LED or Workforce on how to use ESR. They stated there was a power point training package available but were unsure how to access it;<br>• Audit found that staff were having issues logging onto ESR with unknown user names and passwords. Once on ESR staff were having difficulty navigating the system and were unsure how to access the different functions; | Staff members are not appropriately trained. |

| | |
|---|---|
| • Audit discovered during testing that a ward selected as part of the sample had not been assigned a hierarchy with both ward manager and deputy ward manager not having access to the staff's records. This was also the case for the senior nurse; and<br>• Audit found that no areas within Internal Medicine were utilising the ESR function and were not uploading the PADR review dates. | |
| **Recommendation** | **Priority level** |
| Management should ensure that all staff using ESR attends the training courses provided by LED/Workforce on how to use and utilise the ESR function.<br>All ward managers and the senior nurse should check to see that there is a hierarchy in place within their area and that the hierarchy is correct and includes all members of staff under their management.<br>The directorate should start uploading the review dates for individuals PADRs into ESR once they have been complete. This will assist Workforce when running compliance reports and also aid ward managers as it provides reminders when the next PADR review is approaching. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| To be included in the reports for ESR to ensure all have access and training. | Cari Randall January 2018 |
| **Current Position** | |
| Part Complete | |

| |
|---|
| Whilst all line managers evidenced that they had access to ESR, hierarchies are delayed being updated when staff are moved from different departments or there is a new Senior Nurse in the hierarchy. This was found to be a particular issue on Ward B7, where 3 out of 5 staff sampled were not in the correct structure. |

| Updated Management Response | Updated Responsible Officer / Deadline |
|---|---|
| Timely changes made by ESR when staff or hierarchies change. | General Manager/Directorate management team, Integrated Medicine Directorate<br><br>March 2019 |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

**Follow up -** All recommendations implemented and operating as expected.

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

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

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

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

 **No assurance** - The Board 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.

**Follow up -** No action taken to implement recommendations.

## Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

# 2019 Audit Plan **Cardiff and Vale University Health Board**

Audit year: 2018-19

Date issued: January 2019

Document reference: 1043A2019-20

This document was produced by Dave Thomas, Mark Jones, Mike Usher and Tom Haslam on behalf of the Auditor General for Wales.

# Contents

# 2019 Audit Plan

## Summary

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

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

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

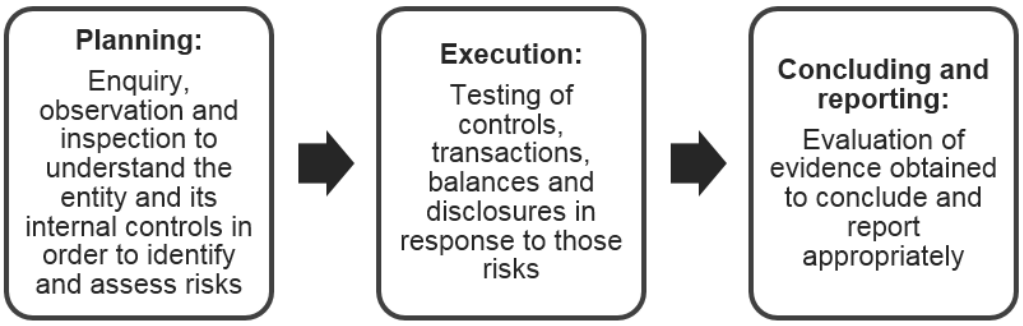
3 My responsibilities, along with those of management and those charged with governance, are set out in Appendix 1.

## Financial audit

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

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

Exhibit 1: my financial audit approach



6 My audit planning and testing to date has highlighted certain financial audit risks and some other areas for audit attention. Exhibit 2 summarises the current risks and the corresponding audit work that I plan to take to address them.

Exhibit 2: Financial audit risks

| Financial audit risks | Proposed audit response |
|---|---|
| **Significant risks** | |
| The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].<br>The current financial pressures on the Health Board increase the inherent risk that management judgements and estimates could be biased, for example, in an effort to achieve the planned revenue deficit of £9.9 million for 2018-19. | My audit team will:<br>• test the appropriateness of journal entries and other adjustments made in preparing the financial statements;<br>• review accounting estimates for biases;<br>• evaluate the rationale for any significant transactions outside the normal course of business; and<br>• add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above. |
| Under the NHS Finance (Wales) Act 2014, health boards ceased to have annual resource limits with effect from 1 April 2014. They instead moved to a rolling three-year resource limit, for revenue and capital net expenditure, with the first three-year period running to 31 March 2017.<br>The Health Board has exceeded its revenue limit for the three years to both 31 March 2017 and 31 March 2018. I therefore qualified my regularity opinion on the Health Board's 2016-17 and 2017-18 financial statements.<br>For 2018-19 the Health Board expects to exceed its annual revenue resource allocation by £9.9 million. This expected overspend would result in a cumulative deficit of £65.8 million for the three years to 31 March 2019.<br>In terms of the Health Board's capital resource limit, at 31 December 2018, its net capital expenditure was 53% of the approved limit. | My audit team will continue to monitor the Health Board's financial position for 2018-19 and the cumulative three-year position to 31 March 2019.<br>This review will also consider the impact of any relevant uncorrected misstatements over those three years.<br>If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2018-19 financial statements. As in previous years, I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen. |

| Financial audit risks | Proposed audit response |
| --- | --- |
| The Health Board has a financial duty to prepare and have a rolling three-year integrated medium-term plan (IMTP), which is approved by the Welsh Government each year.<br>The Health Board would have met this financial duty for 2018-19 if the Welsh Government had approved the 2018-19 to 2020-21 IMTP by 30 June 2018.<br>However, the Health Board did not secure an approved 2018-19 to 2020-21 IMTP and it therefore failed to meet its statutory requirement for 2018-19.<br>The Health Board is currently preparing its 2019-20 to 2021-22 IMTP for consideration by the Welsh Government. | My audit team will ensure that appropriate disclosure is made in the financial statements.<br>I would expect to place a substantive report on the financial statements, which would include appropriate reference to the latest position on the Health Board's IMTP. |
| I audit some of the disclosures in the Remuneration Report, such as the remuneration of senior officers and independent members, to a far lower level of materiality due to their sensitivity.<br>These disclosures are therefore inherently more prone to material misstatement. For both 2016-17 and 2017-18, I identified material misstatements in the draft accounts, which the Health Board then corrected. These past misstatements mean that I judge the 2018-19 disclosures to be at risk of further misstatement. | My audit team will review all entries in the Remuneration Report to verify that the Health Board has reflected all known changes to senior positions, and that the disclosures are complete and accurate. |
| I also audit the Health Board's related party disclosures to a far lower materiality. For the 2016-17 and 2017-18 audits I reported weaknesses in the Health Board's arrangements, which led to material misstatement in the draft accounts. As a result of my audits, the Health Board undertook remedial work and corrected its related-party disclosures prior to my certification.<br>These past misstatements mean that I judge the disclosures to be at risk of further misstatement for 2018-19. | My audit team will review and test the completeness and accuracy of the related-party disclosures. |

| Financial audit risks | Proposed audit response |
|---|---|
| The Welsh Government is required to approve all Health Board contracts that exceed £1 million. In previous years the Health Board failed to seek approval from the Welsh Government for some contracts, which it then had to seek retrospectively.<br>Contracts awarded without the required Welsh Government approval may give rise to irregular expenditure which, if material (individually or collectively), would affect my regularity opinion. | My audit team will review the procurement department's log of contracts and obtain evidence of Welsh Government approval for those that exceed £1 million. |
| **Other areas of audit attention** | |
| **New accounting standards**<br>IFRS 9 financial instruments applies from 1 April 2018 and brings in a new principles-based approach for the classification and measurement of financial assets. It also introduces a new impairment methodology for financial assets based on expected losses rather than incurred losses. This will result in earlier recognition of expected credit losses and will impact on how the Health Board calculates its bad debt provision.<br>IFRS 15 revenue from contracts with customers introduces a principles-based five-step model for recognising revenue arising from contracts with customers. It is based on a core principle requiring revenue recognition to depict the transfer of promised goods or services to the customer in an amount that reflects the consideration the body expects to be entitled to, in exchange for those goods or services. It will also require more extensive disclosures than are currently required. | My audit team will assess the likely impacts of the new IFRSs and undertake work to respond to any identified risks of material misstatement. |

7 I do not seek to obtain absolute assurance on the truth, fairness and regularity of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The quantitative level at which I judge such misstatements to be material for the Health Board is calculated as 1% of gross expenditure. On this basis my current planning materiality is £13 million. I review my levels of materiality throughout the audit, for example when the Health Board presents me with its draft financial statements.

8 Whether I judged an item to be material can also be affected by certain qualitative issues such as legal and regulatory requirements, or areas of the financial statements that I consider to be of particular interest to the reader that I therefore judge to be sensitive. I set significantly lower levels of materiality for such areas,

which include the remuneration[1] of senior officers and independent members, certain related party disclosures, and audit fees.

9 The levels at which I judge such misstatements to be material will be reported to the Audit Committee and the Board on 30 May 2019, prior to completion of the audit.

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

11 My fees and planned timescales for completion of the audit are based on the following assumptions:

- information provided to support the financial statements is timely, to the quality expected and has been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[2];
- appropriate accommodation and facilities are provided to enable my audit team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accountable Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete and management has responded to issues that may have affected the financial statements.

12 I also undertake the audit of:

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

13 These audits will be undertaken in accordance with the timescales agreed with the Health Board.

# Performance audit

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

15 I set out in this section, the programme of performance audit work to be undertaken at the Health Board. The content of the programme is informed by an

[1] These disclosures typically include salary, pension benefits and any exit package costs.

[2] The agreed audit deliverables document sets out the expected working paper requirements to support the financial statements and includes timescales and responsibilities

ongoing analysis of the risks and challenges facing NHS Wales, as a whole, as well as consideration of issues and risks that are specific to the Health Board. I have also taken account of the work programme of Healthcare Inspectorate Wales (HIW)[3] [4].

16 The topics I plan to examine as part of my 2019 performance audit work are summarised in Exhibit 3.

Exhibit 3: contents of my 2019 performance audit work programme

| Theme | Approach/key areas of focus |
|---|---|
| **NHS Structured Assessment** | Structured Assessment will continue to form the basis of the work I do at each NHS body to examine the existence of proper arrangements for the efficient, effective and economical use of resources. Building on previous years' work, I will seek to describe the progress that is being made in embedding sound arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management. |
| **All Wales Thematic Reviews** | **Quality Governance arrangements**<br>As an extension of my structured assessment work, I plan to undertake a specific thematic review of quality governance arrangements and how these underpin the work of quality and safety committees. In recent years my structured assessment work across Wales has pointed to various challenges with such governance arrangements. I therefore intend to undertake a review that will allow my team to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting. I shall scope this work in discussion with NHS bodies, and Healthcare Inspectorate Wales. In designing this work, I will also seek to build in an ability to compare approaches to quality governance across NHS bodies. I will also consider the local work that has already been undertaken in the Health Board to review the quality governance arrangements as part of my 2018 audit plan. |

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

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

| Theme | Approach/key areas of focus |
|---|---|
| **All Wales Thematic Reviews** | **Well Being of Future Generations (Wales) Act 2015**<br>The Well-being of Future Generations (Wales) Act 2015 became law in April 2016. The Act requires me to report every five years to the National Assembly on how public bodies apply the sustainability principles. During the first half of 2019, I plan to undertake work at the Health Board that will inform the report I must prepare for the National Assembly by May 2020.<br>My work will consider the Health Board's overall corporate approach to applying the 'Sustainable Development Principle' and 'Five Ways of Working'. My team will also seek to examine one of the Health Board's well-being objectives in more detail, reviewing the steps that have been taken to achieve that objective. When selecting which well-being objectives to review, I will aim to do so in such a way that maximises my ability to compare approaches across NHS bodies. |
| **Locally focused work** | I will also undertake thematic performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers and the Audit Committee and will be reflected in the regular updates that are produced for the audit/other committee. |
| **Implementing previous audit recommendations** | The examination of governance arrangements I undertake as part of my structured assessment work, includes a review of the arrangements that the Health Board has in place to track progress against my previous audit recommendations. This allows my team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables me to more explicitly measure the impact my work is having. |

17 The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with the Health Board, are set out in Appendix 2.

# Fee, audit team and timetable

## Fee

18 A breakdown of your estimated fee for 2019 is set out in Exhibit 4. There have been some small changes to my fees rates for 2019. My audit teams will continue to drive efficiency in their audits to ensure any resulting increases will not be passed onto you. This year's total estimated fee represents a 2% cash-based decrease compared to the actual 2018 fee, as set out below.

Exhibit 4: audit fee

| Audit area | Proposed fee for 2019 (£)[5] | Actual fee for 2018 (£) |
|---|---|---|
| **Financial accounts work** | **255,000** | **263,319** |
| **Performance audit work** | **155,652** | **155,652** |
| • Structured Assessment | 72,196 | 74,008 |
| • All-Wales thematic reviews[6] | 63,275 | 63,669 |
| • Local projects | 20,181 | 17,976 |
| **Total fee** | **410,652** | **418,971** |

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

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

## Audit team

21 The main members of my local audit team, together with their contact details, are summarised in Exhibit 5.

Exhibit 5: my local audit team

| Name | Role | Contact number | E-mail address |
|---|---|---|---|
| Mike Usher* | Financial Audit Engagement Lead | 02920 320568 | mike.usher@audit.wales |
| Dave Thomas | Performance Audit Engagement Lead | 02920 320604 | dave.thomas@audit.wales |
| Mark Jones | Financial Audit Manager | 02920 320630 | mark.jones@audit.wales |
| Anne Beegan | Performance Audit Manager | 07879 848666 | anne.beegan@audit.wales |
| John Llewellyn | Financial Audit Leader | 02920 320693 | john.llewellyn@audit.wales |
| Rhodri Davies | Financial Audit Leader | 02920 320637 | rhodri.davies@audit.wales |

* Engagement Director for the Health Board

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

[6] As detailed in the respective audit plans.

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

## Timetable

23 I will provide reports, or other outputs as agreed, to the Health Board covering the areas of work identified in this document. My key milestones and planed audit outputs are set out in Exhibit 6.

Exhibit 6: timetable

| Planned output | Work undertaken | Report finalised |
|---|---|---|
| 2019 Audit Plan | December 2018 to January 2019 | February 2019 |
| **Financial accounts work:**<br>• Audit of Financial Statements Report<br>• Opinion on Financial Statements<br>• Financial Accounts Memorandum | February to June 2019 | June 2019 |
| **Performance work:**<br>• Structured Assessment<br>• Governance arrangements underpinning quality and safety committees<br>• Implementing the Well Being of Future Generations Act<br>• Local project work | Timescales for individual projects will be discussed with the Health Board and detailed within the specific project briefings produced for each study. | |
| Annual Audit Report for 2019 | November to December 2019 | January 2020 |
| 2020 Audit Plan | December 2019 to January 2020 | February 2020 |

# Future developments to my audit work

24 Details of other future developments, including forthcoming changes to key International Financial Reporting Standards (IFRS), the Wales Audit Office's Good Practice Exchange seminars and my planned work on the readiness of the Welsh public sector for Brexit, are set out in Appendix 3. This appendix also contains relevant information on data protection legislation.

# Appendix 1

## Respective responsibilities

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

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

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

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

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

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

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

# Appendix 2

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

Exhibit 7: 2018 performance audit work still in progress

| Performance audit project | Status | Comment |
|---|---|---|
| Clinical Coding Follow up | Draft report | Draft report planned for March 2019. |
| Operating Theatres Follow up | Set-up | Fieldwork due to commence in spring 2019. Draft reports planned for July 2019. |
| IT Follow up | Set-up | |
| Orthopaedic Services Follow up | Set-up | Fieldwork due to commence in spring 2019. Draft report planned for September 2019. |

# Appendix 3

## Other future developments

### Forthcoming key IFRS changes

Exhibit 8: changes to IFRS standards

| Standard | Effective date | Further details |
|---|---|---|
| IFRS 16 Leases | Expected in 2020-21 | IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting. |

### Future changes to UK GAAP, which are relevant to the Health Board's charitable funds' account

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

More significant amendments are expected from 2022-23, reflecting recent changes in International Financial Reporting Standards, including accounting for financial instrument and leases.

### Good Practice Exchange (GPX)

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

## Brexit: preparations for the United Kingdom's departure from membership of the European Union

In accordance with Article 50 of the Treaty of Rome, on 29 March 2019 the United Kingdom will cease to be a member of the European Union. Negotiations are continuing, and it currently remains unclear whether agreement will be reached on a transition period to 31 December 2020, or whether a 'no deal' immediate exit will take place next March.

The Auditor General has commenced a programme of work looking at the arrangements that the devolved public sector in Wales, including all NHS bodies, is putting in place to prepare for, and respond to, Britain's exit from the European Union. This will take the form of a high-level overview to establish what is being put in place across the Welsh public sector, and what the key issues are from the perspectives of different parts of the Welsh public service.

The Auditor General intends to carry out this initial work in two tranches. In autumn 2018, he issued a call for evidence to compile a baseline summary of arrangements being put in place. This will be followed up by further audit fieldwork in spring 2019.

The aim is to produce a report in summer 2019. The report's key messages and recommendations will be framed in the context of the UK moving to a new relationship with the European Union by the end of the planned transition period.

However, if it becomes clear that the UK is likely to leave the European Union without a Withdrawal Agreement (the 'no deal' scenario), we will publish a report as early as possible in 2019, ahead of the UK leaving the European Union on 29 March.

## Data Protection Legislation

Data protection legislation, including the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) has introduced updated requirements for processing personal data.

The Auditor General for Wales' (AGW's) access rights are not affected by the new data protection legislation or the Digital Economy Act, which also grants data sharing powers. Information about the AGW's access rights is available in the Guide to Legislation, as well as the shorter Access Rights leaflet which can be found on our website.

Fair Processing (Privacy) Notices provided to your employees, contractors and service users should include reference to the collecting and sharing of data with the AGW in connection with his audit work and studies.

Our own general fair processing notice is available on our website and, where appropriate, we shall provide further fair processing notices in connection with our work.

Where it is necessary to transfer information, we ask that this is done securely, through suitable methods such as hand to hand transfer of data using memory sticks or other secure means. We can accept password protected files if the password protection is strong, and the password is communicated to us separately and by a different means to the information, such as SMS text message.

If you would like to discuss any of the matters raised above, our Data Protection Officer can be contacted at martin.peters@audit.wales

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| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | Timetable For the Production of the 2018-19 Annual Report | | | | | | | | | | |
| **Meeting:** | Audit Committee | | | | | | | | **Meeting Date:** | 26.02.19 | |
| **Status:** | **For Discussion** | x | **For Assurance** | | **For Approval** | x | **For Information** | | | | |
| **Lead Executive:** | Director of Corporate Governance | | | | | | | | | | |
| **Report Author (Title):** | Interim Head of Corporate Governance | | | | | | | | | | |

**SITUATION**

The purpose of this report is to provide Members of the Audit Committee with the opportunity to discuss and comment on the draft timetable for the production of the 2018-19 Annual Report (see *Appendix 1*), prior to submission to the Board.

**REPORT**

**BACKGROUND**

The Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. This guidance is based on HM Treasury's Government Financial Reporting Manual (FReM)1 and is intended to simplify and streamline the presentation of the annual reports and accounts so that they better meet the needs of those who read and use them.

NHS bodies are required to publish, as a single document, a three part annual report and accounts document, which must include:

**Part 1 The Performance Report**, which must include:
• An overview
• A Performance analysis

**Part 2 The Accountability Report**, which must include:
• A Corporate Governance Report
• A Remuneration and Staff Report
• A Parliamentary Accountability and Audit Report

**Part 3 The Financial Statements**

The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be must be completed and submitted to Welsh Government by 1 July 2019. Further detail on the content and format of the Annual Report can be found at *Appendix 2*.

**ASSESSMENT**

A detailed timetable for the production of the 2018-19 Annual Report is provided at *Appendix 1*. The timetable highlights proposed amendments and/or requirements for additional 'out of committee' action that will be required to in order to accommodate the reporting timeframes set by Welsh Government.

The timetable has been considered by the Management Executive whose teams will be completing the various elements of the report.

Following consideration by the Audit Committee, a copy of the timetable will be shared with Wales Audit Office (WAO) and Internal Audit to ensure that they are aware of the points at which draft and final documents will be made available to them for audit and scrutiny.

The suite of documents that make up the 2018-19 Annual Report will be presented at the Annual General Meeting scheduled for 25 July 2019.

**RECOMMENDATION**

The Audit Committee is asked to:

**REVIEW** the proposed timetable and approach for the Annual Report 2018-19.

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

| **Five Ways of Working (Sustainable Development Principles) considered** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sustainable Development Principles: Five ways of working | Prevention | x | Long term | | Integration | | Collaboration | | Involvement | | |
| **Equality and Health Impact Assessment Completed:** | Not Applicable | | | | | | | | | | |

# Appendix 1: DRAFT GOVERNANCE TIMETABLE FOR THE ANNUAL REPORT 2018-19

| Main Tasks | Lead Exec | January | February | March | April | May | June | July | ANNUAL GENERAL MEETING (AGM) |
|---|---|---|---|---|---|---|---|---|---|
| **Annual Report Part 1**<br><br>**Performance Report (including Wellbeing Statement, Sustainability)** | Sharon Hopkins, Deputy Chief Executive | Review content requirements and frame the scope of the report. | Draft report, circulated for comment. | Coordination and review of comments, updating of draft report.<br><br>Draft report / update to be considered by **Management Executive** on **18 March 2019.** | Finalise Draft<br><br>**Internal Audit** to receive draft report by **8 April 2019** to comment in respect of Sustainability elements – **Internal Audit** to return comments by **19 April 2019.** | **Final Draft Report to Management Executive by 13 May 2019 and Audit Committee by 30 May 2019.**<br><br>Draft Report to **Welsh Government by 31 May 2019** | Comments back from WG to be incorporated by **21 June 2019**<br><br>**Approval of the Final Report by Audit Committee by 30 June 2019**<br><br>Welsh Translation (from the 2 June)<br><br>Equality Impact Assessment mid-June 2019 | **The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the 1 July 2019** | **The Annual Report and Audit Accounts will be presented at a** 31 July 2019)**Public Meeting (AGM) on 25 July 2019** (Welsh Government Deadline – |
| **Annual Report Part 2a**<br><br>**Accountability Report – Governance Statement** | Nicola Foreman Director of Corporate Governance | Review Content requirements and frame the scope. | Draft report, circulated for comment. | Draft submitted to Internal Audit & Wales Audit Office by the **31 March 2019** | Reviewed at Management Executive Meeting on **8 April 2019** Internal Audit Sign off Draft Report in readiness for submission to **Audit Committee** on **23 April 2019** | **26 April 2019 Draft Submission to WG & WAO**<br><br>Comments back from WG to be incorporated by **17 May 2019**<br><br>**30 May 2019 Audit Committee Endorse Sign off of Accounts by the Board**<br><br>**30 May 2019 Board Approve Accounts for Submission to WG & WAO**<br><br>**Submission to Welsh Government and WAO by 31 May** | Welsh Translation (from the 2 June)<br><br>Equality Impact Assessment | **The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the 1 July 2019** | |

# GOVERNANCE TIMETABLE FOR THE ANNUAL REPORT 2018-19

| Main Tasks | Lead Exec | January | February | March | April | May | June | July | |
|---|---|---|---|---|---|---|---|---|---|
| **Annual Report Part 2b**<br><br>**Accountability Report**<br>**Remuneration and Staff Report** | Martin Driscoll Executive Director of Workforce & OD<br><br>Bob Chadwick, Executive Director of Finance | Review Content requirements and frame scope | Draft report issued for comment. | Draft to Internal Audit & Wales Audit Office by the **31 March 2019** | Reviewed by Management Executive on **8 April 2019**<br><br>Internal Audit Sign off<br><br>Draft Report to Audit Committee by **23 April 2019** | **26 April 2019 draft submitted to WG & WAO**<br><br>Comments back from WG to be incorporated by **17 May 2019**<br><br>**30 May 2019 Audit Committee Endorse Sign off of Accounts by the Board**<br><br>**30 May 2019 Board Approve Accounts for Submission to WG & WAO**<br><br>**Submission to Welsh Government by 31 May 2019 sent from Wales Audit Office** | Welsh Translation (from the 2 June)<br><br>Equality Impact Assessment mid-June | **The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the 1 July 2019** | **The Annual Report and Audit Accounts will be presented at a Public Meeting (AGM) on the 25 July 2019** (Welsh Government Deadline – 31 July 2019) |
| **Annual Report Part 3**<br><br>**Audited Financial Statements (Annual Accounts)** | Bob Chadwick, Executive Director of Finance | Review Content requirements and frame scope of report. | | | Review of Annual Accounts Audit Committee meeting **23 April 2019**<br><br>Draft **Submission of Unaudited Accounts to Welsh Government by NOON on 26 April 2019** | **30 May 2019 Audit Committee Endorse Sign off of Accounts by Board**<br><br>**30 May 2019 Trust Board Approve Accounts for submission to WG & WAO**<br><br>**Submission to Welsh Government by 31 May 2019 sent from Wales Audit Office** | Query Welsh Translation requirements<br><br>WG to issue Debtor & creditor matrix<br>Income and expenditure matrix by **5 June 2019**<br><br>Equality Impact Assessment mid-June | **The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the 1 July 2019** | **The Annual Report and Audit Accounts will be presented at a Public Meeting (AGM) on the 25 July 2019** (Welsh Government Deadline – 31 July 2019) |
| **Standalone Report**<br><br>**Annual Quality Statement** | Ruth Walker, Executive Nurse Director | Review Content requirements and frame the scope of the report. | Draft report issued for comment. | Draft to Q&S&E Committee by **16 April 2018** | Internal Audit Office Sign off<br><br>Incorporate IA Comments and finalise<br><br>Welsh Translation<br><br>Equality Impact Assessment | **Submission to Welsh Government by 31 May 2019** | | | **The Annual Report and Audit Accounts will be presented at a Public Meeting (AGM) on the 25 July 2019** (Welsh Government Deadline – 31 July 2019) |

## GOVERNANCE TIMETABLE FOR THE ANNUAL REPORT 2018-19 – Version 3 – 9.1.2019

| Main Tasks | Lead | January | February | March | April | May | June | July | |
|---|---|---|---|---|---|---|---|---|---|
| **Annual Report – Executive Summary** | Nicola Foreman Director of Governance | Review Content requirements and frame the scope. | Draft the Executive Summary | Issue draft for comment. | Finalise Summary | Welsh Translation<br><br>Equality Impact Assessment | | **The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the 1 July 2019** | **The Annual Report and Audit Accounts will be presented at a Public Meeting (AGM) on the 25 July 2019** (Welsh Government Deadline – 31 July 2019) |

# Appendix 2: Annual Report and Accounts 2018/19 - Contents and Format

| | |
|---|---|
| The Annual Report & Account comprises three main elements:<br>**A. The Performance Report (including an overview and a performance analysis)**<br>**B. The Accountability Report (including a corporate governance report, a remuneration and staff report, a National Assembly for Wales Accountability and Audit Report)**<br>**C. The Financial Statements (include the Audited Annual Accounts 2018/19)**<br>All three sections are signed by the Accountable Officer in addition to the Annual Governance Statement | **Executive** |
| **A. Performance Report** | |
| **(1) Overview** | |
| A statement from the CEO providing their perspective on performance of the organisation during 2018/19 – need to document IMTP status and include financial duties | **Len Richard** |
| A statement of the purpose and activities of the organisation – summary of diagnostic phase of plan, duties against delivery framework and wider duties – Human rights, CHC and welsh language | **Len/ Abi/Martin** |
| The key issues and risks that could affect the entity in delivering its objectives – also include where not going to deliver against national targets, reasons why and what we are doing to improve | **Nikki** |
| An explanation of the adoption of the going concern basis. | **Bob** |
| Performance on other matters promoted by HM Treasury | **Bob** |
| Performance Summary – summary of achievements against plan and areas improvements required should be high level and cover each part of performance section. | **Sharon/ Steve** |
| **(2) Performance Analysis**<br>Report / summarise on delivery against performance measures<br>- Each delivery framework domain<br>- Delivery against finance and workforce plans<br>- Wider performance matters inc. partnership working<br>- Main achievement against service specific delivery plans and delivery against local requirements | **Sharon/ Martin/Steve** |

| | |
|---|---|
| Information on how we measure performance – why it is a KPI, how we check performance against measures and narrative to explain link between KPIs, risk and uncertainty | **Sharon** |
| Detailed analysis of explanation of development and performance of the entity during the year and explanation of the relationships and linkages between different pieces of info. Use a wide range of data including key financial information from financial statements | **Sharon** |
| Non financial information including social matters, respect for human rights anti-corruption and anti-bribery matters | **Bob** |
| Environmental matters including the impact of the UHB on the environment.<br>Mandatory sustainability Reporting | **Abi** |
| Page on each domain and where delivery is against plan/national target and reasons for none delivery | **Sharon** |
| Trend analysis where delivery not met demonstrating where delivery will be met | **Sharon** |
| Key financial and workforce information from the financial statements | **Bob** |
| Information on investments and disinvestments and why and what it has achieved | **Bob/Abi** |
| Performance of other matters raised during the year – such as specific issues raised in the public domain e.g. HIW and WAO reports | **ALL** |
| **(3) Well-being of Future Generations (Wales) Act 2015 – Well-being Statement of Annual Reporting** | |
| Publish a statement setting Well-being objectives and explain why objective will help achieve goals and how the sustainable development principle is applied – Must reflect diversity of UHB area. | |
| Must publish Annual Report showing progress in meeting objectives – can provide link to published statement which the UHB may have regarding well-being objectives and ensure these are reflected in the Performance Report. | |
| **(4) Annual Quality Statement** | |
| Requires to produce Annual Quality Statement by 1st June 2019. Made available separately to Annual Report and Accounts but Annual Report and Accounts must include a reference on how AQS can be accessed. | **Ruth** |
| **(5) Sustainability Report – See annex 5** | **Abi** |
| **(6) Other Mandatory items** | |
| Expenditure patters of primary and secondary care expenditure over last 5 years should be disclosed and performance against Resource Limits. | **Bob** |
| **B. Accountability Report (reviewed by auditors for consistency with financial statements)** | |
| **(1) Corporate Governance Report**<br><br>To explain the composition of the organisation and the entity's governance structures and how they support the achievement of objectives. Comprises three elements: | **Nikki** |
| **(i) The Directors report** | **Nikki** |
| Names of Chairman and Chief Executive and Directors during the financial year up to the point the ARA is approved | |

| | |
|---|---|
| Composition of the management Board (including advisory and non-executive members) | |
| Names of Directors forming an Audit Committee | |
| Details of company directorships of other significant interests held by members of the Board | |
| Information of personal data related incidents were reported to the information commissioners officer | **Sharon** |
| Information on environmental, social and community issues | **Abi** |
| Statement for public sector information holders confirming they have complied with the cost allocation and charging requirements set by HM Treasury | **Bob** |
| **(ii) Statement of Accountable Officers Responsibilities** | |
| Accountable Officer to explain responsibility for preparing the financial statements | **Nikki/Len** |
| Accountable Officer to confirm that as far as he or she is aware there is no relevant audit information of which the entities auditors are unaware and as Accountable Officer has taken all the steps necessary to make himself aware of any audit information | **Nikki/Len** |
| Accountable Officer to confirm that the annual report and accounts as a whole is fair and balanced. | **Len** |
| **(iii) Statement of Directors' responsibilities in respect of the accounts** | |
| Previously included in the Annual Accounts – It should be signed by the Chair, CEO and FD | **All** |
| **(iv) Annual Governance Statement** | **Nikki** |
| Key feature of annual report and accounts and demonstrates publicly the management and control of resources and extent the UHB complies with its own governance requirements | |
| Brings together annual report and disclosures relating to governance, risk and control | |
| Should add value to the effectiveness of corporate governance and internal control | |
| **(2) Remuneration and staff Report**<br><br>Sets out organisations remuneration policy for directors and senior managers and how the policy has been implemented. Sets out amounts awarded to directors and senior managers and where relevant the link between performance and remuneration. Should include Executive Members and Board Secretaries as well as non-Executive Members and associate members. | **Bob/Martin** |
| **Disclosure**<br>Information about names individuals will be given in all circumstances | |
| **Remuneration Relationship**<br>Details of remuneration relationship are reported in the Annual Accounts | |
| **(i) Remuneration Report**<br><br>• Details of the Remuneration Committee and ToR | |

| | |
|---|---|
| • Statement on policy of remuneration of senior managers for current and future financial years<br>• Methods of performance assessment<br>• Explanation of remuneration subject to performance<br>• Summary of explanation of duration of contracts, notice periods and termination arrangements<br>• Details of service contracts for each senior manager who has served during the year<br>• Details of significant awards made to past managers<br>• Salaries and other remuneration. | |

| **(ii) Staff report**<br>Must include the following information: | **Martin** |
|---|---|
| **Staff numbers** | |
| • Staff numbers - analysed in the groupings within the accounts (staff on outward secondment should not be included) | |
| • Average number of employees is calculated as the WTE number of employees under contract of service each week in the financial year, divided by the number of weeks in the financial year. | |
| • Staff composition – number of employees of each sex who were directors, senior managers and employees | |
| • Sickness absence data | |
| • Staff policies applied during the year – | |
| - For giving full and fair consideration to applications for employment made by disabled persons, having regard to aptitudes and abilities | |
| - Continuing employment of and arranging appropriate training of employees who became disabled during the period | |
| - Training, career development and promotion of disabled employees. | |
| - Diversity issues and equal treatment in employment and occupation | |

| | |
|---|---|
| • Expenditure on consultancy | |
| • Off payroll engagements: | |
| **(3) National Assembly for Wales Accountability and Audit Report**<br><br>Should contain disclosure on the following: | **Bob** |
| (i) Regularity of Expenditure | |
| (ii) Fees and charges | |
| (iii) Statement if the entity has not complied with cost allocation and charging requirements set out by HM Treasury | |
| (iv) Statement of material remote contingent liabilities | |
| **(4) Audit Certificate and AGW Report**<br><br>Report from Auditor | **Auditor** |
| **C. The Financial Statement 2018/19** | |

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

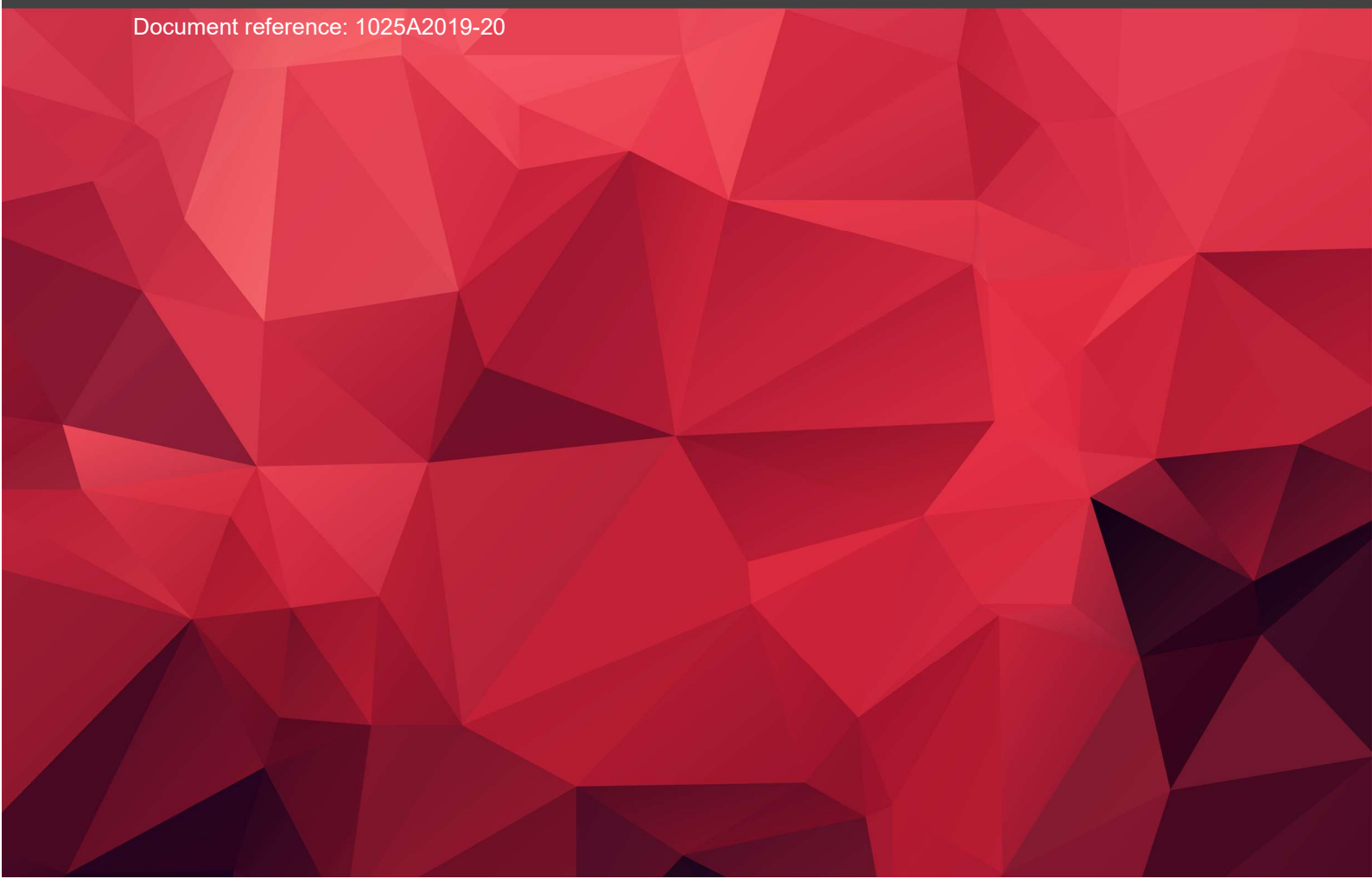
Archwilydd Cyffredinol Cymru
Auditor General for Wales

# Structured Assessment 2018 – **Cardiff and Vale University Health Board**

Audit year: 2018

Date issued: January 2019

Document reference: 1025A2019-20



The team who delivered the work comprised Tom Haslam, Urvisha Perez, Mark Jones, John Llewellyn and Andrew Strong.

# Contents

# About this report

1 This report sets out the findings from the Auditor General's 2018 structured assessment work at Cardiff and Vale University Health Board (the Health Board). We undertook this work to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

2 Our 2018 work has included interviews with officers and independent members, observations at board, committee and management meetings and reviews of relevant documents, performance and financial data. This year we conducted a Board member survey across all health boards and NHS trusts. There was a poor response from board members at the Health Board. Only seven of the 25 (28%) board members invited to take part responded. Consequently, we have not used the findings in this report.

3 This year's structured assessment work follows similar themes to previous years' work. We have broadened the scope to include the Health Board's arrangements for procurement, asset management and improving efficiency and productivity. We have grouped our findings under three themes – the Health Board's governance arrangements, its approach to strategic planning and the wider arrangements that support the efficient, effective and economical use of resources. We end with our recommendations.

4 Appendix 1 summarises the Health Board's progress in addressing previous structured assessment recommendations. Appendix 2 sets out the Health Board's response to the recommendations arising from our 2018 work.

# Background

5 Under the NHS Wales Escalation and Intervention Framework, the Heath Board's status is at targeted intervention. This reflects challenges around the organisation's financial position and its inability to produce an approvable, financially balanced Integrated Medium-Term Plan (IMTP).

6 The Health Board is also failing to meet some Welsh Government waiting time targets, such as referral to treatment time, A&E waits and time to treatment following a cancer diagnosis. The Board is prioritising actions in areas of poor performance and there have been some improvements.

7 The Health Board reported a financial deficit of £26.9 million at the end of 2017-18. This was within the control total deficit of £30.9 million agreed with the Welsh Government. However, it contributes to a mounting year-on-year cumulative deficit, which stood at £56 million at the end of March 2018. The Health Board is working to a one-year operational plan – the Annual Operating Plan (AOP) - because Welsh Government did not approve the 2018-20 IMTP.

8 The Board has spent the last 12 months consolidating earlier changes to key personnel and board membership and building upon these. Last year several new independent members (IM) were appointed to the Board, there was a new Chief Executive and Executive Director of Workforce and Organisational Development. In July 2018, a new Director of Corporate Governance joined the organisation.

9 Organisational structures are largely the same as last year, except for proposals to merge the Dental Clinical Board with the Surgical Clinical Board. Some executive responsibilities have changed. For example, from October 2018, the former Director of Public Health is now the Director of Informatics, Commissioning, Innovation and Transformation.

10 Our 2017 structured assessment work found that the Health Board's savings programme was reducing the financial deficit and that operational arrangements were mostly effective. We also highlighted weaknesses in Board oversight and assurance and informatics' support for services.

11 The Health Board received the 2017 structured assessment report in February 2018. It was the only NHS body not to provide a management response before we started our 2018 structured assessment work. The Audit Committee finally received the completed management response on 25 September 2018 with a six-month update that showed limited progress against our recommendations.

# Main conclusions

## Summary

12 Our main conclusion is the **Health Board's strategic planning arrangements are generally sound, and while it has made some progress, significant improvements are still needed in governance, risk management and performance monitoring arrangements.**

13 The findings which underpin these conclusions are considered in more detail in the following sections.

## Governance

14 As in previous years, we have examined the Health Board's governance arrangements. We reviewed:

- the way the Board and its subcommittees conduct their business;
- the extent to which organisational structures support good governance and accountability; and
- whether the information the Board (and its subcommittees) receives helps it to oversee and challenge performance and monitor achievement of organisational objectives.

15 We found that **some governance arrangements have improved but we have concerns about risk management and some other basic governance processes.**

### Conducting business effectively

16 We looked at how the Board organises itself to support the effective conduct of business. **The Health Board is taking steps to improve board and committee arrangements but has not yet achieved consistent good practice across the organisation.**

17 Sound governance arrangements are fundamental to help provide strategic direction, challenge the effectiveness of delivery and ensure that corrective actions resolve issues where they arise. In our 2017 structured assessment we found that the Board and some of its committees did not provide sufficiently rigorous and consistent oversight. This was partly due to turnover in independent members. Like many health boards, in 2017 the Health Board experienced a large turnover of independent members. Four independent members left, including the Board's Vice-

chair and the Chair of the Audit Committee. With three existing vacancies, this meant recruiting a total of seven new independent members. Of these seven, only one had previous NHS Board experience. Inducting these new members and familiarising them with Health Board and NHS matters was a significant task. New members were formally inducted between October 2017 and January 2018 through a mixture of internal and all Wales sessions[1].

18 Every other month there is a board development session timetabled between public board meetings. In 2017-18, these sessions were used for team building and learning. The 2018-19 Board development programme is designed to help the Board and its committees to focus on more strategic business.

19 During 2018, the Health Board took steps to strengthen Board and committee working. At the February 2018 board development session, board members agreed the following improvement objectives for the Board:

- concentrating more on the Health Board's strategy and not operational matters;
- focussing more on the Health Board's mission, 'Caring for People, Keeping People Well' and the 10 strategic objectives in Shaping our Future Wellbeing;
- improving alignment between strategic objectives and key corporate risks;
- receiving higher levels of assurance and scrutiny;
- reducing the volume of papers; and
- avoiding duplication of papers and discussion between different Committees and/or the Board.

20 The Health Board has made some changes to support these objectives. For example:

- **Committee membership.** The Health Board has recently reshuffled the allocation of independent members to committees. This is an attempt to optimise their contribution by best utilising their individual skills, specialisms and interests.
- **Board rules.** These now support the desired changes in behaviour. For example: considering issues from a strategic perspective; challenging constructively; seeking clarification on papers beforehand; and taking a holistic view. Copies of the Board rules are displayed at Board meetings.
- **Board and committee cover report template.** An updated version now encourages greater focus and clarity. Instructions to the Board and committee on the purpose of papers is simpler, either 'for assurance' or 'for decision'. Other categories have been removed. The template limits the main report's length to no longer than two and a half pages. The new template was tested at the September 2018 Board meeting.
- **Pre-submitted questions prior to Board meetings.** To improve efficiency, independent members submit some questions to executive members before the Board meeting. These questions are devised at a meeting the Board chair holds with independent members a few days before Board meetings. This process does not stop members from asking questions at the meeting but gives officers a chance to prepare a definitive answer.

21 The recent improvements to Board and committee working are positive but success will need lasting changes in behaviour and discipline. All our interviewees recognised the attempt to lift Board and committee discussion to a more strategic level. Generally, we found improvements in the volume of Board and committee meeting papers compared to last year. However, the

[1] All-Wales training and seminars were provided through Academi Wales and the NHS Confederation.

Committees' terms of reference and work programmes are not all up to date. The Health Board is aware of this and working to address it.

22 In our 2017 structured assessment we raised concerns about the balance of work between the S&E and R&D committees. After six months of operation the Health Board reviewed these committees and replaced them with the S&D Committee, citing a lack of clarity over responsibilities and some duplication. The Strategy and Engagement (S&E) and Resource and Delivery (R&D) Committees held their final meetings in November 2017 and January 2018 respectively. The Strategy and Delivery (S&D) Committee met for the first time in March 2018 and we observed its third meeting in September 2018. It is still relatively new, but we observed that it was working well. For example; there were good levels of challenge and discussion; the meeting ran to time; and the chair made good use of the cover reports. However, we are concerned that the S&D Committee may face issues around the size of its remit. (Similar to the former People, Planning and Performance Committee, which was stood down because of its large and unwieldy remit). However, executives and independent members told us they were aware of the challenge and determined to keep S&D Committee discussions at a strategic level.

23 The Board's other committees have remained the same. We observed some improvements in scrutiny and challenge at the Board and its key committees[2]. This may be a result of both new executives and new independent members being more settled in their roles.

24 Also, in our 2017 structured assessment we reported that the Finance Committee and Quality, Safety and Experience (QSE) Committee were two of the better run committees. This remains the case, but the other committees are improving. The Finance Committee meets monthly for a short, focused discussion on the financial position, progress against the Health Board's cost reduction programme and to consider the finance risk register. The meeting papers are clearly written and concise, which aids good discussion. Since July 2018, the Finance Committee scrutinises the financial position in depth and then provides assurance to the Board. Previously the Board received the same finance report as the committee, which duplicated efforts. In 2017, we highlighted delays in uploading the Finance Committee papers onto the Health Board's website. At the time of writing, this remains so with two month's papers missing (October 2018 and November 2018).

25 As part of our 2018 review, we observed the QSE Committee's annual special meeting. This meeting focused on learning from serious incidents, concerns and clinical negligence from the past year. The papers were clearly written and succinct and showed trend analysis of themes, which highlighted areas of concern. In addition, members received updates on initiatives to encourage learning, for example clinical debriefing sessions. This was a positive meeting with good scrutiny and member engagement. The QSE committee continues to receive assurances from clinical boards on a rotating basis and has a standing agenda item for the Community Health Council.

26 The Audit Committee's performance this year has been variable. There is good agenda management and meetings run to time. The chair allows enough time for members to explore matters as needed. The quality of scrutiny and questioning has varied but is improving. For example, following a recent report about medical equipment, independent members were swift to seek a meeting with executives to discuss this further. However, the length, organisation and format of committee papers is sometimes a barrier to effective scrutiny. Committee papers

[2] As part of our structured assessment work, we observed the Board and the following committees – Finance Committee, Quality Safety and Experience Committee, Strategy and Delivery Committee and Audit Committee.

range in length from around 100 pages to 500 pages, with variation in the standard of presentation, structure and format. Independent members need papers that are easy to absorb, understand and handle. In addition, the Audit Committee currently lacks a consistent and comprehensive way to keep track of the different streams of assurance that it receives. This can prevent the effective follow up of previous agenda items and weakens assurance. The December 2018 Audit Committee received a workplan that should help to ensure all requisite business is scheduled and dealt with in an effective and efficient way. Audit Committee members display a genuine wish to make a difference and hold executive officers to account. However, some members have expressed frustration at the committee's perceived lack of authority among the rest of the organisation.

27 Across our observations of the Board and its committees, we have seen good but inconsistent chairing skills. We observed instances of good practice such as: adhering to accepted process such as asking for declarations of interest; systematically reviewing and agreeing minutes; ensuring meetings start on time; managing the agenda items; scrutinising information; and facilitating discussion. However, these good practices are not always deployed consistently.

## Managing risks to achieving strategic priorities

28 We looked at the Board's approach for assuring itself that risks to achieving strategic priorities are well managed. **Delays in revising the corporate risk assurance framework means that until recently the Board has had insufficient oversight of strategic risks.**

29 The Health Board's Corporate Risk and Assurance Framework (CRAF) combines the corporate risk register and Board Assurance Framework (BAF). In our 2017 structured assessment we noted the Health Board was reviewing the CRAF before a planned relaunch in April 2018.

30 However, the Health Board was slow in reviewing and revising the CRAF. The Board and its committees have not received the CRAF since November 2017. Also, there have been very few progress updates to the Board on the CRAF review; the last was January 2018.

31 Health Board executives report they manage corporate risks at management executive meetings. However, this is not ideal because it means corporate risks are not visible to, or scrutinised by, the Board. Furthermore, we did not find any evidence that Board members received suitable assurance that the executive team were managing corporate risks during the CRAF review. We note the Health Board has not updated its risk management policy since 2013.

32 The new Director of Corporate Governance is making progress with developing a Board Assurance Framework (BAF). The Health Board intends to replace the CRAF with: a separate BAF setting out the strategic risks to achieving the strategic objectives; and a corporate risk register setting out the top organisational risks.

33 The Board received the draft BAF in November 2018 and the Audit Committee received it in December 2018. The BAF was developed in discussions at management executive meetings. They identified the following six risks as posing the greatest risk to the Health Board's strategic objectives:

- workforce;
- financial sustainability;
- sustainable primary and community care;
- safety and regulatory compliance;
- sustainable culture change; and
- capital assets (including estates, IT and medical equipment).

34 The draft BAF lists the Health Board's strategic objectives and sets out the:

- principal risks that threaten the achievement of objectives;
- controls in place to manage/mitigate the principal risks;
- assurances on the controls in place;
- gaps in control;
- gaps in assurance; and
- actions to address the gaps in control and assurance to enable delivery of objectives.

35 Compared to the CRAF, which listed over 90 risks, the draft BAF is clearer and more focused. This should be easier for the Board and its committees to review. Each risk has an assigned executive lead, committee and entry date.

36 Also, the Health Board is reviewing operational risk management. It started this work last year alongside the CRAF review. So far, the Health Board has designed a new risk register template, a guide for identifying risks and an explanation of how the risk register works. The Board received the draft risk management guide in January 2018 as part of the CRAF review update. The Head of Governance has been working with services to review their risks and transfer their risk register to the new template. The governance team will ensure that training includes awareness of the correct process. Currently, the Health Board has a paper-based risk management system but are considering an IT based solution.

37 The governance team is setting up a Risk Management Group. This group's purpose will be to review risk registers and challenge those risks proposed for escalation to the BAF or corporate risk register. Previously, clinical board risks scoring 12 or more automatically escalated to the CRAF. This made the CRAF large and unwieldy. The Risk Management Group will seek to manage as many risks as possible at an operational level.

## Embedding a sound system of assurance

38 We examined whether the Health Board has an effective system of internal controls to support board assurance. **We found some areas of sound practice, but the Health Board needs to make several significant improvements to its system of assurance.**

39 The Health Board has some good arrangements for quality governance. Internal Audit gave the Health Board's Annual Quality Statement a rating of substantial assurance. In July 2018 the Board received the Health Inspectorate Wales annual report, which was largely positive. The Board receives a regular patient safety, quality and experience report. Reporting is starting to include more feedback from the primary and community care sectors.

40 There is a clinical audit programme with the Executive Medical Director responsible for this. The Clinical Governance Team manages the audit programme. Clinical audits are discussed at clinical board QSE groups and are then passed to the QSE Committee. In June 2018, the QSE Committee received the clinical audit plan for 2018-19.

41 The Health Board has a comprehensive annual walkabout schedule. Executives and independent members form pairs until arrangements are refreshed. Generally, those with a clinical background are partnered with those without. Walkabouts are targeted at clinical areas of concern or complaint, also services not recently visited. Information picked up at walkabouts are triangulated with other patient experience information and internal inspections. The Health Board recognises it needs to improve the way it records walkabouts.

42 The Health Board has updated its process for receiving and reviewing staff concerns. The Health Board has several mechanisms to enable staff to raise concerns. These include freedom to speak out, safety valve and anonymous letters, which are all directed to the

governance team. The Executive Director of Nursing and Director of Corporate Governance decide jointly how to progress each one.

43 The Health Board has improved complaint handling compliance. In March 2018, 74% of formal complaints were responded to within 30 days (March 2017, 48%). For 2018-19, the Health Board aims to achieve and sustain a response rate of 80%. Recent performance, as reported in November 2018, was 80%. The Health Board now handles most complaints informally. Between July 2017 and August 2018, 60% of complaints were managed through the informal complaints process, with less than 2% resulting in a formal complaint. The Health Board received fewer formal complaints in 2017-18 (1080) compared to 2016-17 (1118).

44 In 2017 the Health Board identified issues with paediatric surgery based on reported complaints, concerns, claims and incidents. Executive level meetings with the Children and Women's Clinical Board began as soon as the issues became known. The Health Board took a mature approach to quality governance and asked the Royal College of Surgeons to review the relevant clinical records, which they did in July 2017. The QSE Committee also received notice of the issue in July 2017. Because of its sensitive nature, early discussions took place in the QSE Committee's private session.

45 The Royal College of Surgeons reported their findings in October 2017. The Health Board shared the report in private with both Welsh Health Specialised Services Committee (WHSSC) and with Welsh Government. But in line with their duty of candour, the September 2018 Board meeting received the report in a public session, outlining the issues and actions taken.

46 During our work, we did find several weaknesses in the systems of internal control that support board assurance. These are set out in the bullet points below. At the time of our fieldwork the new Director of Corporate Governance had been in post for six weeks. She is aware of the issues we have highlighted and plans to tackle them within the next 12 months.

- **The Scheme of Delegation** was reviewed in February 2018 in response to our public interest report. However, it was not updated to reflect delegated responsibility for calculating nurse staffing levels required under the Nurse Staffing Levels (Wales) Act.
- **The Standing Orders and Standing Financial Instructions** are both dated May 2015 with no evidence that either document has been reviewed since. Both documents should be reviewed annually.
- **Registers of declarations of interest and gifts, hospitality and sponsorship** were on the agenda for the September 2017 Audit Committee, but only the register of interest was presented. In September 2018, the Audit Committee reviewed both registers, but the document format was not easy to read. There is a risk that those reviewing the registers may find it difficult to identify issues such as non-declarations. In December 2018, the Audit Committee received a limited assurance report from Internal Audit on the organisation's standards of business conduct, covering arrangements for declarations of interest and gifts, hospitality and sponsorship. The report identified several weaknesses across the systems in place for both processes. These ranged from the completion of forms, to the recording of details in the registers and the robustness of reporting to Audit Committee.
- **New and revised policies** are presented to the relevant committees for approval. But we found no assigned responsibilities or tracking methods to ensure organisation-wide policies are up to date. There is a risk that policies become outdated with no alert mechanism. Potentially this could undermine the Health Board's new BAF because up to date policies are usually a key BAF control. We found several policies on the Health Board's website beyond their review date.

47 A robust tracking method for audit recommendations gives health boards assurance that recommendations are being addressed. Also, it allows audit committees to hold officers to account for limited progress or inaction. The Health Board has two recommendations trackers, one for Wales Audit Office recommendations and one for recommendations made by other external inspectorates. We found weaknesses in the Audit Committee's tracking arrangements:

- Audit Committee receives both trackers but there is no protocol to guide how often they should be reviewed. Both trackers were last presented to Audit Committee in September 2018, but they are not always on the same agenda.
- Neither tracker holds information on the number of recommendations and their status. The trackers include reviews spanning several years with the status of many best described as 'ongoing'.
- For audit reports referred to other committees, it is unclear how the Audit Committee receives assurance that recommendations are complete.
- The format of both trackers is not easy to read so may be a barrier to identifying common themes and learning.
- Neither of the two trackers includes Internal Audit recommendations.

48 In our 2016 structured assessment we recommended strengthening tracking arrangements for external audit recommendations. We consider this recommendation as still standing and should be extended to include Internal Audit recommendations.

49 As part of our work we reviewed performance management arrangements. In our 2017 structured assessment we reported that operational performance management was sound, but Board and committee oversight was ineffective. In April 2018, the Health Board strengthened its clinical board performance review and escalation arrangements. The updated method summarises clinical board performance in assurance reports. The executive team discuss these assurance reports and, if necessary, decide on each clinical board's escalation status. A higher escalation level triggers an action plan to restore performance and attracts greater executive team attention.

50 The Health Board's three-year plan refers to the performance management framework. However, the performance management framework was last updated in 2013 so it doesn't reflect the significant changes that have taken place since. For example, organisational structures, committees and clinical board performance arrangements. The Health Board is currently mapping all performance measures to ensure scrutiny by the proper committee.

51 In 2017, we reported that performance information reported at committee level was less detailed than that reported to Board. This is still the case. For example, the new S&D Committee is responsible for providing assurance to Board on performance and workforce. It receives Tier 1 target performance data but without any narrative. The Chief Operating Officer gives the S&D Committee a detailed verbal explanation of performance, which is reflected in the minutes. However, the Board receives the whole performance dashboard, including national and local targets along with exception reporting for priority and deteriorating targets. This appears contrary to the Board's improvement objectives that aim to take a more strategic view and receive higher levels of scrutiny and assurance through its committees.

## Ensuring a sound framework for information governance and cyber security

52 We examined the Health Board's approach to information governance and cyber security. **The Health Board needs to urgently improve information governance arrangements and strengthen its cyber security framework.**

53 Last year, we reported the Health Board was unlikely to meet the requirements of the General Data Protection Regulation (GDPR). The Health Board did not achieve the May 2018 deadline for complying with the requirements of the GDPR. The information governance department reports a lack of capacity. The Health Board has recently recruited extra information governance staff, which should help it to achieve full GDPR compliance by May 2019.

54 Achieving full compliance needs more work, for example:

- completing information asset registers for all clinical boards;
- appointing a permanent Data Protection Officer;
- completing privacy impact assessments before information processing; and
- identifying where needed, a network of information asset owners and administrators.

55 In 2016, the Information Commissioner's Office (ICO) gave 'limited assurance' to the Health Board's data protection arrangements. The Health Board has not yet fully addressed all the ICO's 2016 recommendations. It reports a lack of capacity within the Information Governance department. Although there is an action plan in place, most actions remain incomplete. The Health Board also needs to update its information governance strategy.

56 The Health Board's compliance with Caldicott Information Confidentiality is generally static. In April 2018 it scored 70% on the self-assessment (April 2017 68%). Compliance with mandatory information governance training has improved to 69% but remains below the national target of 95%.

57 The Health Board's response to statutory information access requests is poor. In 2018 the Health Board's performance within the required timeframe was well below the statutory target of 100%:

- Freedom of Information Act requests - 40% compliance
- Data Protection Act subject access requests - 44% compliance.

58 Early in 2018, part of an external NHS Wales project reviewed information governance and information security at the Health Board. This identified the need to improve cyber security arrangements. The Health Board responded by developing a cyber security improvement action plan. The plan includes setting up a specialist cyber security team, updating security patches and replacing unsupported software and hardware. During our audit, the Health Board updated its IT disaster recovery plans, but only after we asked for copies. We found no evidence the Health Board has a systematic, routine approach to:

- updating its IT disaster recovery plans and resilience plans; and
- testing resilience plans to ensure they are effective and work as intended.

59 This year the Information Governance and Information Technology sub-committee[3] has overseen the Informatics department's work. The sub-committee's focus on operational matters has been detrimental to more strategic issues such as overseeing strategic plan delivery and managing assurances.

[3] This reports to the S&D Committee

## Strategic planning

60 Our work examined how the Board sets strategic objectives and how well the Health Board plans to achieve its objectives. Finally, we wanted to know how effective the Health Board is at checking progress with its plans. **The Health Board's 2015 vision remains relevant and strategic planning arrangements are generally sound but better performance monitoring arrangements are needed.**

61 We looked at how the Board goes about setting its priorities, engaging with key stakeholders and setting them out in a clear IMTP or AOP. The Health Board's 10 year strategy, Shaping our Future Wellbeing Strategy: 2015-25[4] set outs its mission, vision and strategic aims, which are:

- **Mission** - 'Caring for People, Keeping People Well'.
- **Vision** - 'a person's chance of leading a healthy life is the same wherever they live and whoever they are'.
- **Strategy** - 'Achieve joined up care based on home first, avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them'.

62 The Health Board's 10-year strategy was developed following extensive stakeholder consultation, which included the Board and Stakeholder Reference Group. Ongoing engagement activity is also shaping the 10-year strategy's underpinning work programmes and future IMTP development. For example, developing three health and wellbeing centres. The Health Board reports that stakeholder engagement is working well. In our December 2018 Review of primary care services report we found the timing of consultation with stakeholders may not always be optimum. For example, consultees sometimes feel they are being informed rather than consulted with.

63 The Health Board has a hierarchy of plans that are consistent with each other. The 10-year strategy sets the high-level vision and strategy. Under this the Health Board has a three-year plan, which is consistent with the 10-year strategy. The lack of an approved IMTP means the Health Board is working to an Annual Operating Plan, which is consistent with the three-year plan.

64 We looked at how the Health Board developed both its 10-year and 3-year strategies and if they are properly supported by plans based on cost, resource and savings analysis. The IMTP submitted to Welsh Government in January 2018 was not accepted due to the funding assumptions it was based on. The Health Board revisited its IMTP but at that time was not able to submit an IMTP that was financially balanced. Consequentially Welsh Government asked the Health Board to work to an Annual Operational Plan.

65 The Health Board has commenced the preparation of its 2019-21 IMTP, which Welsh Government will consider for approval by 30 June 2019. There is a detailed timeline for developing the 2019-21 IMTP and the S&D Committee received this in September 2018. The Health Board's ability to develop an approvable 2019-21 IMTP may have an influence on nay Welsh Government decision on the organisation's 'targeted intervention' status. The Health Board reports it has the necessary resources to develop strategic plans and an approvable IMTP.

66 In our 2017 structured assessment we reported the Health Board's IMTP planning process was generally sound. Since then there have been no significant changes to the process, other than some refinements. The planning process was understood by those we spoke to during our

[4] Shaping Our Future Wellbeing 2015-2025.

work. However, during our work we found some discrete areas where planning is less robust. For example, asset management and IT[5].

67 The Health Board's IMTP planning approach is supported by:

- well defined roles and responsibilities;
- an IMTP template to ensure consistency of approach between clinical boards;
- an established cycle of demand and capacity analysis;
- learning and evaluation activities; and
- financial objectives and plans.

68 The Health Board's clinical strategy is expressed within its 10-year strategy, which by its nature is a high-level document. An underpinning clinical services strategy, currently being developed, will sit alongside the 10-year strategy to provide a greater level of detail about clinical services.

69 The Health Board has a one-year financial plan for 2018-19 which delivers a deficit of £9.9m and requires the delivery of £33.8m savings and a further £9.3m financial improvement. The Health Board has identified the required financial improvement to achieve this and it remains an area of focus[6].

70 The Health Board's workforce and organisational development plan states that it has been developed to integrate with service and financial objectives, including workforce reductions to help meet cost saving targets. The Director of Finance and the Director of Workforce and Organisational Development report a good level of joint working between them. The workforce and organisational development plan is consistent with the Health Board's three-year plan. Under the 'sustainable' workforce objective, the Health Board is working towards complying with the Nurse Staffing Levels (Wales) Act. This includes making sure staff understand and comply with the Act's requirements. The Board received a report on the nurse establishment in May 2018.

71 Finally, we looked at whether there is effective monitoring of strategic plans and change programmes. The 10-year strategy was launched in 2015. In September 2018, the S&D Committee received an assessment of the Health Board's progress against the 10-year strategy, ten strategic objectives and high-level performance indicators. The Health Board acknowledges that it is slightly behind trajectory in some areas of its 10-year strategy.

72 The Health Board has recently developed a transformation programme to support the implementation of the 10-year strategy. In March 2018, the Board received a paper on 'Developing the Cardiff and Vale way'. This describes the Health Board's change journey so far and introduces its new transformation programme. This has been influenced by learning from Canterbury Health Board in New Zealand and takes a whole-system, multi-disciplinary approach. Both the Board and the S&D Committee have scrutinised this new programme[7].

73 In our 2017 structured assessment we recommended that the S&D Committee should regularly examine progress in delivering the Annual Operating Plan and IMTP. This year we found the S&D Committee does receive progress reports on individual areas of the Annual Operating Plan and three-year plan. However, we found no evidence that S&D Committee receives an overall or collated progress summary against all Annual Operating Plan deliverables. The Board receives updates on the IMTP plan development, but we did not find any evidence of the Board receiving progress updates on Annual Operating Plan delivery.

[5] See paragraphs 125 to 127

[6] More detail on the Health Board's financial position is at paragraphs 89 to 101

[7] We explore this programme further in paragraphs 117 to 119

## Wider arrangements that support the efficient, effective and economical use of resources

74 Efficient, effective and economical use of resources depends on how the organisation manages its workforce, finances and other physical assets. In this section we comment on those arrangements, and on the Health Board's action to maximise efficiency and productivity. We examine if the Health Board is procuring goods and services well.

75 **The Health Board has a wide array of challenges for ensuring effective use of its resources, mostly recognises where it needs to improve and has recently created a transformation programme to help improve performance and efficiency.**

### Managing the workforce

76 The workforce is the Health Board's biggest asset and pay represents a large proportion of expenditure. It is important that the workforce is well managed and productive because staff are critical for delivering services and achieving efficiency savings and quality improvements. **The Health Board is aware of its workforce challenges and is developing plans to tackle them but has so far failed to address consultant job planning.**

77 The following table shows how the Health Board is performing against some key measures compared with the Wales average. Exhibit 1 shows that the health board's performance is mixed.

Exhibit 1: Performance against key workforce measures[8]

| | Health Board | Wales average |
|---|---|---|
| Sickness absence | 5.1% | 5.3% |
| Turnover | 9.8% | 6.9% |
| Vacancy | 3.2% | 2.6% |
| Appraisals | 61.0% | 67.0% |
| Statutory and mandatory training | 75.0% | 73.0% |

Source: NHS Wales Workforce Dashboard, Health Education and Improvement Wales, July 2018

78 Sickness absence has a financial impact on health board budgets, such as the need for agency and temporary staff. Exhibit 1 shows the Health Board's July 2018 sickness rate (5.1%) was higher than in 2017 (4.8%), but still slightly below the Wales average (5.3%). The Health Board is planning some work to better understand sickness absence, especially short-term sickness trends and the support provided for staff absent with long-term sickness. The Health Board aims to reduce sickness absence to 4.6% in 2018-19 and to 4.2% by 2020-21.

79 The Health Board has several initiatives to reduce reliance on medical and nursing temporary and agency use. In 2017 the Health Board stopped using off-contract agency staff and it aims

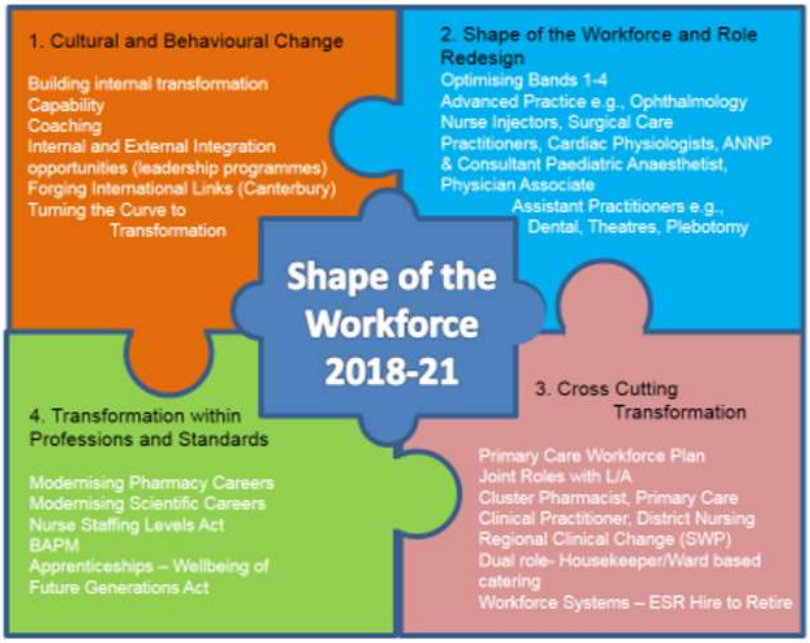
[8] Sickness: rolling 12-month average at July 2018; Turnover: 12-month period July 2017 to June 2018; Vacancy: based on advertised vacancies at July 2018; Appraisal: preceding 12 months at July 2018; Statutory and mandatory training: at July 2018

to continue this during 2018-19. In July 2018, agency costs were 1.7% of the total pay bill, which is low compared with the rest of Wales (4%). 'Project 95' aims to reduce nurse vacancy and agency spend by filling at least 95% of substantive posts. This has helped reduce the band 5 and 6 nursing vacancy rate from 8.6% in 2016-17 to 6.8% in 2017-18 and contributed to the reduction in agency expenditure.

80 However, in July 2018, the Health Board's overall vacancy rate was 3.2%[9]. This equates to 405 vacancies, of which 205 were nursing and midwifery vacancies. The Health Board's overall vacancy rate is higher than the Wales average of 2.6%, the second highest rate compared to other health boards and 0.6% higher than the same period last year (July 2017).

81 The Health Board recognises that recruitment and retention is only part of the solution to the workforce challenge. A sustainable workforce may need fundamental changes in design, composition and deployment. The workforce and organisational development plan outlines how the Health Board will use workforce transformation to achieve its vision in the 10-year strategy. Exhibit 2 summarises the approach the Health Board is taking over the course of 2018-21.

Exhibit 2: Summary of the approach to workforce transformation 2018-21




Source: Cardiff and Vale Integrated Medium Term Plan 018-21, workforce and organisational development strategy and delivery plan.

82 In 2016, we followed up progress against our 2011 recommendations on consultant job planning. We found that the Health Board needed to eliminate variable job planning practice. The May 2018 Internal Audit review of the Health Board's consultant job planning arrangements found them to provide limited assurance. The Health Board has detailed guidance, training and a system for recording core activity on the electronic staff record system. However, not all consultants are completing a job plan annually, which is a core requirement. A sample of job plans revealed several weaknesses: the standard job planning template was not

[9] Vacancy rates shown as a proportion of full-time equivalent staff in post.

used; compliance with the guidance was poor; outcome measures were not agreed and monitored; and few reviewed job plans had the required signatures. The Health Board has developed an action plan following the internal audit review and a follow-up audit is planned for early 2019.

83 The target for job plan compliance is 85%, but at August 2018 the Health Board's compliance rate was 50%. In September 2018, the S&D Committee discussed this issue. It stressed that there should be consequences for consultants without a job plan and this needed to be viewed alongside a consultant's licence to practice.

84 The Health Board's learning and development strategy falls under the capable workforce theme of the workforce and organisational development plan. At July 2018, the Health Board's:

- Overall staff appraisal rate was 61%, which is lower than the Wales average (67%) and third lowest compared to other health bodies. The national target is 85%.
- Compliance with statutory and mandatory training (i.e. the core skills training framework) was 75%, which is better than the Wales average of 73%. The national target is 85%.

85 The Health Board has plans to improve appraisals, succession planning, leadership and statutory compulsory training.

- **Staff appraisals** – the appraisal process will include wider conversations with direct reports about staff member potential and performance. The executive team have approved this plan and presented it to S&D Committee in September 2018, with an aim to launch in spring 2019.
- **Leadership** - the Health Board will be running 180-degree reviews for their top 70 leaders. The aim is for them to understand their leadership style, how it feels to work in their team and the impact they have on team performance. Leaders will be supported to think about different management styles to improve team performance, development and culture.
- **Statutory and compulsory training** - the Health Board has a working group that has been reviewing statutory and mandatory training requirements for different roles. From September 2018 staff will only complete training models that are appropriate to their role, which has not been the case previously.

86 'Values and behaviours' is one of the seven transformation programme themes. In January 2019, the Health Board will launch a series of accessible interactive events to help promote its values and behaviours. The Health Board aim to create a 'buzz' across the organisation about its values and behaviours. Once staff have attended an event they will be asked to make a pledge and invite three more people to attend one of the events.

87 The NHS Wales staff survey results were not available when we did our work. However, the Health Board's response rate was 21% compared with 29% across Wales. The Health Board are planning to examine the reasons for the poor response rate.

88 The Health Board's cross-cutting cost improvement programme (CIP) includes three workforce related themes: nursing productivity; medical productivity; and workforce productivity. Each theme has an executive lead and feeds into the Cross-Cutting Board, which reports direct to the Finance Committee.

## Managing the finances

89 As part of our work we looked at financial and budget management, financial controls, and operational support and processes. **The Health Board is improving its financial management and is aiming for a balanced annual position by 2020-21 but is still projecting a significant annual deficit**.

90 For the financial year 2017-18, the Health Board operated within its capital resource limit[10] for both the annual limit and the three-year limit[11]. However, the Health Board continued to exceed its annual and three-yearly expenditure limits for net revenue. Consequently, the Auditor General qualified his regularity opinion in the Health Board's annual financial statements[12].

91 For 2017-18, the Health Board reported:

- a £26.8 million deficit against the 2017-18 revenue resource limit of £872.2 million; and
- a £56 million deficit against the three-year total revenue resource limit of £2,585 million (2015-16 to 2017-18).

92 For 2018-19 the Health Board expects to:

- operate within its capital resource limit, as it has done in recent years; and
- improve its annual revenue position, albeit with a forecast deficit of £9.9 million.

93 The Health Board's forecast deficit of £9.9 million takes account of the £10 million extra revenue funding the Welsh Government confirmed in July 2018. The Welsh Government provided this extra funding on condition that the Health Board's revenue deficit does not exceed £9.9 million. However, the Health Board's financial return to Welsh Government shows that at the end of December 2018, its net revenue expenditure had exceeded the profiled deficit by £3,000. This deficit has improved markedly on the previous month's financial return, which had reported a profile deficit of £492,000 as at 30 November 2018.

94 Our 2017 structured assessment found the Health Board had effective arrangements for identifying savings and developing savings plans but was unable to achieve the volume of savings needed to offset its cost pressures and growing financial deficit. We recommended the Health Board's CIP should use more ambitious 'stretch' savings targets for services where greater levels of savings were possible. These targets should use comparative information such as benchmarking data where possible.

95 For 2018-19 the Health Board's CIP targets remained on the existing basis for all clinical boards. This was 1% of non-recurrent savings (totalling £8.445 million) and 3% of recurrent savings (totalling £25.335 million). At 30 November 2018 (month eight), the Health Board is £0.743 million short of its 2018-19 CIP target of £33.780 million. The Health Board reports that:

- £21.502 million has been identified against the recurrent target of £25.335 million, being a shortfall of £3.833 million; and
- £11.536 million has been identified against the non-recurrent target of £8.445 million, thus exceeding the target by £3.091 million.

[10] Capital expenditure typically means purchasing or improving the Health Board's assets. The Health Board's main assets are its land and buildings, medical equipment and IT.

[11] As required by the NHS Finance Act (Wales) 2014. The Health Board must spend within its financial allocations measured over a rolling three-year financial period.

[12] www.assembly.wales

96 In response to our 2017 structured assessment recommendation, the Health Board intends to change the basis of its CIP targets from 2019-20, by:

- eliminating non-recurrent CIP targets;
- all clinical boards having a 2% recurrent CIP target, centred on core efficiencies; and
- including an extra CIP target of no more than 2%, based on benchmarking data and significant service changes.

97 The Health Board has satisfactory financial management and control arrangements. This has allowed the Auditor General to certify each year's accounts as materially true and fair. This part of our work mainly considers whether the Health Board's annual accounts are materially accurate and conform to the required accounting standards and principles.

98 The Finance Committee receives financial reports that are generally well structured and informative. However, the financial reporting is 'traditional', with reports organised by key financial ledger categories, such as income, pay and non-pay expenditure, cash flows and important capital schemes.

99 The Health Board is trying to improve its understanding and reporting of activity and associated cost drivers. The All Wales Costing System Implementation Project (the costing project) is managing these improvements. The Health Board uses costing software called Synergy. Typically, Synergy deals with one-off requests or specific projects, rather than routine reporting to help decision making. In addition, Synergy produces the Health Board's Welsh Costing Returns for the Welsh Government. The limitations of the Synergy system make this is a difficult and time-consuming process for the Health Board.

100 The costing project will replace the Health Board's Synergy software with new software, PCG Monitoring. All Welsh health boards are implementing this new software, which we understand many English health bodies also use. The Health Board and software supplier are introducing and testing the new software while still using the old software. The Health Board expects its new software to enable:

- improved understanding of costs and income;
- better comparisons or analysis of costs and income internally, and with other health bodies; and therefore
- an improved use of resources that will help to deliver a balanced financial position.

101 Despite the costing project's importance, which is fundamental to improving the Health Board's financial position, we understand the Board has not received a briefing or update on the project's objectives, benefits or progress.

## National Fraud Initiative (NFI)

102 We looked at how effectively the Health Board considered potential fraud highlighted through the National Fraud Initiative. **The investigation of potential fraud, highlighted by the latest National Fraud Initiative exercise, has been inadequate.**

103 Every two years, the National Fraud Initiative (NFI) uses a data-matching exercise to help detect fraud and overpayments by matching data across organisations and systems. It is an effective tool for public bodies to strengthen their anti-fraud and corruption arrangements.

104 The last exercise in January 2017 provided the Health Board with 9,980 data-matches, which highlight anomalies for review. We would not expect the Health Board to review all data matches. We recommend prioritising those the NFI consider as high-risk, called 'recommended matches'.

105 The Health Board received 851 recommended matches. The Health Board's progress was:

- November 2017 - 11 recommended data matches reviewed (1.3%).
- November 2018 - 448 recommended data matches reviewed (53%).

106 Despite this progress, the Health Board is still not using NFI effectively. Our concerns include:

- Failure to review three-way data-matches between payroll, creditor payments and Companies House. These are high-risk matches because they can identify undeclared staff interests and possible corrupt practices.
- The Health Board did review two matches between payroll and Home Office immigration data but did not record the result. So, it is not clear whether staff members' immigration status concerns are resolved.
- High-risk creditor payment matches can represent duplicate payments. The Health Board has reviewed some of these and all were overpayments. The Health Board had already identified and recovered these. We are concerned the Health Board has not reviewed all such matches and it does not have a robust way to prevent duplicate payments.
- The Health Board received matches between staff and supplier addresses. Also, between staff and supplier bank details. Both can help identify undeclared staff interests in the Health Board's suppliers. For:
    - Staff and supplier addresses - the Health Board recorded 'no issue' for all matches but has not explained within the NFI web application how it decided this.
    - Staff and supplier bank details - the Health Board has not reviewed any of these data matches.

## Procurement

107 We considered how well the Health Board procures the goods and services necessary for its operation. **The Health Board has invested in procurement and has detailed procurement plans and effective arrangements for monitoring procurement activity and spend.**

108 The NHS Wales Shared Services Partnership – Procurement Service (NWSSP-Procurement Service) manages most of the Health Board's procurement. The Director of Finance is the executive lead for procurement. The Health Board has provided extra staff for the procurement team, which is managed by NWSSP-Procurement Service. The Head of Procurement manages the team's 22 staff. The team is well organised and integrated with the clinical boards. Each clinical board has a procurement business manager and an administrator. The rest of the procurement team is split between managing contracts (new contracts, existing and renewals)

and identifying procurement needs. The Health Board has provided a procurement nurse who focuses on efficiency by identifying trends at ward level.

109 There is an all-Wales Procurement Strategy, which is underpinned by an all-Wales business plan. There is a service level-agreement between NWSSP-Procurement Service and the Heath Board. In addition, each year the Head of Procurement develops a Health Board specific project outline document (POD). The POD, agreed with the Director of Finance, sets out the local procurement deliverables and annual objectives. For 2018-19 these are:

- apply procurement discipline to reduce procurement expenditure during 2018-19;
- support the clinical boards in identifying new non-pay[13] schemes and efficiency benefits during 2018-19 and 2019-20;
- improve clinical boards' procurement capability to reduce non-pay expenditure;
- monitor the delivery of the clinical boards' non-pay 2018-19 schemes; and
- delivery of the local procurement engagement plan and procurement responsibilities.

110 The Director of Finance and Head of Procurement meet monthly to review progress on POD delivery. In addition, all clinical boards meet monthly with their finance and procurement business managers to review their finance and procurement performance dashboards. The dashboards highlight progress against plans and risks to delivery.

111 The Health Board implemented the all-Wales 'no purchase order no pay' policy from the 1st June 2018. The Finance Committee receives monthly updates on the Health Board's public-sector payment compliance. The procurement team keeps a procurement risk register, which usually feeds up to the CRAF[14]. Significant procurement risks are reported to the Audit Committee.

112 Procurement is a cross-cutting theme within the Health Board's CIP. The Head of Procurement reports to the Cross-Cutting Board, and then to the Finance Committee. In 2017-18, the Health Board made good progress against its cross-cutting savings target of £2 million. This target was retained for 2018-19.

## Performance, efficiency and productivity

113 We looked at what the Health Board is doing to improve service performance, efficiency and productivity. **Despite improvements, some activity targets remain challenging and the Health Board has established a transformation programme to help enhance performance and efficiency.**

114 The Health Board continues to work in a challenging environment and recognises where it needs to improve performance. This is reflected in its strategic and transformational plans.

115 Exhibit 3 provides commentary on the Health Board's performance against some key waiting time measures.

[13] Non-pay refers to spend other than staff, for example equipment and IT.

[14] We have significant concerns about the Health Board's Corporate Risk and Assurance Framework, see paragraphs 28 to 37.

Exhibit 3: Performance against key waiting time targets

| Performance area | Health board performance |
|---|---|
| Diagnostics and therapy waiting times | Compared to two years ago, a smaller percentage of patients now wait more than eight weeks for diagnostic services.<br>• The national target is for no patent to wait more than eight weeks.<br>• In April 2016, 27% of patients at the Health Board were waiting more than eight weeks (Wales average 16%)<br>• In May 2018 6% of patients at the Health Board were waiting more than eight weeks (Wales average 6%) |
| Referral to treatment time | The national target is for no patient to wait more than 36 weeks from referral to treatment. The Health Board is not meeting this target, (similar to the rest of Wales). However, the Health Board consistently performs better than the Wales average.<br>The Health Board manages performance over a 3-month period. This means that in any 3-month period the number of patients waiting over 36 weeks is reduced to as close to zero as possible.<br>Since March 2017, the proportion of patients waiting over 36 weeks has consistently been reduced to 1%. The Health Board has maintained an improved position against this target for 13 consecutive 3-month periods.<br>Whilst positive, the Health Board recognises that they now need to move towards managing this target on a monthly cycle. |
| | The target for percentage of patients waiting less than 26 weeks from referral to start of treatment is 95%. The Health Board is not meeting this target, (similar to the rest of Wales). The Health Board performs worse than the Wales average and has seen little improvement against this target over the last two years, with performance around 85%. |
| Ambulance handover times | The aim of this target is to reduce ambulance handover times. It measures the percentage of patients handed over within 15 minutes of notification on arrival at major A&E departments.<br>Over the last two years, the Health Board's performance has been generally worse than the Wales average. In August 2017, 65% of patients were handed over within 15 minutes. Performance then declined and at its lowest was 35% in February 2018.<br>This reflects a downward trend in performance nationally. |
| A&E Waits | At least 95% of patients attending A&E should wait less than four hours. The Health Board is not meeting this target, (similar to Wales). Over the last two years the Health Board has generally performed better than the Wales average.<br>The worst performance was in February 2018 (76%). Since then performance has been on an upward trend and the Health Board achieved 91% in June 2018. |

| Performance area | Health board performance |
|---|---|
| | No patient should wait more than 12 hours at A&E. The Health Board performs better than the Wales average against this target. The Health Board met this target for 17 months in the 28 months between April 2016 and July 2018. |
| Cancer treatment times | For non-urgent cancer cases, at least 98% of patients should start treatment within 31 days of diagnosis. The Health Board's performance is variable. The Health Board met this target for 19 months in the 27 months between April 2016 and June 2018. |
| | For urgent suspected cancer cases, 95% of patients with cancer should start definitive treatment within 62 days of referral.<br>The Health Board has only met this target for 2 months in the 27 months between April 2016 and June 2018. Health Board performance fluctuates around the Wales average. |
| Delayed transfers of care (DTOC) | Across Wales, the overall number of DTOCs reduced by 6% between 2016-17 and 2017-18.<br>At the Health Board, in the same period DTOCs reduced by 27%.<br>During 2017-18, 2732 patients across Wales experienced a delay of four weeks or more. At the Health Board, 530 patients experienced a delay of this length. This represents 19% of the Wales total. |
| Length of stay | Length of stay has worsened since April 2016. In May 2018 the Health Board's length of stay[15] was one day longer than the Wales average of 10.5 days. |
| Outpatients appointments | Between 2015-16 and 2016-17 performance was static:<br>• 10% of new patients did not attend a new outpatient appointment.<br>• 11% of patients did not attend a follow-up outpatient appointment.<br>The target for both measures is to demonstrate a reduction over a 12-month period.<br>We recently published a report on the management of follow up outpatient appointments across Wales. We found that the Health Board has the highest number of follow-up outpatients delayed more than twice as long as they should be. The Health Board has developed a process to sort patients by clinical need. |

Source: Wales Audit Office analysis of Health Board data as reported to Welsh Government

[15] Rolling 12-month average length of stay (days) for emergency admissions for combined medicine.

116 The Health Board's 10-year strategy is based on several design principles, which are aligned with the principles of prudent healthcare. These focus on:

- empowering the person;
- 'Home First';
- delivering outcomes that matter to people;
- avoiding unwarranted variation; and
- reducing harm and waste.

117 The Health Board is working to embed the principles of prudent and values-based healthcare, even though they may not be labelled as such. The Director of Public Health and Executive Medical Director provide joint leadership for this area. In its 2018-19 AOP, the Health Board's priorities emphasise the need to improve efficiency and productivity. These improvements include integrating health and social care, progressing its transformation programme and cancer treatment waiting times. The Health Board's recently introduced transformation programme is designed to accelerate delivery of its 10-year strategy and support efficient working. The programme is intended to improve service performance, but the waiting time measures set out in Exhibit 3 show that urgent improvement to performance is required.

118 Exhibit 4 shows the programme's four key deliverables and seven supporting enablers. At present there are 10 projects in the programme.

Exhibit 4: Health Board's transformation programme's key deliverables and enablers

| Four key deliverables | Seven key supporting enablers |
|---|---|
| • To reduce outpatient appointments on hospital sites.<br>• Reduce length of stay.<br>• Reduce unwarranted harm, waste and variation.<br>• To reduce theatre inefficiencies and improve productivity. | • Secure a pathway approach and methodology.<br>• Secure a refreshed programme for accessible information for clinical staff (including the necessary platform) to drive improvement.<br>• Review the programme to secure a digitally enabled organisation and workforce.<br>• Develop a Cardiff and Vale Alliance approach which integrates with partner organisations.<br>• Develop the 'Cardiff and Vale approach' to management and leadership (including the learning partnership alliance with Canterbury) which will support culture change and build capability and capacity.<br>• Secure the model for primary care to drive a population outcomes approach for the system, enabling sustainability for general practice.<br>• Embed our vision's values and behaviours (as expressed in the Shaping Our Future Wellbeing Strategy). |

Source: Transformation update paper received by the Board in July 2018.

119 In October 2018 the Director of Public Health relinquished her role to take up the role of Director of Informatics, Commissioning, Innovation and Transformation. The Health Board is recruiting a Head of Operational Transformation. But other than this, it reports that it has sufficient resources for its transformation programme. The programme is drawing on existing resources such as the programme management office, the continuous improvement team and others such as finance and workforce. The Health Board has a small budget to recruit interested and available staff on to specific projects. In addition, the Health Board has 520 staff trained on the Leading Improvement in Patient Safety (LIPS) programme and LEAN principles. However, they are underutilised. The Health Board plans to use these staff to develop a network of transformation champions.

## Using informatics to support service delivery

120 We assessed how well the Health Board's arrangements support service delivery with technology. **The Health Board's strategic approach to informatics is not matched with realistic investment and governance, which is generating some risks.**

121 The Health Board has a 5-year informatics Strategic Outline Programme (SOP), which was agreed in 2016. This sets out the improvements to information management and communication technology services that will help deliver the Health Board's strategic objectives. It is now being rewritten into a digital strategy, consistent with Health Board priorities and available budget.

122 There is a new Head of Digital and Health Intelligence, responsible for progressing digital transformation in 2019. The Health Board plans to revisit the informatics SOP and prioritise digital projects into an approved digital transformation strategy in early 2019. The Health Board also plans to complete a review in early 2019 of the structure and governance of its information and information technology functions to support delivery of its digital approach. This aims to bring information and information technology together to help ease delivery of the digital transformation programme. Governance and project management structures for the Health Board's wider transformation programme are under development. These will need to include arrangements for overseeing the digital aspects of the transformation programme.

123 Digital technology could improve productivity and deliver efficiencies. For example: diagnostics modernisation; technology enabled care; and e-pharmacy. However, the success of these projects relies on the Health Board having a modern and resilient IT infrastructure. Some IT infrastructure and technology upgrades took place in 2017-18. However, resources remain constrained, which may limit how IT supports service change. It may also present business continuity and resilience risks because of ageing IT infrastructure.

124 In addition, there are several local risks arising from national IT systems managed by the NHS Wales Informatics Service (NWIS). For example:

- The Welsh Laboratory Information Management System.
- Several serious disruptions to national IT systems in 2018 resulting in loss of service.
- Delays in implementing the programme of national IT systems in 2018. For example, the delayed deployment of the Welsh Community Care Information System has potentially impacted the reliability and availability of IT service across health and social care.

## Managing the estate and other physical assets

125 We considered how the Health Board manages its estate and other physical assets. **Asset management strategies are at different levels of development and several asset related risks may need stronger corporate oversight.**

126 The Health Board's asset-related policies and procedures are generally comprehensive, up to date, and accessible through its intranet. The Health Board does not have an overarching asset management strategy. Instead it has several separate strategies at different stages of development. We reviewed the Health Board's asset management strategies for estates, medical equipment and IT. We found the Health Board:

- Has a draft 10-year estates strategy for 2018-28, which the Board considered in September 2018.
- Does not have a current medical equipment management strategy, although an early draft does exist.
- Developed an Informatics Strategic Outline Programme (SOP) for 2016-2021. In 2017 we reported that the Health Board had not prioritised the SOP's full amount of capital and revenue funding.

127 The Health Board is facing several asset related risks:

- High backlog maintenance costs for its estate. At the time of our audit, backlog costs were £130 million. Within this backlog there was £24 million in high-priority backlog costs, a reduction of £2 million compared with last year. High backlog maintenance is a risk because it diverts funding from proactive to reactionary maintenance.
- The IT department has identified several important risks such as: impact of national IT system failures on local healthcare delivery; cyber security threats on service continuity; NWIS related implementation delays; and lack of capacity to deliver new projects at the same time as maintaining business as usual operations.
- In June 2018 we issued our Review of Medial Equipment: Update on Progress report. This provides an update on progress against our 2013 recommendations, most of which the Health Board has not addressed. Our 2018 report set out eight further recommendations, which we consider to be critical for improving the Health Board's oversight and management of medical equipment.

The Health Board's management of some of these corporate risks has been weak, partly due to the absence of an up-to-date and meaningful corporate risk register[16].

[16] Highlighted in an earlier section of the report, see paragraphs 28 to 37

# Recommendations

128 This year we have identified some improvement areas previously identified in earlier structured assessment work. It is important that the Health Board tackles our previous recommendations with pace. Our 2018 recommendations are set out in Exhibit 1.

Exhibit 5: 2018 recommendations

| 2018 recommendations |
|---|
| **2017 recommendations**<br>R1 The Health Board should complete our 2017 structured assessment recommendations by the end of 2019. |
| **Audit recommendation tracking**<br>R2 The Health Board should improve its recommendation tracking by:<br>a. addressing our outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations;<br>b. including the tracking of internal audit recommendations; and<br>c. completing a review of all outstanding internal and external audit recommendations and reporting the findings to the Audit Committee. |
| **Governance**<br>R3 The Health Board should:<br>a. Update the Scheme of Delegation to reflect the delegated responsibility for calculating nurse staffing levels for designated acute medical and surgical inpatient wards;<br>b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;<br>c. Improve the format of the registers for declarations of interest and gifts, hospitality and sponsorship and clarify the frequency with which the registers are presented to the Audit Committee;<br>d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;<br>e. Review all committee terms of reference to make sure they are up to date, do not overlap, and are reviewed annually; and<br>f. Ensure all committees have an up-to-date work programme, which is linked to the cycle of Board meetings and reviewed annually. |
| **Performance management**<br>R4 The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013. |
| **Financial management**<br>R5 The Health Board should provide the Finance Committee, or Board, with an update on progress with its testing and delivery of the All Wales Costing System Implementation Project.<br>R6 The Health Board should ensure that all recommended matches from the next NFI exercise in January 2019 are reviewed and where necessary investigated in a timely manner. |

| 2018 recommendations | |
|---|---|
| **Information Governance** | |
| R7 | The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements. |
| R8 | The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019. |
| R9 | The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests. |
| **Information Technology** | |
| R10 | The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach. |
| R11 | The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective. |

# Appendix 1

## Progress implementing previous recommendations

Exhibit 6: Status of previous recommendations

| Recommendation | Action taken in response | Completed |
|---|---|---|
| **2017 recommendations** | | |
| R1 For 2018-19, the Health Board needs to use intelligence such as benchmarking data to identify stretch targets on a case-by-case basis in areas where greater levels of savings could be made. | The Health Board intends to change the basis of cost-improvement-targets (CIP) for 2019-20. | Yes. Changes are planned for 2019-20. |
| R2 To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the Annual Operating Plan, and subsequent three year integrated medium term plans. | The new S&D Committee's work plan includes scrutiny of key elements of the Annual Operating Plan, 10-year strategy and transformation programme. The Committee and the Board still need to receive appropriate progress updates against the Annual Operating Plan deliverables to ensure they are on track. | Partly |

| Recommendation | Action taken in response | Completed |
|---|---|---|
| R3 To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of the papers presented is appropriate and manageable. | The length of Board and committee papers has improved compared to last year, but inconsistencies and variation remain. The Health Board's introduction in September 2018 of a revised cover report template should encourage more succinct reporting. | Partly |
| R4 To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner. | At December 2018, the October 2018 Finance Committee papers were not available on the Health Board's website. | No |
| R5 The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by:<br>• mapping risks to the Health Board's strategic objectives;<br>• reviewing the required assurances;<br>• improving clarity of risk descriptors; and clarifying to the reader the date when risks are updated and/or added. | Until recently, the Health Board had made little progress in updating the CRAF. The CRAF was last presented to the Board and committees in November 2017. We recognise the Health Board has recently taken steps to start developing a separate Board Assurance Framework and Corporate Risk Register. The draft BAF was received at both the Audit Committee and Board in November and December respectively. | No |

| Recommendation | Action taken in response | Completed |
|---|---|---|
| R6 The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include:<br>• updating the information governance strategy;<br>• putting in place arrangements for monitoring compliance of the primary care information governance toolkit; and<br>• developing and completing an Information Asset Register;<br>• ensuring that an identified data protection officer is in place; and<br>• improving the uptake of information governance training. | Progress to date:<br>• An up-to-date Information Governance strategy does not yet exist. The Health Board has drafted its strategic approach in the Information Governance Policy. The Health Board plans to agree and implement this approach later in 2018.<br>• NWIS has developed the information governance toolkit for primary care GP's and intend to monitor compliance at a GP cluster level. These compliance monitoring arrangements for are still being developed. The Primary Care Clinical Board is liaising with the NHS Wales Informatics Service to confirm and agree these arrangements.<br>• Information asset registers have been developed within the corporate directorates and clinical boards, but further work is required to fully complete this. The Health Board is planning further work to: identify personal information held; identify information flows; and identify information sharing arrangements.<br>• An interim Data Protection Officer (DPO) is in post as required under the GDPR. The Health Board expects to appoint an experienced and senior information governance manager to the statutory DPO function in early 2019.<br>• More staff have completed information governance training. However, compliance with information governance training (69%) is well below the national target (95%). | Partly |

| Recommendation | Action taken in response | Completed |
|---|---|---|
| R7 The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include:<br>• ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews;<br>• expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee. | Overall this recommendation has been partly addressed.<br>• The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board.<br>• Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics. | Partly |
| R8 The Health Board needs to revisit its Informatics Strategic Outline Plan in light of the financial resources available and seek Board approval of the revised strategic approach. | Executives approved the informatics strategic approach. The Health Board revisited its Informatics Strategic Outline Plan and revised its delivery approach in the unapproved Integrated Medium-Term Plan. | Yes |

| Recommendation | | Action taken in response | Completed |
|---|---|---|---|
| R9 | To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security. | In early 2018, the Health Board received an external review of cyber security arrangements. The review recommended improvements to cyber security arrangements. In response the Health Board is developing a formal cyber security improvement action plan. It plans to bring in specialist cyber security skills in early 2019 to address these recommendations and establish a specialist cyber security team. | Partly |
| R10 | To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents. | The Health Board plans to review in early 2019 the structure and governance of its information and information technology functions to deliver the digital strategy. | No |
| **2016 recommendations** | | | |
| R13 | Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee on the extent to which both performance and financial audit recommendations have been completed, and ensure that all action plans are monitored through to completion by the relevant committees of the Board. | There is a tracker for WAO recommendations. The current arrangements don't provide enough clarity around what happens to recommendations where committees other than the audit committee are responsible. | Partly |

# Appendix 2

## Health Board's response to this year's recommendations

When the relevant committee has considered this report, we will insert a shortened version of the Health Board's response in the report before we publish it on the Wales Audit Office website.

Exhibit 7: management response to 2018 recommendations

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| **2017 recommendation**<br>R1 The Health Board should complete our 2017 structured assessment recommendations by the end of 2019 | Agreed and these will be monitored to ensure this happens through Management Executives and reported to Audit Committee | 31/12/2019 | Director of Corporate Governance |
| **Audit recommendation tracking**<br>R2 The Health Board should improve its recommendation tracking by:<br>a. addressing our outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations;<br>b. including the tracking of internal audit recommendations; and<br>c. completing a review of all outstanding internal and external audit recommendations and reporting the findings to the Audit Committee. | Agreed this will be presented to the next Audit Committee<br>Agreed as above response<br>Agreed as above response | 26/02/2019<br>26/02/2019<br>26/02/2019 | Director of Corporate Governance<br>Director of Corporate Governance<br>Director of Corporate Governance |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| **Governance** | | | |
| R3 The Health Board should: | | | |
| a. Update the Scheme of Delegation to reflect the delegated responsibility for calculating nurse staffing levels for designated acute medical and surgical inpatient wards; | Agreed in progress as result of Internal Audit Report | 31/03/2019 | Director of Corporate Governance |
| b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis; | Agreed and timetabled to be undertaken on an annual basis going forward | 31/03/2019 | Director of Corporate Governance |
| c. Improve the format of the registers for declarations of interest and gifts, hospitality and sponsorship and clarify the frequency with which the registers are presented to the Audit Committee; | Agreed registers will be improved in format and reported to Audit Committee twice a year | 23/04/2019 | Director of Corporate Governance |
| d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date; | Agreed | 31/10/2019 | Director of Corporate Governance |
| e. Review all committee terms of reference to make sure they are up to date, do not overlap, and are reviewed annually; and | Agree in progress | 31/03/2019 | Director of Corporate Governance |
| f. Ensure all committees have an up-to-date work programme, which is linked to the cycle of Board meetings and reviewed annually. | Agreed work plans for each Committee and the Board are in development | 31/03/2019 | Director of Corporate Governance |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| **Performance management**<br>R4 The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013. | We accept that the performance management framework should be reviewed to ensure it fully supports the organisational business. | 30/09/209 | Deputy CEO/Director of Transformation |
| **Financial management**<br>R5 The Health Board should provide the Finance Committee, or Board, with an update on progress with its testing and delivery of the All Wales Costing System Implementation Project. | The UHB accepts the need to provide an update on progress with this project. As a series of Welsh Costing Returns (WCRs) have now been submitted to Welsh Government using the new system, a comprehensive update on the implementation and future use of the costing development can now be made. It is intended to provide a paper to the Finance Committee following finalisation and publication of WCRs within Wales. | April 2019 | Director of Finance |
| R6 The Health Board should ensure that all recommended matches from the next NFI exercise in January 2019 are reviewed and where necessary investigated in a timely manner. | For the forthcoming NFI exercise, the Health Board will endeavour to increase its compliance in respect of the number of recommended matches checked. A large number of these matches are however in relation to Accounts Payable and this will require further matching and review by the NHS Wales Shared Service Partnership. Consequently this is not wholly within the control of the Health Board. | December 2019 | Director of Finance |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| **Information Governance**<br>R7 The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements. | CAV UHB is committed to continually improving mitigation of its risks of non-compliance. We are taking an improvement approach in line with the rest of Wales and in regular discussion with the ICO's office.<br>Progress has been made on the registering of major assets and new flows of information. We intend to progress the assessment of our existing significant flows, adopting a risk based approach. | 01/06/2019 | Director of Digital & Health Intelligence |
| R8 The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019. | Delivery of the CAV UHB's updated action plan will reduce the risks we carry in relation to non-compliance with GDPR.<br>Prioritisation of risks and mitigating actions are part of our continuous improvement plan, aimed at achieving full GDPR compliance during 2019. | 31/12/2019 | Director of Digital & Health Intelligence |
| R9 The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests | CAV UHB has recently appointed additional staff resulting in a positive impact on response times for FOI and Subject Access Requests. This will be monitored as we continue to move towards achieving fully compliant response times. | 31/03/2019 | Director of Digital & Health Intelligence |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| **Information Technology**<br>R10 The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach. | The newly appointed head of digital and health intelligence is developing a new structure to reflect combined information and IT services with the aim of establishing functions that can best support the digital transformation agenda. | 31/03/2019 | Director of Digital & Health Intelligence |
| R11 The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective. | The CAV IT Disaster Recovery plan is reviewed annually at a minimum and in response to specific circumstances. Testing is undertaken (both Check list and Technical) and multiple system restores are performed successfully annually. Additional infrastructure and software have been put in place to improve this process. A schedule of testing is being developed as part of the technical roadmap work. | 31/03/2019 | Director of Digital & Health Intelligence |

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| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | **Closure Report - Audit of Cardiff and Vale UHB's contractual relationships with RKC Associates Ltd and its Owner** | | | | | | | | |
| **Meeting:** | AUDIT COMMITTEE | | | | | | **Meeting Date:** | 26.02.19 | |
| **Status:** | **For Discussion** | ✓ | **For Assurance** | ✓ | **For Approval** | ✓ | **For Information** | | |
| **Lead Executive:** | DIRECTOR OF CORPORATE GOVERNANCE | | | | | | | | |
| **Report Author (Title):** | DIRECTOR OF CORPORATE GOVERANCE | | | | | | | | |

**SITUATION**

The report of the Auditor General for Wales regarding the UHB's Contractual Relationships with RKC Associates Ltd and its Owner was published in July 2017. It identified a number of serious concerns in relation to the awarding of the consultancy contracts to RKC Associates Ltd, the management of the recruitment process to appoint the replacement Director of WOD, and the way in which information was relayed to the UHB Board and its Remuneration and Terms of Service Committee

**REPORT**

**BACKGROUND**

A report was provided to the Board on 27 July 2017 where it was agreed that the Audit Committee would monitor the progress of actions and provide the Board with the assurances required. A further report was received by the Board on 28th September 2017 updating members of the Board on progress against the action plan.

**ASSESSMENT**

The UHB, in conjunction with its colleagues in Procurement and Human Resources / Workforce, developed a comprehensive action plan to make the necessary improvements required to ensure no similar incidents of this kind occurred in the future. The action plan (attached at the appendix) contained 26 actions and these are now all considered to be complete therefore provides the Audit Committee with the assurances it requires to sign off the plan as complete.

It will be important that the actions within the action plan are sustained going forward and it is therefore recommended that the Audit Committee receive an assurance report from the Director of Corporate Governance on an annual basis to confirm that the UHB is still compliant.

**ASSURANCE** is provided by:

- Discussion at Management Executive Team on 11th February 2019.

**RECOMMENDATION**

The Audit Committee is asked to:

- **Review** the attached action plan in relation to UHB's Contractual Relationships with RKC Associates Ltd and its Owner
- **Recommend** closure of the action plan to the Board on 31st March 2019
- **Receive** an assurance report from the Director of Corporate Governance on an annual basis to ensure ongoing compliance and sustainability of actions in the future.

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

| **Five Ways of Working (Sustainable Development Principles) considered**<br>*Please tick as relevant, click here for more information* | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Prevention | | Long term | ✓ | Integration | | Collaboration | | Involvement | |

| | |
|---|---|
| **Equality and Health Impact Assessment Completed:** | Not Applicable |

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

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

**UHB Response to Conclusion 1**

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

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

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

Prior to the Wales Audit Office report, a review of our processes was already in train in response to changes to the IR35 legislation[1] relating to off-payroll working in the public sector. In addition, the process around requesting approval of contracts has been changed, a procurement checklist that sets out a defined approval hierarchy has been implemented to ensure compliance with Standing Orders and EC Regulations and that more than one signatory is obtained. All external Consultancy contracts are now signed off by the CEO.

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

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

| Conclusion 1 Action Plan | Lead | Completion | Update | Status |
|---|---|---|---|---|
| **Training**<br>1. Provide training for all Board members on the law, rules and regulations relating to employment and procurement at the August Board Development Day. | Director of Corporate Governance | Aug 2017 | **Complete**<br>Training delivered on 31/08/17. | |
| 2. Cascade the training provided at Clinical Board senior management teams and throughout the organisation to Directorate Management level. | Executive and Clinical Board Directors | Oct 2017 | **Complete**<br>Discussed at ME on 04/09/17 & cascaded. | |
| **Review**<br>3. Undertake review of external consultancy categories in the purchase to pay system for period 2014-2017 to ensure compliance with procurement rules. | Head of Procurement | Aug 2017 | **Complete**<br>Reports received by CEO and Director of Finance. | |
| 4. Review the Procurement Guide for Staff and revise to reflect process changes connected with the IR35 legislation. | Head of Procurement | Sep 2017 | **Complete** | |
| **Process**<br>5. Provide the Procurement Guide for Staff to the Management Executive Team meeting for cascading to Clinical Boards, and Corporate Departments. | Director of Finance | Sep 2017 | **Complete**<br>Approved by ME on 25/09/17 | |
| 6. Publish the Procurement Guide for Staff across the UHB and place on intranet and internet for ease of staff access. | Director of Corporate Governance | Oct 2017 | **Complete** | |
| 7. Implement a no purchase order, no payment system to prevent the processing of manual payments. | Head of Procurement | June 2018 (original date set was Mar 2018) | **Complete**<br>The NHS Wales Shared Services Partnership have been working with Health Boards to implement an all Wales no purchase order no pay policy. Initially implemented from June 2018 and fully adopted form September 2018. | |
| 8. Develop and cascade process guidance for off-payroll working. | Head of Procurement | Aug 2017 | **Complete**<br>Approved by ME on 14/08/17, taken to HSMB on 17/08/17 for cascading by Clinical Board Directors. | |

**Conclusion 2 - The way in which an HR consultancy contract was awarded to RKC Associates in February 2016, along with the actions of key decision-makers, compromised the integrity of the procurement process**

a) The UHB embarked upon a procurement process for a contract and invited and evaluated tenders for that contract, despite the fact that RKC Associates had been engaged in advance of the tender process.

b) The robustness and integrity of the advertised procurement process was compromised in several key respects and the UHB's Chief Operating Officer participated in the process despite knowing that RKC Associates had already been engaged in advance of the procurement process commencing.

c) The Procurement Department failed to keep adequate documentation of the procurement process.

d) The UHB delayed seeking formal written approval for the fixed-term appointment of a new Director of Workforce and Organisational Development, resulting in the UHB incurring unnecessary expenditure on a consultancy contract.

**UHB Response to Conclusion 2**

The UHB has taken steps to strengthen its existing processes and extend training at all levels to reinforce the requirements in relation to these areas.

We recognise however that policies / procedures and training, whilst the foundation of good practice, are part of a bigger picture that includes a culture of sound behaviours and values, adherence to the rules at all levels of the organization, checks to ensure this is happening and an environment that enables individuals to confidently highlight departure from any rules no matter how senior those involved. As part of the communication with the UHB following receipt of this report, the CEO has asked staff to share any concerns they may have with him and provided assurance that anything raised will be explored to provide reassurance regarding our systems / processes and decisions made.

Procurement compliance reports are already presented to the UHB's Audit Committee outlining for example Contract Extensions and Single Quotation or Single Tender Actions. Steps are also being taken to put in place more vigorous checks around our processes to flag potential issues and to achieve more robust oversight and business scrutiny by our Management Executive Team, Board and its Committees.

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

| Conclusion 2 Action Plan | Lead | Completion | Update | Status |
|---|---|---|---|---|
| **Training**<br>1. Develop and deliver an enhanced training programme for procurement staff focusing on the conclusions of the Wales Audit Office report. | Head of Procurement | Sep 2017 | **Complete**<br>All training complete, refresher sessions will continue. | |
| 2. Obtain quality management accreditation for the Procurement Department in respect of its tendering processes. | Head of Procurement | Mar 2018 (original date set was Nov 2017) | **Complete**<br>Audit took place 15/02/18 & full ISO Accreditation awarded with no findings of non-compliance. | |
| 3. Develop a Procurement flowchart for use by Board and Senior Managers. | Head of Procurement | Oct 2017 | **Complete**<br>Flowchart considered by ME on 11/12/17 & agreed that Executives will cascade through Management Structures. | |
| **Audit**<br>4. Enhance existing audit processes within the Procurement Department to verify compliance with contract procedure. | Head of Procurement | Sep 2017 | **Complete**<br>Forward programme for audit planned & training of Clinical Boards & departments to continue. | |
| 5. Review Internal Audit Programme to include audits relevant to the issues highlighted in this report and to test compliance with new processes. | Director of Finance | Nov 2017 (original date set was Sep 2017) | **Complete**<br>Specific audit included in 2018 plan, to look at overall progress of action plan & review in detail a sample of actions. | |
| **Assurance**<br>6. Enhance the statutory compliance report provided at each Audit Committee to include our compliance with and exceptions to recruitment requirements, Standing Orders and Standing Financial Instructions. | Directors of Finance and Workforce and Organisational Development | Sep 2017 | **Complete**<br>Standing agenda item with first report received at Audit Committee on 26/09/17. | |
| 7. Review the Terms of Reference for the Remuneration and Terms of Service Committee to include a requirement to report any Executive level secondments and Consultancy appointments for approval to this Committee. | Director of Corporate Governance | Jan 2018 (original date set was Oct 2017) | **Complete**<br>Review approved by Board on 30/11/17. Amendment made to note at the next meeting of the Remuneration and Terms of Service Committee. | |

**Conclusion 3 - The process followed by the UHB that led to the appointment of the owner of RKC Associates to the position of Director of Workforce and Organisational Development in April 2016 was fundamentally compromised, lacked transparency and was poorly documented.**

a) It is unclear why the UHB decided to proceed with a recruitment process for a Board level position with only a single candidate who had not applied for the position when it was originally advertised.

b) The recruitment process was poorly documented and, as a consequence, it is not clear when the person who had been overseeing the recruitment exercise became a candidate.

c) The integrity of the recruitment process was compromised because the sole candidate had access to some of the assessment questions in advance of being interviewed for the position.

d) The information provided to the Board and its Remuneration and Terms of Service Committee regarding the appointment was inaccurate, incomplete and inconsistent.

**UHB Response to Conclusion 3**

High level appointments are not as frequent as other positions within the UHB and are often challenging to recruit due to small numbers of applicants with the relevant skills and experience.

As a result of this report, the UHB has looked at how these senior appointment processes are conducted and how the office of the Chief Executive and Director of Workforce and Organisational Development can work better together to ensure compliance with processes and that satisfactory documentation is maintained.

We also recognise that we can better support our Independent Board Members in relation to their Committee roles, to equip them to confidently scrutinise decisions and hold us to account.

| Conclusion 3 Action Plan | Lead | Completion | Update | Status |
|---|---|---|---|---|
| **Review**<br>1. Review the procedures used to recruit Executive Directors and other Senior Managers. | Assistant Director of Workforce and Organisational Development | June 2018 (target date set Jul 2017) | **Complete**<br>Relevant documents have been revised and approved by the UHB's Strategy and Delivery Committee on 28th June 2018. | |
| 2. Review the quality of information and its presentation to the Remuneration and Terms of Service Committee. | Chair and Director of Corporate Governance | Mar 2018 (target date set Sep 2017) | **Complete**<br>New process introduced in January 2018 whereby all papers are assured by Chair & Director of Corporate Governance prior to publication. Checklist formulated to support this scrutiny. | |
| **Process**<br>3. Revise the Executive recruitment process to include a clear defined role for the Director of Workforce and Organisational Development which can be delegated to their Deputy or Director of Corporate Governance if circumstances require or a conflict arises. | Chief Executive | Aug 2017 | **Complete**<br>Process revised & now to be reflected in the updated Recruitment and Selection Policy & Procedure. | |
| **Training**<br>4. Arrange training for Independent Board Members, including those sitting on the Remuneration and Terms of Service Committee, covering their roles and responsibilities. This should also provide them with example questions they may wish to ask and the minimum information they may require to assist them in discharging their role. | Director of Corporate Governance | Aug 2017 | **Complete**<br>Included in the programme for the August Board Development Day. | |
| 5. Provide legal and governance training for all Board members on their roles and responsibilities at the October Board Development Day. | Director of Corporate Governance | Oct 2017 | **Complete**<br>Included in the programme for the October Board Development Day. | |
| **Additional Improvements** | | | | |

| Action Plan | Lead | Completion | Update | Status |
|---|---|---|---|---|
| **Whistleblowing**<br>1. Review current Procedure for NHS Staff to Raise Concerns which includes whistleblowing to ensure it is fit for purpose and easy for staff to raise any concerns regarding non-compliance. | Director of Workforce and Organisational Development | Jan 2018 (target date set Oct 2017) | **Complete**<br>All Wales Procedure adopted, Working Group established to re-launch Procedure, agree underlying process & improve culture. | |
| 2. Develop an internal protocol providing a system for senior leaders to raise concerns, with clear lines of reporting should a concern relate to the Chair, Vice Chair or Chief Executive. | Director of Corporate Governance | October 2018 (target date set Oct 2017) | **Complete**<br>Raising concerns was launched during the week 22-26 October along with communications from the CEO and an animation played throughout the UHB | |
| **Governance and Accountability Framework**<br>3. Revise the UHB Governance and Accountability Framework to reflect any amendments by the Directors of Finance All Wales Group to the Standing Financial Instructions and Standing Orders. | Director of Corporate Governance | March 2019 (target date set Mar 2018) | **Complete**<br>Model Standing Orders reviewed and being presented to the Board on 31st March 2019 for approval | |
| 4. Review and revise the UHB's Scheme of Delegation. | Director of Finance | Feb 2018 (target date set Oct 2017) | **Complete**<br>Review presented to Audit Committee on 27/02/18 & Scheme of Delegation revised to include off-payroll working. | |
| 5. Circulate a bulletin to the UHB Board and throughout the UHB reinforcing the Nolan principles of Good Governance and duties of probity / candour and the Values and Standards of Behaviour Framework. | Directors of Corporate Governance and Communications | Feb 2019 (target date set Oct 2017) | **Complete**<br>Nolan Principles added permanently to website for all Board Members to access | |
| **Communication**<br>6. Communicate openly and transparently with staff about the findings of this report, the actions being taken by the UHB and their progress. This will include public meetings of Board / Audit Committee and meetings of LPF, Clinical Board Directors, HSMB and publishing of the action plan on the intranet for access by all staff, supplemented by other communication bulletins. | Chief Executive and Chair | Oct 2017 | **Complete**<br>Reports at Board, ME, HSMB, LPF. Continued dialogue with Senior Trade Union / Staff Side representatives, CEO communication placed on intranet and internet. Action plan monitored by Audit Committee. | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | Draft Annual Report 2018/19 – Audit Committee | | | | | | | | |
| **Meeting:** | Audit Committee | | | | | | **Meeting Date:** | 26.02.19 | |
| **Status:** | **For Discussion** | x | **For Assurance** | | **For Approval** | x | **For Information** | | |
| **Lead Executive:** | Director of Corporate Governance | | | | | | | | |
| **Report Author (Title):** | Director of Corporate Governance | | | | | | | | |

**SITUATION**

The purpose of the report is to provide Members of the Audit Committee with the opportunity to discuss the attached Annual Report prior to submission to the Board for approval.

**REPORT**

**BACKGROUND**

It is good practice and good governance for the Committees of the Board to produce an Annual Report from the Committee to demonstrate that it has undertaken the duties set out in its Terms of Reference and provide assurance to the Board that this is the case.

**ASSESSMENT**

The attached Annual Report 2018/19 of the Audit Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference. The Committee has achieved an overall attendance rate of XX% and has met on six occassions during the year including a Special Meeting.

**RECOMMENDATION**

The Audit Committee is asked to:

**REVIEW** the draft Annual Report 2018/19 of the Audit Committee.
**RECOMMEND** the Annual Report to the Board for approval.

| **Shaping our Future Wellbeing Strategic Objectives** | | | |
|---|---|---|---|
| 1. Reduce health inequalities | | 6. Have a planned care system where demand and capacity are in balance | |
| 2. Deliver outcomes that matter to people | x | 7. Be a great place to work and learn | x |
| 3. All take responsibility for improving our health and wellbeing | | 8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology | |
| 4. Offer services that deliver the population health our citizens are entitled to expect | | 9. Reduce harm, waste and variation sustainably making best use of the resources available to us | |

| | | | |
|---|---|---|---|
| 5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time | | 10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives | |

| **Five Ways of Working (Sustainable Development Principles) considered** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sustainable Development Principles: Five ways of working | Prevention | x | Long term | | Integration | | Collaboration | | Involvement | | |
| **Equality and Health Impact Assessment Completed:** | Not Applicable | | | | | | | | | | |

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

# Annual Report of Audit Committee 2018/19

## 1.0 INTRODUCTION

In accordance with best practice and good governance, the Audit Committee produces an Annual Report to the Board setting out how the Committee has met its Terms of Reference during the financial year.

## 2.0 MEMBERSHIP

The Committee membership is a minimum of three Independent Members one of which must have financial experience and one whom must be a member of the Quality, Safety and Experience Committee. During the financial year 2018/19 the Committee comprised four Independent Members. In addition to the Membership, the meetings are also attended by the Director of Finance (Executive Lead for the Committee), Director of Corporate Governance, Internal Audit and Wales Audit Office. The Chair of the Board is not a Member of the Committee but attends at least annually after agreement with the Committee Chair. Other Executive Directors are required to attend on an ad hoc basis.

## 3.0 MEETINGS AND ATTENDANCE

The Committee met five times during the period 1 April 2018 to 31 March 2019. This is in line with its Terms of Reference. The Audit Committee achieved an attendance rate of 84% (80% is considered to be an acceptable attendance rate) during the period 1st April 2018 to 31st March 2019 as set out below:

| | | | | | | |
|---|---|---|---|---|---|---|
| | **24/04/2018** | **31/05/2018** | **25/09/2018** | **04/12/2018** | **26/02/2019** | **Attendance** |
| John Union (Chair from 04.12.18) | √ | √ | X | √ | √ | **80%** |
| John Antoniazzi (Chair until 30.09.18) | √ | √ | X | N/A | N/A | **67%** |
| Eileen Brandreth (from 04.12.18) | N/A | N/A | N/A | X | √ | **50%** |
| Charles Janczewski | N/A | √ | √ | √ | √ | **100%** |
| Dawn Ward | √ | √ | √ | √ | √ | **100%** |
| **Total** | **100%** | **100%** | **50%** | **75%** | **100%** | **84%** |

## 4.0 TERMS OF REFERENCE

The Terms of Reference were reviewed and approved by the Committee on 26th February 2019 and were approved by the Board on 31st March 2019.

## 5.0 WORK UNDERTAKEN

During the financial year 2018/19 Audit Committee reviewed the following key items at its meetings:

**Private Audit Committee**

**April & September 2018**

- Counter-fraud Progress Report
- Procurement Compliance Report
- Workforce and Organisational Development Compliance Report

**Public Audit Committee**

**April, September, December 2018**

- Internal Audit Progress Report

**April 2018**

- Internal Audit Plan 2018/2019
- Tracking Report on WAO Recommendations
- Audit Enquiries to those charged with Governance and Management
- Handover of Care at Emergency Departments – Welsh Ambulance Service Trust Internal Audit Report
- WAO Informatics Systems in NHS

**May 2018**

- Internal Audit Annual Report 2017/2018
- Audit Enquiries to those charged with Governance and Management
- Counter fraud Annual Report 2017/2018
- Report on Annual Accounts of the UHB 2017/2018
- WAO ISA 260 Report

**September 2018**

- WAO Update Report and Medical Equipment Update
- Tracking Report on WAO Recommendations
- Post Payment Verification Scheme of Delegation

- Consultant Job Planning – Review of Progress against Recommendations and Review of Action Plan
- Continuing Healthcare Follow-Up - |Review of Action Plan and Timescales
- Structured Assessment Report 2017 – 6 Month Review
- Regulatory and Review Bodies Tracking Report
- Annual Report of Hospitality Register and Register of Declarations of Interest
- Patient Safety
- WAO Financial Statement Report – Recommendations Addendum

**December 2018**

- Terms of Reference
- Audit Committee Work plan
- Business Continuity Progress Report
- Losses and Special Payments
- WAO Update Report and Medical Equipment Update
- Tracking Report
- Board Assurance Framework

## 6.0 REPORTING RESPONSIBILITIES

The Committee has reported to the Board after each of the Audit Committee meetings by presenting a summary report (introduced from November 2018) of the key discussion items at the Audit Committee. The report is presented by the Chair of the Audit Committee.

## 7.0 OPINION

The Committee is of the opinion that the draft Audit Committee Report 2018/19 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

**John Union**

**Committee Chair**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | Work Plan 2019/20 – Audit Committee | | | | | | | | |
| **Meeting:** | Audit Committee | | | | | | **Meeting Date:** | 26.02.19 | |
| **Status:** | **For Discussion** | x | **For Assurance** | | **For Approval** | x | **For Information** | | |
| **Lead Executive:** | Director of Corporate Governance | | | | | | | | |
| **Report Author (Title):** | Director of Corporate Governance | | | | | | | | |

**SITUATION**

The purpose of the report is to provide Members of the Audit Committee with the opportunity to review the Audit Committee Work Plan 2019/20 prior to presentation to the Board for approval

**REPORT**

**BACKGROUND**

The work plan for the Committee should be reviewed annually prior to presentation to the Board to ensure that all areas within its Terms of Reference are covered within the plan.

**ASSESSMENT**

The work plan for the Audit Committee 2019/20 has been based on the requirements set out within the Audit Committee Terms of Reference which assumes that the Committee meets five times a year with a special meeting for all the end of year arrangments.

**RECOMMENDATION**

The Audit Committee is asked to:

**REVIEW** the Work Plan 2019/20
**APPROVE** the Work Plan 2019/20
**RECOMMEND** approval to the Board of Directors

| **Shaping our Future Wellbeing Strategic Objectives** | | | |
|---|---|---|---|
| 1. Reduce health inequalities | | 6. Have a planned care system where demand and capacity are in balance | |
| 2. Deliver outcomes that matter to people | x | 7. Be a great place to work and learn | x |
| 3. All take responsibility for improving our health and wellbeing | | 8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology | |
| 4. Offer services that deliver the population health our citizens are entitled to expect | | 9. Reduce harm, waste and variation sustainably making best use of the resources available to us | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time | | | | | 10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives | | | | | | |
| **Five Ways of Working (Sustainable Development Principles) considered** | | | | | | | | | | | |
| Sustainable Development Principles: Five ways of working | Prevention | x | Long term | | Integration | | Collaboration | | Involvement | | |
| **Equality and Health Impact Assessment Completed:** | Not Applicable | | | | | | | | | | |

| Audit Committee Work Plan 2019 - 20 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A -Approval D- discussion I - Information | Exec Lead | 26-Feb | 23-Apr | 21-May | 30-May | 24-Sep | 3-Dec | 25-Feb | 21-Apr |
| **Agenda Item** | | | | | | | | | |
| **Governance** | | | | | | | | | |
| Review the system of assurance | NF | | | | | D | | | D |
| Review the risk management system | NF | | | | | | | | D |
| Note the business of other Committees and review inter-relationships | NF | | | | | D | D | D | D |
| Review Draft AGS | NF | | D | | A | | | | |
| Review Draft Quality Statement | RW | | D | | A | | | | |
| Review other sources of Assurance | NF | | | | | D | D | D | D |
| Review the UHB Annual Report | NF | | D | | A | | | | |
| Review of Standing Orders | NF | D | | | | | | D | |
| Report on Declarations of Interest and Gifts and Hospitality | NF | | D | | D | D | D | D | D |
| Receive reports from Regulatory Bodies | NF | D | D | | | D | D | D | D |
| Receive tracking report from recommendations from Regulatory Bodies | NF | D | D | | D | D | D | D | D |
| Undertake Annual Review of PAC Report | NF | | | | | | | D | |
| **Financial Focus** | | | | | | | | | |
| Agree final accounts timetable and plans | RC | | | | | | | A | |
| Review of audited annual accounts and financial statements | RC | | | D | A | | | | D |
| Review changes to SFIs and changes to accounting policies | RC/NF | | D | | | | | | D |
| Review losses and special payments | RC | | D | | A | | A | | |
| Single Tender Actions | RC | D | D | | D | D | D | D | D |
| **Internal Audit** | | | | | | | | | |
| Review and approve annual internal audit plan | IA | | A | | | | | | A |
| Review and approve internal audit Terms of Reference | IA | | A | | | | | | A |
| Review the effectiveness of internal audit | IA | | | | | | D | | |
| Review of internal audit progress reports | IA | D | D | | | D | D | D | D |
| Receive annual internal audit report and associated opinions (HoIA) | IA | | | D | A | | | | |
| Receive Tracking Report on internal audit recommendations | NF | D | D | | D | D | D | D | D |
| **External Audit** | | | | | | | | | |
| Agree Auditor General's Audit Plan | WAO | A | | | | | | A | |
| Review the effectivenes of external audit | WAO | | | | | | D | | |
| Review External Audit Progress Reports | WAO | D | D | | | D | D | D | |
| Receive the Auditors report to those charged with governance | WAO | D | | | A | | | | |
| Receive the Auditors Annual Audit Report | WAO | A | | | | | | A | |
| Receive Annual Structured Assessment Report | WAO | D | | | | | | D | |
| **Clinical Audit** | | | | | | | | | |
| Review annual Clinical Audit Plan | RW | | D | | | | | | D |
| Review Clinical Audit Terms of Reference | RW | | D | | | | | | D |
| Review effectiveness of Clinical Audit | RW | | | | | | D | | |
| Review Clinical Audit Progress Reports | RW | | D | | | D | D | D | D |
| | | | | | | | | | |
| **Counter Fraud** | | | | | | | | | |
| Review and approve annual counter fraud plan | CF | | A | D | | | | | |
| Review counter fraud progress reports | CF | | D | | | D | D | D | D |
| Review the effectiveness of Counter Fraud Specialist | CF | | | | | | D | | |
| Receive counter fraud annual report | CF | | D | | A | | | | |
| | | | | | | | | | |
| **Audit Committee** | | | | | | | | | |
| Annual Work Plan | NF | A | | | | | | A | |
| Self assessment of effectiveness | NF | D | | | | | | | |
| Induction Support for Committee Members | NF | | D | | | | | | |
| Review Terms of Reference | NF | A | | | | | | A | |
| Produce annual Audit Committee Annual Report | NF | A | | | | | | A | |
| Private discusison with internal and external auditor | NF | D | D | | | D | D | D | D |
| Minutes of Audit Committee Meeting | NF | A | A | | | A | A | A | A |
| Action log of Audit Committee Meeting | NF | D | D | | | D | D | D | D |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | Terms of Reference – Audit Committee | | | | | | | | |
| **Meeting:** | Audit Committee | | | | | | **Meeting Date:** | 26.02.19 | |
| **Status:** | **For Discussion** | x | **For Assurance** | | **For Approval** | x | **For Information** | | |
| **Lead Executive:** | Director of Corporate Governance | | | | | | | | |
| **Report Author (Title):** | Director of Corporate Governance | | | | | | | | |

**SITUATION**

In line with the UHB's Standing Orders, Terms of Reference for Committees of the Board, should be reviewed on an annual basis.

This report provides Members of the Audit Committee with the opportunity to review the Terms of Reference prior to submission to the Board for approval.

**REPORT**

**BACKGROUND**

The Terms of Reference for the Audit Committee were last reviewed in May 2015.

**ASSESSMENT**

The Terms of Reference for the Audit Committee Committee have been reviewed by the Director of Corporate Governance. There are a limited number of changes to the document, these have been tracked and left in the draft so Committee Members can identify the changes that have been made.

**RECOMMENDATION**

The Audit Committee is asked to:

**APPROVE** the changes to the Terms of Reference for the Audit Committee and **RECOMMEND** the changes to the Board for approval.

| **Shaping our Future Wellbeing Strategic Objectives** | | | |
|---|---|---|---|
| 1. Reduce health inequalities | | 6. Have a planned care system where demand and capacity are in balance | |
| 2. Deliver outcomes that matter to people | x | 7. Be a great place to work and learn | x |
| 3. All take responsibility for improving our health and wellbeing | | 8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology | |

| | | | |
|---|---|---|---|
| 4. Offer services that deliver the population health our citizens are entitled to expect | | 9. Reduce harm, waste and variation sustainably making best use of the resources available to us | |
| 5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time | | 10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives | |

| **Five Ways of Working (Sustainable Development Principles) considered** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sustainable Development Principles: Five ways of working | Prevention | x | Long term | | Integration | | Collaboration | | Involvement | | |
| **Equality and Health Impact Assessment Completed:** | Not Applicable | | | | | | | | | | |

# Audit and Risk Assurance Committee

## Terms of Reference ~~and Operating Arrangements~~

**Updated ~~September 2016~~November 2018**

# AUDIT AND RISK ASSURANCE COMMITTEE

# TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

## 1. INTRODUCTION

1.1 The UHB Standing Orders provide that "*The Board may and, where directed by the ~~Assembly~~ Welsh Government must, appoint Committees of the LHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders (3.4.1) and the UHB Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Audit and Risk Assurance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

## 2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the UHB's assurance framework - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the UHB's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its assurance framework may be strengthened and developed further.

## 3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- the adequacy of the UHB strategic governance and assurance framework and processes for risk management and internal control designed to support the Accountable Officer's statement on internal control, providing reasonable assurance on:

- the organisations ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards and other directions and requirements set by the ~~Assembly~~ Welsh Government and others;
- the reliability, integrity, safety and security of the information collected and used by the organisation;
- the efficiency, effectiveness and economic use of resources; and
- the extent to which the organisation safeguards and protects all its assets, including its people
- the adequacy of the arrangements for declaring, registering and handling interests at least annually
- the adequacy of the arrangements for dealing with offers of gifts or hospitality

to ensure the provision of high quality, safe healthcare for its citizens;

- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;
- the Schedule of Losses and Compensation;
- the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);
- the adequacy of executive and managements response to issues identified by audit, inspection and other assurance activity;
- ~~(where appropriate) proposals for tendering for Internal Audit services or for purchase of non-audit services from contractors who provide audit services;~~

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- ~~proposals for the appointment of the external auditor made by the Auditor General for Wales~~

- anti-fraud policies, whistle-blowing processes and arrangements for special investigations; and

- any particular matter or issue upon which the Board or the Accountable Officer may seek advice

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by:

- reviewing the ***comprehensiveness*** of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the UHB's activities, both clinical and non-clinical;

- reviewing the ***reliability and integrity*** of these assurances; and

- considering and approving policies as determined by the Board.

3.3 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- there is an effective Internal Audit function that meets the standards set for the provision of Internal Audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- there is an effective Counter Fraud Service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Quality, ~~and~~ Safety and Experience Committee; ~~(or equivalent)~~

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees

- the work carried out by key sources of external assurance, in particular, but not limited to the UHB External Auditors, is appropriately planned and co-ordinated and that the results of

external assurance activity complements and informs (but does not replace) internal assurance activity

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;.
- the systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- the results of audit and assurance work specific to the UHB, and the implications of the findings of wider audit and assurance activity relevant to the UHB's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

**Authority**

3.4 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

**Access**

3.6 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee.

3.7 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.8 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

**Sub Committees**

~~3.9~~The Committee may, subject to the approval of the UHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business. ~~These include:~~

- ~~Finance Task and Finish Group~~
- ~~Resource Allocation Group.~~

**3.9**

## 4. MEMBERSHIP

**Members**

4.1 A minimum of three (3) members, comprising:

| | |
|---|---|
| Chair | Independent member of the Board |
| Vice Chair | Chosen from amongst the Independent members on the Committee |
| Members | At least one other independent members of the Board *[one of which should be the member of the Quality and Safety Committee (or equivalent)]* |

The committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

**Attendees**

4.2 In attendance

Chief Executive
Director of Finance (Lead Executive)
~~Director of Workforce and Organisational Development~~
Director of Corporate Governance~~/Board Secretary~~
~~Assistant Director of Patient Safety and Quality~~
Head of Internal Audit
Local Counter Fraud Specialist
Representative of External Auditor
Other Executive Directors will attend as required by the Committee Chair

4.3 By invitation The Committee Chair may invite:

- any other UHB officials; and/or

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- any others from within or outside the organisation
- to attend all or part of a meeting to assist it with its discussions on any particular matter.

**Secretariat**

4.4 Secretary - As determined by the Director of Corporate Governance ~~/ Board Secretary~~

**Member Appointments**

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by the Assembly Government.

4.6 Committee members' terms and conditions of appointment, (including any remuneration and reimbursement) are determined by the Board, based upon the recommendation of the UHB Chair {and on the basis of advice from the UHB's Remuneration and Terms of Service Committee}.

**Support to Committee Members**

4.7 The Director of Corporate Governance ~~/Board Secretary~~, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of organisational development for committee members as part of the UHB's overall OD programme developed by the Director of Workforce and Organisational Development.

## 5. COMMITTEE MEETINGS

**Quorum**

5.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the committee Chair or Vice Chair.

**Frequency of Meetings**

5.2 Meetings shall be held no less than quarterly, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB annual plan of Board Business.

**Withdrawal of Individuals in Attendance**

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

## 6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the UHB overall framework of assurance.

6.5 The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

## 7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

7.2 The Committee shall provide a written, annual report to the board and the Accountable Officer on its work in support of the ~~Statement of Internal Control~~Annual Governance Statement, specifically commenting on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

7.3 The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.4 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

## 8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- quorum (set within individual Terms of Reference)

## 9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | Audit Enquiries to those Charged with Governance and Management | | | | | | | | |
| **Meeting:** | Audit Committee Meeting | | | | | | **Meeting Date:** | 26.02.19 | |
| **Status:** | **For Discussion** | | **For Assurance** | **x** | **For Approval** | **x** | **For Information** | | |
| **Lead Executive:** | Director of Finance | | | | | | | | |
| **Report Author (Title):** | Deputy Director of Finance. | | | | | | | | |

**SITUATION**

The WAO as part their Final Accounts Audit are responsible for obtaining reasonable assurances that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. The WAO have written to the UHB to gain responses on a number of risk, legal, fraud and governance questions. These responses are required both from management and those charged with governance.

**REPORT**

**BACKGROUND**

The WAO have sent the Health Board Finance Director a letter which formally seeks documented consideration and understanding on a number of governance areas that impact on their audit of our financial statements. These considerations are relevant to both the management of the Health Board and 'those charged with governance' (the Board).

The areas of governance on which views are being sought are summarized as:

- Management processes in relation to the risk of fraud and ethical behaviour;
- Management's and Board awareness of any actual or alleged instances of fraud;
- How management and the Board gain assurance that all relevant laws and regulations have been complied with;
- Whether there is any potential litigation or claims that would affect the financial statements;
- Management processes to disclose related party transactions and the Board's oversight of these processes.

The letter received from the Wales Audit office is attached and a response to their questions has been requested by 5 April 2019.

**ASSESSMENT**

The draft response to the questions posed by the Wales Audit Office is attached and is detailed in Appendices 1, 2 and 3 of the accompanying letter.

The Audit committee, as part of its lead role in Final Accounts review and scrutiny, is asked to review the draft response, propose any changes to strengthen the response and support its submission to the Wales Audit Office within the timescales they have requested. To ensure

good governance, this draft response has also been sent to the Chief Executive and Chair for their review and endorsement.

**ASSURANCE** is provided by:

- The response to the enquiries made by the Wales Audit Office.

**RECOMMENDATION**

- The Audit Committee is asked to: **REVIEW** the draft response to the Wales Audit Office enquiries;
- **APPROVE** 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.

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

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Wales Audit Office / Swyddfa Archwilio Cymru

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Mr Chris Lewis
Deputy Director of Finance
Cardiff and Vale University Local Health Board
Headquarters
University Hospital of Wales
Heath Park
CARDIFF
CF14 4XW

**Reference:** 0121.mju.lewis.cv

**Date issued:** 21 January 2019

Dear Chris,

# Cardiff and Vale University Local Health Board 2018-19: audit enquiries to those charged with governance and management

As you know, each year I am responsible for obtaining reasonable assurance that the financial statements taken are free from material misstatement, whether caused by fraud or error. My 2019 Audit Plan, which the Audit Committee will consider on 26 February 2019, will set out the respective responsibilities of auditors, management and those charged with governance.

This letter formally seeks documented consideration and understanding on a number of governance areas that impact on my audit of your financial statements. These considerations are relevant to both the management of the Cardiff and Vale University Local Health Board (the UHB) and 'those charged with governance' (the Board).

I have set out below the areas of governance on which I am seeking views.

1. Management processes in relation to:
   - undertaking an assessment of the risk that the financial statements may be materially misstated due to fraud;
   - identifying and responding to risks of fraud in the organisation;
   - communication to employees of views on business practice and ethical behaviour; and
   - communication to those charged with governance the processes for identifying and responding to fraud.
2. Management's and the Board's awareness of any actual or alleged instances of fraud.
3. How management and the Board gain assurance that all relevant laws and regulations have been complied with.
4. Whether there is any potential litigation or claims that would affect the financial statements.

5. Management processes to identify, authorise, approve, account for and disclose related party transactions and relationships and the Board's oversight of these processes.

The information you provide will inform our understanding of the UHB and its business processes and support our work in providing an audit opinion on your 2018-19 financial statements.

I would be grateful if you could complete the attached tables in Appendices 1 to 3. Your responses should be formally considered and communicated to us on behalf of both management and those charged with governance by 5 April 2019. In the meantime, if you have queries please feel free to contact me or Mark Jones.

Yours sincerely,

**Mike Usher**
**Engagement Director**

cc Bob Chadwick, Director of Finance

# Appendix 1

## Matters in relation to fraud

International Standard for Auditing (UK and Ireland) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for the Health Board is the Board. Management, with the oversight of the Board, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

## What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- the intentional misappropriation of assets (cash, property, etc); or
- the intentional manipulation or misstatement of the financial statements.

We also need to understand how the Board exercises oversight of management's processes. We are also required to make enquiries of both management and the Board as to their knowledge of any actual, suspected or alleged fraud and for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

| Enquiries of management - in relation to fraud | |
|---|---|
| **Question** | **2018-19 Response** |
| 1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud and what are the principal reasons? | The assessed risk is extremely low as management are not aware of any fraud or potential fraud that would materially impact on the financial statements. This assessment is made on the basis of a robust and comprehensive counter fraud and internal audit services. Any potential fraud cases are rigorously investigated and pursued by counter fraud. Internal Audit also undertake a detailed annual review of the main financial systems from which the financial statements are prepared which has been reviewed as giving substantial assurance. |
| 2. What processes are employed to identify and respond to the risks of fraud more generally and specific risks of misstatement in the financial statements? | The Health Board has a year-end accounts closure process, including an analytical review which aims to mitigate against the risks of any financial misstatements. The Health Board's internal auditors also annually review the fundamental financial systems upon which the financial statements are based. This is also supported by a robust and well-resourced counter fraud programme. In addition, the Health Board has undertaken, through the Counter Fraud Department, a range of measures such as establishing a Post Payment Verification Panel which evaluates and monitor 'errors' with claims that have been submitted to Primary Care Services by the individual GP Practices and Opticians. All senior staff in the Finance Department must be professionally qualified accountants whose professional institutes have strong code of conducts and professional ethics. Any deliberate mis-statements would likely result in the individual being stuck off from their professional body. |
| 3. What arrangements are in place to report fraud issues and risks to the Audit Committee? | The Audit Committee agrees a Counter Fraud Work Plan at the start of the year. It then receives regular Counter Fraud progress |

| Enquiries of management - in relation to fraud | |
|---|---|
| **Question** | **2018-19 Response** |
| | reports at all of its normal business meetings. It also receives an annual counter fraud report which details the work that has been undertaken during the year, together with a Self-Risk Assessment that is required to be submitted to the NHS Counter Fraud Authority which measures the Health Board's level of counter fraud work against a set of agreed National Standards for NHS Bodies in relation to fraud, bribery and corruption. |
| 4. How has management communicated expectations of ethical governance and standards of conduct and behaviour to all relevant parties, and when? | All staff have access to the Standards of Behaviours Framework Policy via the Intra and Internet plus this is included upon recruitment and at induction. Consultant Medical and Dental Staff are reminded of the need to declare interests etc, when completing their job plans. Board members are made aware of the policy on recruitment and are also prompted to complete a declaration on an annual basis. This requires them to confirm that they have read and understood the policy. 'Declarations of Interest' is also a standing item on the agenda of all Board and Committee meetings. In addition, the Standards of Behaviours Framework policy has been circulated and also raised at the Health Systems Management Board to ensure that it is cascaded through Clinical Boards. This has been done to make sure that expectations of ethical governance and standards of conduct and behaviour are being communicated to all professional staff and not only to Medical and Dental staff. This policy and process will be strengthened during the next financial year due to the fact that the Health Board has received a limited assurance report on Standards of Behaviour. |
| 5. Are you aware of any instances of actual, suspected or alleged fraud within the audited body since 1 April 2018? | Yes, this is fully reported to the Audit Committee at its regular business meeting in its private session via a counter fraud progress report. Also, as part of their private meetings, the Board receives minutes from the private meeting of the Audit Committee, which |

| Enquiries of management - in relation to fraud | |
|---|---|
| **Question** | **2018-19 Response** |
| | include reference and any significant points highlighted in the Counter Fraud Progress Reports. |
| 6. Are you aware of any fraud within the NHS Wales Shared Services Partnership since 1 April 2018? | No, but this is also fully reported to both the NWSSP and Velindre NHS Trust (as the hosting body) Audit Committees at its regular business meeting via a counter fraud progress report. |
| **Enquiries of those charged with governance – in relation to fraud** | |
| **Question** | **2018-19 Response** |
| 1. How does the Board exercise oversight of management's processes for identifying and responding to the risks of fraud within the audited body and the internal control that management has established to mitigate those risks? | The Board has delegated the review and monitoring of management processes for identifying and responding to fraud risks to the Audit Committee. This monitoring is supported by the work of the Audit Committee and the internal audit and counter fraud functions for which the Finance Director is the lead Executive Director. The Audit Committee receives regular reports on counter fraud matters and on the adequacy of internal control that exist within the Health Board and on the actions being taken to mitigate these risks. The Chair of the Audit Committee is an Independent Member of the Board and reports back to the Health Board on these matters and the minutes of both the public and private meetings of the Audit Committee are included in the meeting papers of the Board. |
| 2. Are you aware of any instances of actual, suspected or alleged fraud with the audited body since 1 April 2018? | Yes, as part of their private meetings, the Board receives minutes from the private meeting of the Audit Committee, which includes any significant points highlighted in the Counter Fraud Progress Reports. |

# Appendix 2

## Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, the Board, is responsible for ensuring that the Health Board's operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements; and
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

## What are we required to do?

As part of our risk assessment procedures we are required to make inquiries of management and the Board as to whether the Health Board is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

| Enquiries of management – in relation to laws and regulations | |
|---|---|
| **Question** | **2018-19 Response** |
| 1. How have you gained assurance that all relevant laws and regulations have been complied with? | Assurances are gained via the appropriate Board Committees where these issues are discussed. Where relevant these are linked to the Corporate Risk and Assurance Framework for the Health Board. This process will be strengthened due to the Health Board receiving a limited assurance report on Regulatory Compliance. |
| 2. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations since 1 April 2018, or earlier with an ongoing impact on the 2018-19 financial statements? | Yes, there has been a Health and Safety Executive notice of legal action against the Health Board with a court hearing scheduled for February 2019. A provision for a financial penalty was included within the 2017/18 financial statements. |
| 3. Are there any potential litigations or claims that would affect the financial statements? | There are some of Employment Tribunal cases involving the Health Board and these have been accounted for within the financial statements. |
| 4. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance? | Whilst no reports have been issued, the Health Board has been reviewed by HRMC this year in respect of compliance with VAT regulations. These have been accounted for in the financial statements. |
| **Enquiries of those charged with governance – in relation to laws and regulations** | |
| **Question** | **2018-19 Response** |
| 1. How does the Board, in its role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with? | Assurances are gained via the appropriate Board Committees where these issues are discussed. Where relevant these are linked to the Corporate Risk and Assurance Framework for the Health Board. |
| 2. Are you aware of any instances of non-compliance with relevant laws and regulations? | Yes, the Health and Safety Executive notice of legal action. |

| | | |
|---|---|---|
| 3. | Are you aware of any non-compliance with laws and regulations within the NHS Shared Services Partnership since 1 April 2018? | No. |

# Appendix 3

## Matters in relation to related parties

International Standard for Auditing (UK and Ireland) 550 covers auditors' responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

## What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

| Enquiries of management – in relation to related parties | |
|---|---|
| **Question** | **2018-19 Response** |
| 1. Confirm that you have disclosed to the auditor:<br>• the identity of any related parties, including changes from the prior period;<br>• the nature of the relationships with these related parties;<br>• details of any transactions with these related parties entered into during the period, including the type and purpose of the transactions. | Yes, these are all disclosed to the auditor. |
| 2. What controls are in place to identify, authorise, approve, account for and disclose related party transactions and relationships? | Staff are required to make declarations in accordance with the Standards of Behaviour Framework Policy, incorporating Gifts, Hospitality and Sponsorship. All Board members are asked to make a declaration on an annual basis, which is then recorded and published in the Declarations of Board Members' Interests. Where a Board Member's interests change during the year, they have a personal responsibility to declare this and inform the Board Secretary.<br>These related party transactions are identified in the annual accounts and their materiality quantified.<br>For all Committees and the Board we have a standing agenda item at the beginning of each meeting 'Declaration of Interest' in relation to items on the agenda. |
| **Enquiries of the those charged with governance – in relation to related parties** | |
| **Question** | **2018-19 Response** |
| 1. How does the Board, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships? | The Audit Committee receives bi-annual reports relating to compliance with the policy and the Gifts, Hospitality and Sponsorship Register. It also scrutinises the Annual Accounts which contain details of related party transactions. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | Self Assessment – Audit Committee | | | | | | | | |
| **Meeting:** | Audit Committee | | | | | | **Meeting Date:** | 26.02.19 | |
| **Status:** | **For Discussion** | x | **For Assurance** | | **For Approval** | x | **For Information** | | |
| **Lead Executive:** | Director of Corporate Governance | | | | | | | | |
| **Report Author (Title):** | Director of Corporate Governance | | | | | | | | |

**SITUATION**

The purpose of the report is to provide Members of the Audit Committee with the opportunity to discuss the attached self-assessment and associated process to be undertaken by the Director of Corporate Governance.

**REPORT**

**BACKGROUND**

It is good practice and good governance for the Committees of the Board to undertake an assessment of their effectiveness on an annual basis.

**ASSESSMENT**

Attached to the report is an effectiveness assessment to be undertaken by the Members and the Executive Lead of Audit Committee . The assessment will be sent out to Members to complete and then the results will be analysed by the Director of Corporate Governance. The results of the review and an action plan to improve will then be reported back to the next meeting of the Audit Committee .

**RECOMMENDATION**

The Audit Committee is asked to:

**APPROVE** that the attached effectiveness review is undertaken and results and action plan reported back to the next meeting of the Committee.

| **Shaping our Future Wellbeing Strategic Objectives** | | | |
|---|---|---|---|
| 1. Reduce health inequalities | | 6. Have a planned care system where demand and capacity are in balance | |
| 2. Deliver outcomes that matter to people | x | 7. Be a great place to work and learn | x |
| 3. All take responsibility for improving our health and wellbeing | | 8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology | |

| | | | |
|---|---|---|---|
| 4. Offer services that deliver the population health our citizens are entitled to expect | | 9. Reduce harm, waste and variation sustainably making best use of the resources available to us | |
| 5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time | | 10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives | |

| **Five Ways of Working (Sustainable Development Principles) considered** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sustainable Development Principles: Five ways of working | Prevention | x | Long term | | Integration | | Collaboration | | Involvement | | |
| **Equality and Health Impact Assessment Completed:** | Not Applicable | | | | | | | | | | |

# Audit Committee – Self Evaluation 2018/19

**Key to NHS Handbook status (shown in Status column where applicable): 1=must do 2=should do 3=could do**

| | Establishment, Composition, Organisation, Resources, Duties | Status | Strong | Adequate | Needs Improvement | Comments |
|---|---|---|---|---|---|---|
| 1 | The audit committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with Welsh Government guidance and have been approved by the committee and the full board. | 1 | | | | |
| 2 | The board was active in its consideration of audit committee composition, including the designation or consideration of an "audit committee financial expert." (At least one committee member should have a financial background) | 2 | | | | |
| 3 | The audit committee's actions reflect independence from management, ethical behaviour and the best interests of the Trust and its stakeholders. | | | | | |
| 4 | The audit committee's meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings. | 2 | | | | |
| 5 | Audit committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the audit committee's responsibilities. | 2 | | | | |
| 6 | Appropriate internal or external support and resources are available to the audit committee and it has sufficient membership and authority to perform its role effectively. | 1 | | | | |
| 7 | The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees | 2 | | | | |

| | Establishment, Composition, Organisation, Resources, Duties | Status | Yes | No | Comments |
|---|---|---|---|---|---|
| 8 | Are the terms of reference reviewed annually to take into account governance developments (including integrated governance principles) and the remit of other committees within the organisation? | 2 | | | |
| 9 | Are changes to the committee's current and future workload discussed and approved at Board level? | 2 | | | |
| 10 | Are committee members independent of the management team? | 1 | | | |

| | Agenda Management, Oversight of the Financial Reporting Process, Compliance with the Law and Regulations Governing the NHS and Internal Control | Status | Strong | Adequate | Needs Improvement | Comments |
|---|---|---|---|---|---|---|
| 11 | There is appropriate consideration of the Trust's financial reporting risks and the related internal controls, which are reflected in the audit committee's discussions and agenda items. | | | | | |
| 12 | The audit committee's agenda-setting process is thorough and led by the audit committee chair. | | | | | |

| Agenda Management, Oversight of the Financial Reporting Process, Compliance with the Law and Regulations Governing the NHS and Internal Control | | Status | Yes | No | Comments |
|---|---|---|---|---|---|
| 13 | Is the Committee's role in the approval of the Annual Accounts clearly defined? | 1 | | | |
| 14 | Has the Committee established a plan for the conduct of its work across the year? | 2 | | | |
| 15 | Is a Committee meeting scheduled to discuss proposed adjustments to the Accounts and issues arising from the audit, and does the Committee annually review the accounting policies of the organisation? | 2 | | | |
| 16 | Has the committee formally considered how it integrates with other committees that are reviewing risk e.g. risk management and clinical governance? | 2 | | | |
| 17 | Has the committee formally considered how its work integrates with wider performance management and standards compliance? | 2 | | | |
| 18 | Has the committee been briefed on its assurance responsibilities with regard to internal control and risk management, particularly with regard to the Statement of Internal Control, the Assurance Framework, Standards for better Health and the Head of Internal Audit's opinion? | 2 | | | |
| 19 | Has the committee reviewed whether the reports it receives (including assurance statements from the Head of Internal Audit) are timely and have the right format and content to ensure its internal control and risk management responsibilities are discharged? | 2 | | | |
| 20 | Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge both line management and auditors on critical and sensitive matters? | 2 | | | |
| 21 | Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities? | 2 | | | |

| Oversight of the audit process | | Status | Yes | No | Comments |
|---|---|---|---|---|---|
| 22 | There is active consideration of audit plans and results of external audit? | | | | |
| 23 | There is appropriate consideration of Internal Audit's plan, resources, and ability? | | | | |
| 24 | There is appropriate consideration of Internal Audit's reports, management's response, and improvement actions? | | | | |
| 25 | Are the terms of reference for Internal Audit approved by the Committee and routinely reviewed? | 1 | | | |
| 26 | Does the Committee review and approve the internal audit plan at the beginning of the financial year? | 1 | | | |
| 27 | Does the committee approve any material changes to the Internal Audit plan? | 1 | | | |
| 28 | Does the committee effectively monitor the implementation of management actions arising from Internal Audit reports? | 2 | | | |

| Oversight of the audit process | | Status | Yes | No | Comments |
|---|---|---|---|---|---|
| 29 | Are any scope restrictions placed on Internal Audit and, if so, what are they and who establishes them? | 2 | | | |
| 30 | Does the Committee review the effectiveness of Internal Audit and the adequacy of staffing and resources within Internal Audit? | 2 | | | |
| 31 | Has the committee agreed a range of Internal Audit performance measures to be reported on a routine basis? | 3 | | | |
| 32 | Does the Committee receive and monitor actions taken in respect of prior year External Audit plans? | 2 | | | |
| 33 | Does the Committee review the External Auditor's Annual audit letter and asses the performance of the External Audit? | 1 | | | |

| Continuous Improvement | | Status | Strong | Adequate | Needs Improvement | Comments |
|---|---|---|---|---|---|---|
| 34 | The audit committee's self-evaluation process is in place and effective | 2 | | | | |

| Overall Evaluation | | Status | Strong | Adequate | Needs Improvement | Comments |
|---|---|---|---|---|---|---|
| 35 | What is your overall assessment of the performance of the Audit Committee? | | | | | |

**Additional Comments**:

Name

Position

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | Annual Review of Standing Orders and Reservation and Delegation of Powers | | | | | | | | | | |
| **Meeting:** | Audit Committee | | | | | | | **Meeting Date:** | 26.02.19 | | |
| **Status:** | **For Discussion** | x | **For Assurance** | | **For Approval** | x | **For Information** | | | | |
| **Lead Executive:** | Director of Corporate Governance | | | | | | | | | | |
| **Report Author (Title):** | Director of Corporate Governance | | | | | | | | | | |

**SITUATION**

The purpose of this report is to provide Members of the Audit Committee with the opportunity to discuss and comment on the draft revisions to the University Health Board's Standing Orders and Reservation and Delegation of Powers, prior to submission to the Board.

**REPORT**

**BACKGROUND**

Cardiff and Vale University Health Board's (UHB's) Standing Orders were last reviewed in 2015, following the issue of revised Model Standing Orders by the Welsh Government in 2014. The Model Standing Orders were to be used as a guide with amendments and adaptations being made to reflect the requirements of the individual boards. With a few exceptions, the health board's current Standing Orders reflect the Model Standing Orders issued in 2014.

As the Committee has been previously advised, the Board Secretary Peer Group agreed to review Standing Orders and the Scheme of Delegation in 2017. The outcome of this work was fed through to the Welsh Government to be considered as part of the discussions related to the White Paper *Services fit for the future - Quality and Governance in health and care in Wales.* Welsh Government are currently reviewing Standing Orders but a date for their finalisation has not been confirmed.

*Requirements for Annual Review*

Standing Order (SO) 11, as set out in the 2015 version of UHB's Standing Orders (SOs) and Reservation and Delegation of Powers, states that SOs shall be reviewed annually by the Audit Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in to the SOs, including the Terms of Reference of each of the Committees of the Board.

The Board Secretary is responsible for advising the Board of the implications of any decision to vary or amend SOs, and Section A (xxviii) makes it clear that such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers; and
- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board.

- A notice of motion under SO 6.5.14 has been given.

**ASSESSMENT**

A thorough review of the UHB's SOs has been undertaken and consideration given to the recommendations made to Welsh Government by the Board Secretary Peer Group. A copy of the draft revised SOs is provided at Appendix 1. A summary of the key amendments made and recommended to the Audit Committee for approval is provided below:

Foreword:

This has been amended to:

- Reflect the fact that when agreeing SOs LHBS must ensure that they are made in accordance with directions issued by Welsh Ministers.
- Make it clear that all supporting schedules adopted by the LHB shall be treated as though they are incorporated in to the SOs.

Section A – Introduction

*Statutory Framework*

This has been amended to reflect the following Directions, Acts, Regulations and Standards:

- The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8 (W.08)) as amended by the Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8 (W.8)).
- The Social Services and Well-being (Wales) Act 2014 (2014 anaw 4) and the Partnership Arrangements (Wales) Regulations 2015 (2015 No.1989 (W.299)), made under Part 9 of the Social Services and Well-being (Wales) Act 2014 are referenced at (xi and xiv).
- The Welsh Language (Wales) Measure 2011 (2011 nawm 1); replacing Section 5 of the Welsh language Act 1993.
- The Health and Care Standards which came into force from 1 April 2015.

*NHS framework*

This section has been amended to:

- Reference the Well-being of Future Generations (Wales) Act 2015 (2015/2).
- Replace references to the Assembly Government with Welsh Government.
- Replace the reference to Ministerial letters with Welsh Health Circulars; from 2014 WHCs replaced Ministerial letters.

*Applying Standing Orders*

In this section reference is now made to the Terms of reference of Joint Committees; these will be included in Schedule 4 of the document.

*The role of the Board Secretary*

The accountability and reporting arrangements of the Board Secretary have been updated to reflect those set out in the model Role Profile for the Board Secretary issued in 2009.

Section B – Standing Orders

*SO 1: The Local Health Board*

- Paragraph 1.1.1 has been amended to reflect arrangements for the appointment of all Board Members.

*SO 2: Reservation and Delegation of LHB Functions*

- Paragraph 2.0.3 has been updated to reflect requirements of The Social Services and Well-being (Wales) Act 2014

- 2.1 Delegation of Board functions - the wording of paragraph 2.2.1 wording has been added to reinforce that some matters cannot be delegated

*SO 3: Committees*

- 3.5.2: Joint Committees of the Board - The Emergency Ambulance Services Committee (EASC) and the NHS Wales Shared Services Partnership Committee are now referenced.

*SO4: Advisory groups*

This section has been streamlined with the wording relating to the terms on terms of reference and operating arrangements, support, advice and feedback being moved to the front of the section and not duplicated under specific advisory groups.

*SO5: Working in Partnership*

This SO has been amended to reflect the Social Services and Well-being (Wales) Act 2014 and current partnership arrangements, including Regional Partnership and Public Service Boards.

*SO6: Meetings*

- 6.1 Putting Citizens First: Now includes reference to the provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

- 6.2. Annual Plan of Board Business: Paragraph 6.2.5 has been amended to reflect revised arrangements required by Welsh Government. Under these arrangements the

UBH is required to hold an Annual General Meeting before the 31 July.

- 6.4 Preparing for Meetings:

  Paragraph 6.4.3 has been amended to confirm that Board members will be sent an Agenda and a complete set of supporting papers at least 10 clear days before a meeting. The 2015 Standing Orders referred to 7 days, which was not in compliance with Schedule 3 of The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009.

  Paragraph 6.4.4 now reflects that impact assessments need to cover a range of aspects such as Welsh language etc.

  Paragraph 6.5.2 now reinforces the requirement for committees of Board to conduct as much of their formal business in public.

- 6.6 Record of Proceedings: Paragraph 6.6.2 now references the General Data Protection Regulation 2018.

*SO 9: Gaining Assurance on the Conduct of Board Business*

Paragraphs 9.0.4 and 9.0.5 have been added to strengthen arrangements for The Welsh Health Specialised Services Committee (WHSSC) and The Emergency Ambulance Services Committee (EASC). Further, *9.3: External Assurance* has been amended following advice received from Wales Audit to better reflect the role of the Auditor General and Public Accounts Committee.

**RECOMMENDATION**

The Audit Committee is asked to:

**REVIEW** the proposed amendments to Standing Orders.
**RECOMMEND** to the Board that it adopts the proposed amendments.
**NOTE** that once they have been reviewed and agreed by the relevant Committee or Advisory Group, the Terms of Reference of each of the Board's Committees and Advisory Groups will be included in Schedule 3 and 4 of the Standing Orders.
**NOTE** work on the Scheme of Reservation and Delegation is ongoing. This will be circulate to Committee members for comment prior to submission to the Board.
**NOTE** that prior to submission to the Board, the Contents page will be updated and the Standing Orders document fully proof read.

| **Shaping our Future Wellbeing Strategic Objectives** | | | |
|---|---|---|---|
| 1. Reduce health inequalities | | 6. Have a planned care system where demand and capacity are in balance | |
| 2. Deliver outcomes that matter to people | x | 7. Be a great place to work and learn | x |
| 3. All take responsibility for improving our health and wellbeing | | 8. Work better together with partners to deliver care and support across care | |

| | | | |
|---|---|---|---|
| | | sectors, making best use of our people and technology | |
| 4. Offer services that deliver the population health our citizens are entitled to expect | | 9. Reduce harm, waste and variation sustainably making best use of the resources available to us | |
| 5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time | | 10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives | |

**Five Ways of Working (Sustainable Development Principles) considered**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sustainable Development Principles: Five ways of working | Prevention | x | Long term | | Integration | | Collaboration | | Involvement | | |
| **Equality and Health Impact Assessment Completed:** | Not Applicable | | | | | | | | | | |

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

# STANDING ORDERS RESERVATION AND DELEGATION OF POWERS

**Version ~~3~~ 4 (Draft 1): ~~April 2015 04 02~~February 2019**

**~~Note:~~** ~~Executive Responsibilities of the Director of Workforce and Organisational Development are currently being performed by the Chief Operating Officer.~~

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro yw enw gweithredol Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board is the operational name of Cardiff and Vale University Local Health Board

# Foreword

These Standing Orders are based on the Model Standing Orders ~~are~~ issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs LHBs must ensure they are made in accordance with directions issued by Welsh Ministers. ~~They~~ These SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework ~~is~~ has been developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the LHB.

All supporting schedules adopted by the LHB shall be considered to be incorporated in to these Standing Orders.

Further information on governance in the NHS in Wales may be accessed at www.wales.nhs.uk/governance-emanual/

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# Contents [the contents page will be updated when the Audit Committee have considered the draft amends]

# Section A – Introduction

**Statutory framework**

i) The Cardiff and Vale University Local Health Board (the LHB) is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778 (W.66))**, "the Establishment Order".

ii) The principal place of business is – -Cardiff and Vale University Local Health Board, Headquarters, University Hospital of Wales, Heath Park, Cardiff, CF14 4XW.

iii) All business shall be conducted in the name of Cardiff and Vale University Health Board, as the operational name of the LHB, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006 (c.42)** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006 (c.41)** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

v) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67))** ("The Constitution Regulations") which set out the constitution and membership arrangements of LHBs. Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB's statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511 (W.147)).**

vi) However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.

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vii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("the Joint Committee"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097 (W.270))** which make provision for the constitution and membership of the Joint Committee including its procedures and administrative arrangements.

vii)viii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8 (W.08))** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8 (W.8))** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee. Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566 (W.67))** which make provision for the constitution and membership of the Joint Committee including its procedures and administrative arrangements.

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viii)ix) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function.

ix)x) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

x) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993 (W.193))** made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the ~~health improvement plan of the relevant health plan~~ Area Plan developed

in accordance with the **Social Services and Well-being (Wales) Act 2014 (2014 anaw ~~/~~4).** ~~health improvement plan of the relevant health plan..~~

xi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

xii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xiii) Further duties and powers placed on health boards in relation to co-operation, partnership and pooled funds with local authorities and other partners are set out in the **Partnership Arrangements (Wales) Regulations 2015 (2015 No.1989 (W.299)),** made under Part 9 of the **Social Services and Well-being (Wales) Act 2014.**

~~xii)~~ Guidance on the provisions of Part 9 can be found at https://gov.wales/docs/dhss/publications/151218part9en.pdf

xiv) **The Welsh Language (Wales) Measure 2011 (2011 nawm 1**) makes provision with regards to the development of standards of conduct relating to the Welsh language, ~~which will~~these standards replace the requirement for~~existing system of~~ a Welsh Language Scheme~~s~~ previously provided for by Section 5 of the Welsh Language ~~1993~~ Act (c.38). The Welsh Language Standards (No.7) Regulations 2018 (2018 No. 411 (W.77)) came into force on the 29 June 2018. The Local Health Board will ensure that it has arrangements in place to meet the provisions of the compliance notice issued by the Welsh Language Commissioner under section 44 of the 2011 Measure.~~.~~

~~xiii) Section 5 of the Welsh Language Act 1993 (c.38) places a duty on public bodies to implement a Welsh Language Scheme which outlines how the LHB will comply with its statutory responsibility to provide services through the medium of Welsh. The Welsh Language (Wales) Measure 2011 (2011 nawm 1) makes provision with regards to the development of standards of conduct relating to the Welsh language which will replace the existing system of Welsh Language Schemes provided for by the 1993 Act.~~

~~xiv)~~xv) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. ~~-~~The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as otherwise provided by these SOs.

~~xv)~~xvi) LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: “A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal

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resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

**NHS framework**

~~xvi)~~xvii) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the ~~Assembly Government's~~Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that ~~is~~ are expected at all levels of the service, locally and nationally.

~~xvii)~~xviii) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xix) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; The Health and Care Standards that came into force from 1 April 2015~~the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework~~, ~~the NHS Risk and Assurance Framework,~~ and the NHS planning and performance management systems.

~~xviii)~~ The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: http://www.wales.nhs.uk/governance-emanual/values-and-standards-of-behaviour-framew

xx) The Welsh Ministers,~~;~~ reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015 (2015/2),** has stated that sustainable development should be the central organising principle for the public sector and a core objective for the ~~restructured~~ NHS in all it does.

xxi) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in

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accordance with the sustainable development principle, aimed at achieving the well-being goals.

~~xix) The Welsh Ministers, reflecting their constitutional obligations, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the restructured NHS in all it does.~~

~~xx)~~xxii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of LHB business are also issued ~~in hard copy~~electronically, usually under cover of a ~~Ministerial letter~~Welsh Health Circular.

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## Cardiff Local Health Board's Framework

~~xxi)~~xxiii) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

~~xxii)~~xxiv) The LHB~~s~~ will from time to time agree and approve policy statements which apply to its~~the LHB's~~ Board members and/or all or specific groups of staff employed by Cardiff and Vale University LHB and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.

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~~xxiii)~~xxv) LHBs shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxii below).

~~xxiv)~~xxvi) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

### Applying Standing Orders

xxvii) The SOs of the LHB (together with SFIs and the Values and Standards of Behaviour Framework), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs.* ~~.~~ *and further details on joint-Committees may be found in Schedule 4.*

~~xxv)~~

~~xxvi)~~xxviii) Full details of any ~~non-compliance~~non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any ~~non-compliance~~non-compliance to the Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

**Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

**Variation and amendment of Standing Orders**

~~xxvii)~~xxix) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 6.5.14 has been given.

**Interpretation**

~~xxviii)~~xxx) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the

Chief Executive or the Director of Finance (in the case of SFIs).

~~xxix)~~xxxi) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

**The role of the Board Secretary**

~~xxx)~~xxxii) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within LHBs, and is a key source of advice and support to the LHB Chair and other Board members. Independent of the Board, the Board Secretary acts as the guardian of good governance within the LHB:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of LHB business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

xxxiii)

~~xxxi)~~ As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities in respect of the Board, its Committees and Advisory Groups, ~~[and Chief Executive],~~ and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities. ~~The Board Secretary is directly accountable for the conduct of their role to the Chair [and Chief Executive], and reports on a day to day basis to the Chief Executive.~~

~~xxxii)~~

~~xxxiii)~~xxxiv) Further details on the role of the Board Secretary within Cardiff and Vale University LHB, including details on how to contact them, are available at http://www.cardiffandvaleuhb.wales.nhs.uk/board-members

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# Section B – Standing Orders

## 1. THE LOCAL HEALTH BOARD

1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778 (W.66)) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511 (W.147)). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

### 1.1 Membership of the Local Health Board

1.1.1 The membership of the LHB shall be no more than 20 members comprising the Chair and the Vice Chair, non officer members (~~both~~ appointed by the Minister for Health and Social Services), the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer ~~and non officer~~ members (appointed by the Board).

1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. All such members shall have full voting rights. There may also be Associate Members who do not have voting rights.

*Officer Members [to be known as Executive Directors]*

1.1.3 A total of 9 (including the Chief Executive), appointed by the Board, whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public

Health; Therapies and Health Science. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.

*Non Officer Members [to be known as Independent Members]*

1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.

*Associate Members*

1.1.5 The following Associate Members, appointed by the Minister for Health and Social Services, will attend Board meetings on an ex-officio basis, but will not have any voting rights:

- Director of Social Services (nominated by local authorities in the LHB area)
- Chair of the Stakeholder Reference Group
- Chair of the Healthcare Professionals' Forum

1.1.6 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

*Use of the term 'Independent Members'*

1.1.7 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice Chair
- Non Officer Members

unless otherwise stated.

**1.2 Joint Directors**

1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:

i Either or both persons may attend and take part in Board meetings;
ii If both are present at a meeting they shall cast one vote if they agree;
iii In the case of disagreement no vote shall be cast; and
iv The presence of both or one person will count as one person in relation to the quorum.

### 1.3 Tenure of Board members

1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year, with a maximum term of four years if re-appointed.

1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

### 1.4 The Role of the LHB Board and responsibilities of individual members

*Role*

1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through

effective challenge and scrutiny of the LHB's performance across all areas of activity.

*Responsibilities*

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting rights.

1.4.5 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.

1.4.6 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.7 The Chair shall work in close harmony with the Chief Executive and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.8 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.9 In addition to their corporate role across the breadth of the Board's

responsibilities, the Vice-Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.

1.4.10 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.11 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

## 2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i Schedule of matters reserved to the Board;
ii Scheme of delegation to committees and others; and
iii Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 Subject to Standing Order 2.0.4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf. Where LHBs have a joint duty, e.g. to produce a Health, Social Care and Well Being Strategy or for the provision of Shared/Hosted Services, the LHB remains fully

responsible for its part, and shall agree through the determination of a written Partnership Agreement the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner organisations.

2.0.4 **NHS Wales Shared Services**

***Background Information***

In 2011 the NHS bodies in Wales, together with the Welsh Assembly Government (as it then was) decided to bring together various support services functions across the NHS in Wales under a single management team as a "virtual" Shared Services entity.

In September 2011 the Welsh Ministers gave authority to proceed with the transfer of responsibility for the provision of Shared Services from the virtual model to a body hosted within NHS Wales.

Following an invitation to all NHS bodies to express an interest in becoming the host organisation, Velindre NHS Trust was confirmed as the host organisation on 22nd November 2011.

***Arrangements from 1 ~~1st~~ June 2012***

From 1 ~~st~~ June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations prescribe the membership of the Shared Services Committee in order to ensure that all LHBs and Trusts in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

The Director of Shared Services will be designated as Accountable Oo~~f~~ficer for Shared Services.

These ~~new~~ arrangements ~~also~~ necessitate putting in place a new Memorandum of Co-operation Agreement and a Hosting Agreement

between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

### 2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

### 2.2 Delegation of Board functions

2.2.1 The Board shall agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:

- i By a Committee, sub-Committee or officer of the LHB (or of another LHB or Trust); or
- ii By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
- iii Jointly with one or more bodies including local authorities through a joint-Committee, sub-Committee or joint sub-Committee.

2.2.2 The Board shall agree and formally approve the delegation of specific executive powers to be exercised by Committees, sub-Committees,

joint-Committees or joint sub-Committees which it has formally constituted.

### 2.3 Delegation to officers

2.3.1 The Board ~~will~~ may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

## 3. COMMITTEES

### 3.1 LHB Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the LHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

*Use of the term 'Committee'*

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- joint-Committee
- sub-Committee
- joint sub-Committee

unless otherwise stated. The Board's Advisory Groups are referred to separately.

### 3.2 Joint Committees

3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

### 3.3 Sub-Committees

3.3.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

### 3.4 Committees established by the LHB

3.4.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements.

3.4.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity; and
- Maximise cohesion and integration across all aspects of governance and assurance.

*Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.*

3.4.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board its Committees and Advisory Groups)
- Any budget and financial responsibility, where appropriate;;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.4.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary~~. *Detailed terms of reference and operating arrangements for the Committees established by the Board are set out in Schedule 3*~~.

3.4.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

3.4.6 Executive Directors or other LHB officers shall not normally be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate.

**3.5 Joint Committees established by the LHB**

3.5.1 The LHB has a duty to co-operate with other NHS bodies in exercising its

functions, and with local authorities in order to secure and advance the health and welfare of its citizens. To help discharge these duties and meet the Board's commitment to working in partnership, the Board may and, where directed by the Welsh Ministers must, establish joint-Committees to support it in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.

3.5.2 The Board shall establish, as a minimum, the following joint-Committee:

- The Welsh Health Specialised Services Committee (WHSSC).
- The Emergency Ambulance Services Committee (EASC).
- NHS Wales Shared Services Partnership Committee~~The Shared Services Committee~~

*Joint Committee Standing Orders, terms of reference and operating arrangements*

3.5.3 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);
- Any budget, financial and accounting responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.5.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.

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### 3.6 Other Committees

3.6.1 The Board may also establish other Committees to help the LHB in the conduct of its business.

### 3.7 Confidentiality

3.7.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

### 3.8 Reporting activity to the Board

3.8.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

## 4. ADVISORY GROUPS

4.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.

4.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*

4.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

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### 4.1 Terms of reference and operating arrangements

4.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as other relevant local and national groups);
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.1.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

4.1.3 The Board may determine that the Advisory Group shall be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

## 4.2 Support to the Advisory Groups

4.2.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see XXXX);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within

the Advisory Group accords with the governance and operating framework it has set.

~~4.0.3~~

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~~4.1~~4.3 **Confidentiality**

4.3.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

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## 4.4 Advice and feedback

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4.4.1 The LHB may specifically request advice and feedback from the Advisory Groups on any aspect of its business, and they may also offer advice and feedback even if not specifically requested by the LHB. The Groups may may provide advice to the Board:

- At Board meetings, through the SRG and HPF Chair's participation as Associate Members;
- In written advice;
- In any other form specified by the Board.

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~~4.2~~4.5 **Reporting activity**

~~4.2.1~~4.5.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

~~4.2.2~~4.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

~~4.2.3~~4.5.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

~~4.3~~4.6 **THE STAKEHOLDER REFERENCE GROUP (SRG)**

*Role*

~~4.3.1~~4.6.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:

- Early engagement and involvement in the determination of the LHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB's operations on the communities it serves.

~~4.3.2~~4.6.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

~~4.3.3~~4.6.3 The SRG's role is distinctive from that of Community Health Councils (CHCs), who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

~~4.3.4~~4.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

~~4.3.5~~4.6.5 The LHB may specifically request advice and feedback from the SRG on any aspect of its business, and the SRG may also offer advice and feedback even if not specifically requested by the LHB. The SRG may provide advice to the Board:

- At Board meetings, through the SRG Chair's participation as Associate Member;
- In written advice; and
- In any other form specified by the Board.

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## 4.7 Terms of reference and operating arrangements

4.7.1 In addition to the provisions in XXXX above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

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## ~~4.4 Terms of reference and operating arrangements~~

~~4.4.1 The Board must formally approve terms of reference and operating~~

~~arrangements for the SRG. These must establish its governance and ways of working, setting out, as a minimum:~~

- ~~The scope of its work (including its purpose and any delegated powers and authority);~~
- ~~Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;~~
- ~~Meeting arrangements;~~
- ~~Communications;~~
- ~~Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as community partnerships such as Local Service Boards;~~
- ~~Any budget and financial responsibility;~~
- ~~Secretariat and other support;~~
- ~~Training, development and performance; and~~
- ~~Reporting and assurance arrangements.~~

~~4.4.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the SRG, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.~~

~~4.4.3 The Board may determine that the SRG shall be supported by sub-groups to assist it in the conduct of its work, or the SRG may itself determine such arrangements, provided that the Board approves such action.~~

### ~~4.5~~4.8 Membership

~~4.5.1~~4.8.1 The membership of the SRG, including the approval of nominations to the Group; the appointment of Chair and Vice Chair; definition of member roles, powers and terms and conditions of appointment (including remuneration and reimbursement) will be determined by the Board, taking account of the views of its stakeholders.

~~4.5.2~~4.8.2 There shall be no minimum or maximum requirement in terms of membership size. In determining the number of members, the Board shall take account of the need to ensure the SRG's size is optimal to ensure focused and inclusive activity.

~~4.5.3~~4.8.3 Membership must be drawn from within the area served by LHB, and shall ensure involvement from a range of bodies and groups operating within the communities serviced by the LHB. Where the Board determines it appropriate, the LHB may extend membership to individuals in order to represent a key stakeholder group where there are not already formal bodies or groups established or operating within the area and who may

represent the interests of these stakeholders on the SRG.

4.5.44.8.4 In determining the overall size and composition of the SRG, the Board must take account of the:

- Demography of the areas served by the LHB;
- Need to encourage and reflect the diversity of the locality, to incorporate different ages, race, religion and beliefs, sexual orientation, gender, including transgender, disability and socio-economic status. Where appropriate, the LHB shall support positive action to increase representation;
- Balance needed in both the range of difference stakeholders and the geographical areas covered, taking particular care to avoid domination by any particular stakeholder type or geographical area;
- Design and operation of the partnership/stakeholder fora already influencing the work of the LHB at local community levels;
- Need to complement, and not duplicate the work of CHCs; and
- Need to guard against the over involvement of particular stakeholders through their roles across the range of partnership/stakeholder arrangements in place.

4.5.54.8.5 The Board shall keep under review the size and composition of the SRG to ensure it continues to reflect an appropriate balance in stakeholder representation.

4.64.9 **Member Responsibilities and Accountability:**

*The Chair*

4.6.14.9.1 The Chair is responsible for the effective operation of the SRG:

- Chairing Group meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating arrangements; and
- Developing positive and professional relationships amongst the Group's membership and between the Group and the LHB's Board and its Chair and Chief Executive.

4.6.24.9.2 The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Group in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

~~4.6.3~~4.9.3 As Chair of the SRG, they will be appointed as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

*The Vice Chair*

~~4.6.4~~4.9.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

~~4.6.5~~4.9.5 The Vice Chair is accountable, through the SRG Chair to the LHB Board, for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the SRG.

*Members*

~~4.6.6~~4.9.6 The SRG shall function as a coherent Advisory Body, all members being full and equal members and sharing responsibility for the decisions of the SRG.

~~4.6.7~~4.9.7 All members must:

- Be prepared to engage with and contribute fully to the SRG's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the SRG within the communities it represents.

~~4.6.8~~4.9.8 SRG members are accountable, through the SRG Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the SRG.

**~~4.7~~4.10 Appointment and terms of office**

~~4.7.1~~4.10.1 Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder

group where it has determined that formal bodies or groups are not already established or operating within the area that may represent the interests of these stakeholders on the SRG.

4.10.2 The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Welsh Ministers. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment.;

4.7.24.10.3 The Board Secretary, on behalf of the Chair of the LHB, will oversee the process of nomination and appointment to the SRG.

4.7.34.10.4 Members shall be appointed for a period specified by the Board, but for no longer than 3 years in any one term. Those members can be reappointed but may not serve a total period of more than 5 years consecutively. The Board may, where it considers it appropriate, make interim or short term appointments to the SRG to fulfil a particular purpose or need.

4.7.44.10.5 The ***Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the LHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

4.7.54.10.6 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

4.7.64.10.7 The ***Vice Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the LHB Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the SRG Chair's absence, the Vice Chair shall also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of

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the conditions of appointment for Associate Members set out in the Regulations.

4.7.74.10.8 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.

4.7.84.10.9 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.

4.7.94.10.10 The LHB will require SRG members to confirm in writing their continued eligibility on an annual basis.

**4.84.11 Resignation, suspension and removal of members**

4.8.14.11.1 A member of the SRG may resign office at any time during the period of appointment by giving notice in writing to the SRG Chair and the Board.

4.8.24.11.2 If the Board, having consulted with the SRG Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the SRG that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the SRG

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

4.8.34.11.3 A nominating body or group may request the removal of a member appointed to the SRG to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

4.8.44.11.4 If an SRG member fails to attend any meeting of the Group for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

i The absence was due to a reasonable cause; and
ii The person will be able to attend such meetings within such period

as the Board considers reasonable.

4.8.54.11.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

**4.94.12 Relationship with the Board**

4.9.14.12.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

4.9.24.12.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

4.9.34.12.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

4.9.44.12.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation

**4.104.13 Relationship between the SRG and others**

4.10.14.13.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., ~~Local Service Boards.~~Regional Partnership Boards.

**4.114.14 Working with Community Health Councils**

4.11.14.14.1 The SRG shall make arrangements to ensure designated CHC

members receive the SRG's papers and are invited to attend SRG meetings.

4.11.24.14.2 The SRG shall work together with CHCs within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

~~**4.12 Support to the SRG**~~

~~4.12.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the SRG is properly equipped to carry out its role by:~~

- ~~Overseeing the process of nomination and appointment to the SRG;~~
- ~~Co-ordinating and facilitating appropriate induction and organisational development activity;~~
- ~~Ensuring the provision of governance advice and support to the SRG Chair on the conduct of its business and its relationship with the LHB and others;~~
- ~~Ensuring the provision of secretariat support for SRG meetings;~~
- ~~Ensuring that the SRG receives the information it needs on a timely basis;~~
- ~~Ensuring strong links to communities/groups; and~~
- ~~Facilitating effective reporting to the Board~~

~~enabling the Board to gain assurance that the conduct of business within the SRG accords with the governance and operating framework it has set.~~

**~~4.13~~4.15 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)**

*Role*

~~4.13.1~~4.15.1 The HPF's role is to provide a balanced, multi disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.

~~4.13.2~~4.15.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

~~4.13.3~~4.15.3 The LHB may specifically request advice and feedback from the HPF on any aspect of its business, and the HPF may also offer advice and feedback even if not specifically requested by the LHB. The HPF may provide advice to the Board:

- At Board meetings, through the HPF Chair's participation as Associate Member;
- In written advice; and
- In any other form specified by the Board.

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## 4.16 Terms of reference and operating arrangements

5.13.1 In addition to the provisions in XXXX above the ~~The~~ Board must ~~formally approve terms of reference and operating arrangements for the HPF. These must establish its governance and ways of working, setting~~ out, ~~as a minimum~~ the relationships and accountabilities with others, as well as the National Professional Advisory Group. ~~:~~

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~~**4.14 Terms of reference and operating arrangements**~~

~~4.14.1 The Board must formally approve terms of reference and operating arrangements for the HPF. These must establish its governance and ways of working, setting out, as a minimum:~~

- ~~The scope of its work (including its purpose and any delegated powers and authority);~~
- ~~Membership (including member appointment and removal, role, responsibilities and accountability, and terms and conditions of office) and quorum;~~
- ~~Meeting arrangements;~~
- ~~Communications;~~
- ~~Relationships and accountabilities with others, (including the LHB Board, its Committees and Advisory Groups) as well as the National Professional Advisory Group;~~
- ~~Any budget and financial responsibility;~~
- ~~Secretariat and other support;~~
- ~~Training, development and performance; and~~
- ~~Reporting and assurance arrangements~~

~~4.14.2 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the HPF, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.~~

~~4.14.3 The Board may determine that the HPF shall be supported by a range of sub-fora to assist it in the conduct of its work, e.g., special interest groups, or the HPF may itself determine such arrangements, provided that the Board approves such action.~~

**~~4.15~~4.17 Membership**

~~4.15.1~~4.17.1 The membership of the HPF reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the HPF shall therefore comprise the following eleven (11) members, as a minimum:

- Welsh Medical Committee
  - Primary and Community Care Medical representative
  - Mental Health Medical representative
  - Specialist and Tertiary Care medical representative
- Welsh Nursing and Midwifery Committee
  - Community Nursing and Midwifery representative
  - Hospital Nursing and Midwifery representative
- Welsh Therapies Advisory Committee
  - Therapies representative
- Welsh Scientific Advisory Committee
  - Scientific representative
- Welsh Optometric Committee
  - Optometry representative
- Welsh Dental Committee
  - Dental representative
- Welsh Pharmaceutical Committee
  - Hospital Pharmacists representative
  - Community Pharmacists representative

~~4.15.2~~4.17.2 Where the Board determines it appropriate, the LHB may extend membership to other individuals in order to ensure an appropriate balance in representation amongst healthcare professional groupings and across the range of primary, community and secondary service provision.

**~~4.16~~4.18 Member Responsibilities and Accountability:**

*The Chair*

~~4.16.1~~4.18.1 The Chair is responsible for the effective operation of the HPF:

- Chairing meetings;
- Establishing and ensuring adherence to the standards of good

governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating arrangements; and

- Developing positive and professional relationships amongst the HPF's membership and between the HPF and the LHB's Board, and in particular its Chair, Chief Executive and clinical Directors.

~~4.16.2~~4.18.2 The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the HPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

~~4.16.3~~4.18.3 As Chair of the HPF, they will be appointed as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

*The Vice Chair*

~~4.16.4~~4.18.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

~~4.16.5~~4.18.5 The Vice Chair is accountable through the HPF Chair to the LHB Board for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the HPF.

*Members*

~~4.16.6~~4.18.6 The HPF shall function as a coherent advisory group, all members being full and equal members and sharing responsibility for the decisions of the HPF.

~~4.16.7~~4.18.7 All members must:

- Be prepared to engage with and contribute fully to the HPF's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational

development programmes; and
- Promote the work of the HPF within the healthcare professional discipline they represent.

~~4.16.8~~4.18.8 Forum members are accountable through the HPF Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the HPF.

**~~4.17~~4.19 Appointment and terms of office**

~~4.17.1~~4.19.1 Appointments to the HPF shall be made by the Board, based upon nominations received from the relevant healthcare professional group, and in accordance with any specific requirements or directions made by the Welsh Ministers. Members shall be appointed for a period specified by the Board, but for no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively.

~~4.17.2~~4.19.2 The ***Chair*** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination will be subject to consideration by the Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. Their appointment as Chair will be made by the Minister, but it will not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

~~4.17.3~~4.19.3 The Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Chair has ended.

~~4.17.4~~4.19.4 The ***Vice Chair*** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to the condition that they be appointed from a different healthcare discipline to that of the Chair, along with any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the HPF Chair's absence, the Vice Chair will also perform the role of Associate Member on the LHB Board. The

appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

~~4.17.5~~4.19.5 The Vice Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Vice Chair has ended.

~~4.17.6~~4.19.6 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the HPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The HPF Chair will advise the Board in writing of any such cases immediately.

~~4.17.7~~4.19.7 The LHB will require Forum members to confirm in writing their continued eligibility on an annual basis.

**~~4.18~~4.20 Resignation, suspension and removal of members**

~~4.18.1~~4.20.1 A member of the HPF may resign office at any time during the period of appointment by giving notice in writing to the HPF Chair and the Board.

~~4.18.2~~4.20.2 If the Board, having consulted with the HPF Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the HPF that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the HPF

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

~~4.18.3~~4.20.3 A nominating body or group may request the removal of a member appointed to the HPF to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

~~4.18.4~~4.20.4 If a member fails to attend any meeting of the HPF for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

i The absence was due to a reasonable cause; and

ii The person will be able to attend such meetings within such period as the Board considers reasonable.

4.18.54.20.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

**4.194.21 Relationship with the Board**

4.19.14.21.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.

4.19.24.21.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

4.19.34.21.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

4.19.44.21.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

**4.204.22 Rights of Access to the LHB Board for Professional Groups**

4.20.14.22.1 The LHB Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

i Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or
ii Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

4.20.24.22.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 6.5.7.

**4.214.23 Relationship with the National Professional Advisory Group**

4.21.14.23.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group.

**4.22 Support to the HPF**

4.22.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the HPF is properly equipped to carry out its role by:

- co-ordinating and facilitating any appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the HPF Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Forum meetings;
- Ensuring that the HPF receives the information it needs on a timely basis; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the HPF accords with the governance and operating framework it has set.

## 4.234.24 THE LOCAL PARTNERSHIP FORUM (LPF)

*Role*

4.23.14.24.1 The LPF's role is to provide a formal mechanism where the LHB, as employer, and trade unions/professional bodies representing LHB employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the LHB - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the LHB's workforce.

4.23.24.24.2 It is the forum where the LHB and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

4.23.3 The LHB may specifically request advice and feedback from the LPF on any aspect of its business, and the LPF may also offer advice and feedback even if not specifically requested by the LHB. The LPF may provide advice to the Board:

- In written advice; or
- In any other form specified by the Board.

~~**4.24 Terms of reference and operating arrangements**~~

~~4.24.1 The Board must formally approve terms of reference and operating arrangements for the LPF. These must establish its governance and ways of working, setting out, as a minimum:~~

- ~~The scope of its work (including its purpose and any delegated powers and authority);~~
- ~~Membership (including member appointment and removal, role, responsibilities and accountability, and terms and conditions of office);~~
- ~~Meeting arrangements;~~
- ~~Communications;~~
- ~~Relationships and accountabilities with others (including the LHB Board, its Committees and Advisory Groups, and other relevant local and national groups);~~
- ~~Any budget and financial responsibility (where appropriate);~~
- ~~Secretariat and other support; and~~
- ~~Reporting and assurance arrangements.~~

~~4.24.2 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the LPF, keeping any such aspects to the minimum necessary. The LPF will also operate in accordance with the TUC six principles of partnership working. The detailed terms of reference and operating arrangements are set out in Schedule 5.1.~~

~~4.24.3 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:~~

- ~~Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas; and/or~~
- ~~Detailed discussion in relation to a specific issue(s).~~

**4.25 Membership**

4.25.1 The LHB shall agree the overall size and composition of the LPF in consultation with those staff organisations it recognises for collective bargaining. As a minimum, the membership of the LPF shall comprise:

*Management Representatives*

- LHB Chief Executive
- Executive Director of Finance
- Executive Director of Workforce and Organisational Development

together with the following

- Clinical Board~~s~~ Members and Operational Managers as outlined within the Terms of Reference
- Workforce and Organisational Development staff (as outlined within the Terms of Reference).

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4.25.2 The LHB may determine that other Executive Directors or others may act as members or be co-opted to the LPF.

*Staff Representatives*

4.25.3 The maximum number of staff representatives comprising representation from those staff organisations recognised by the LHB shall be decided using an agree formula.

*In attendance*

4.25.4 The Trade Union member of the LHB Board shall attend LPF meetings in an ex officio capacity.

4.25.5 The LPF may determine that full time officers from those staff organisations recognised by the LHB shall be invited to attend LPF meetings

**4.26 Member Responsibilities and Accountability**

*Joint Chairs*

4.26.1 The LPF shall have two Chairs on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

4.26.2 The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff Representative and Management Representative Chairs;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework; and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the LHB's

Board.

4.26.3 The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the LHB's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

4.26.4 The Chairs are accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

*Joint Vice Chairs*

4.26.5 The LPF shall have two Vice Chairs, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

4.26.6 Each Vice Chair shall deputise for their Chair in that Chairs absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

4.26.7 The Vice Chair is accountable to their Chair for their performance as Vice Chair.

*Members*

4.26.8 All members of the LPF are full and equal members and collectively share responsibility for its decisions.

4.26.9 All members must:

- Be prepared to engage with and contribute to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the LPF within the professional discipline they represent.

**4.27 Appointment and terms of office**

4.27.1 Management representative members shall be determined by the LHB

Board.

4.27.2 Staff representatives shall be determined by the staff organisations recognised by the LHB, subject to the following conditions:

- Staff representatives must be employed by the LHB and accredited by their respective trade union; and
- A member's tenure of appointment will cease in the event that they are no longer employed by the LHB or cease to be a member of their nominating trade union.

4.27.3 The *Management Representative Chair* shall be appointed by the LHB Board.

4.27.4 The *Staff Representative Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Chair's* term of office shall be for one (1) year.

4.27.5 The *Management Representative Vice Chair* shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

4.27.6 The *Staff Representative Vice Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Vice Chair's* term of office shall be for one (1) year.

4.27.7 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

**4.28 Removal, suspension and replacement of members**

4.28.1 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from office unless they are satisfied that:

(a) The absence was due to a reasonable cause; and

(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

4.28.2 If the LPF considers that it is not conducive to its effective operation that a

person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

4.28.3 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

4.28.4 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

**4.29 Relationship with the Board and others**

4.29.1 The LPF's main link with the Board is through the Executive members of the LPF.

4.29.2 The Board may determine that designated Board members or LHB staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

4.29.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.

4.29.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

4.29.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

**4.30 Support to the LPF**

4.30.1 The LPF's work shall be supported by two designated Secretary's, one of whom shall support the staff representative members and one shall support the management representative members.

4.30.2 The Director of Workforce and OD will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

4.30.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representatives. The Staff Representative Secretary's term of office shall be for two (2) years.

4.30.4 Both Secretaries shall work closely with the LHB's Board Secretary who is responsible for the overall planning and co-ordination of the LHB's programme of Board business, including that of its Committees and Advisory Groups.

## 5. WORKING IN PARTNERSHIP

5.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social carethe best possible healthcarethe best possible healthcare for its citizens. This will be delivered, in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of population assessments and Aarea Pplans.

5.0.1 **Health, Social Care and Well Being Strategies.**

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5.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:

- The LHB's own structures and operating arrangements, e.g., Advisory Groups; and
- The involvement (at very local and community wide levels) in partnerships and community groups – such as such as Local ServiceRegional Partnership and Public Service Boards Local Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.

5.0.3 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

## 5.1 Community Health Councils (CHCs)

5.1.1 The **Community Health Councils Regulations 2004** (S.I. 2004/905 (W.89)) (as amended by the **Community Health Councils (Amendment) Regulations 2005** (S.I. 2005/603 W.51)) (to the extent they are still in force), the **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288 (W.37)) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289 (W.38)) place a range of duties on LHBs in relation to the engagement and involvement of CHCs in its operations.

5.1.2 In discharging these duties, the Board shall work constructively with the CHCs working jointly within the LHB's area by ensuring their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for changes in the way in which those services are provided; and
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for

and formally consulting with those CHCs working jointly within the LHB's area on any proposals for substantial development of the services it is responsible for.

5.1.3 The Board shall ensure that each relevant CHC is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

*Relationship with the Board*

5.1.4 The Board may determine that designated CHC members shall be invited to attend Board meetings.

5.1.5 The Board shall make arrangements for regular joint meetings between the CHC members and the Board, to be held not less than once every three calendar months and ensuring attendance of at least one third of the Board's members.

5.1.6 The Board's Chair shall put in place arrangements to meet with the relevant CHC Chair(s) on a regular basis to discuss matters of common interest.

## 6. MEETINGS

### 6.1 Putting Citizens first

6.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;
- Requesting that attendees notify the LHB of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011 (2011 nawm 1). ~~Welsh language requirements.~~

6.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the communities served by the LHB, including any views expressed formally to the LHB, e.g., through the SRG or CHCs.

### 6.2 Annual Plan of Board Business

6.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

6.2.2 The plan shall set out the arrangements in place to enable the LHB to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh

languages, where appropriate.

6.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

6.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be included as a schedule to these SOs [see Schedule 6].

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*Annual General Meeting (AGM)*

6.2.5 The LHB must hold an AGM in public no later than the ~~30th September~~31 July each year. Public notice of the intention to hold the AGM shall be given at least ~~10~~ 14 clear days prior to the meeting, and this notice shall also be made available through community and partnership networks to maximise opportunities for attendance. The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others, such as the LHB's annual Equality Report. A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

**6.3 Calling Meetings**

6.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

6.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

**6.4 Preparing for Meetings**

*Setting the agenda*

6.4.1 The Chair, in consultation with the Chief Executive and Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

6.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

*Notifying and equipping Board members*

6.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 10 clear~~7~~ days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

6.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. ~~Equality I~~impact assessments ~~(EIA),~~ shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that ~~EIA~~ assessment shall accompany the report to the Board to enable the Board to make an informed decision.

6.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

*Notifying the public and others*

6.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 clear days before each meeting of the Board a public notice of the time

and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- ~~At the LHB's principal sites;~~
- On the LHB's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the LHB's communication strategy.

6.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

### 6.5 Conducting Board Meetings

*Admission of the public, the press and other observers*

6.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility ~~such as an induction loop system~~.

6.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> 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 in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

6.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

6.5.4 The Board Secretary, on behalf of the Chair, shall keep under review the

nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

*Addressing the Board, its Committees and Advisory Groups*

6.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the LHB, (whether directly or through the activities of bodies such as CHCs and the LHB's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

*Chairing Board Meetings*

6.5.8 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

6.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

*Quorum*

6.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.

6.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

6.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

*Dealing with motions*

6.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

6.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the

meeting as an additional item to be included on the agenda.

6.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

6.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

6.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

6.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

6.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

6.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

*Voting*

6.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Board.

6.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the community and healthcare professionals within the LHB's area. Such views will usually be presented to the Board through the Chairs of the LHB's Advisory Groups and the CHC representative(s).

6.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

6.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

**6.6 Record of Proceedings**

6.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act ~~1998~~2018, the General Data Protection Regulation 2018 and the LHB's Communication Strategy and Welsh language requirements.

## 6.7 Confidentiality

6.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework or legislation such as the Freedom of Information Act 2000, etc.

# 7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board will form part of these SOs.

## 7.1 Declaring and recording Board members' interests

7.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the Constitution Regulations. Board members must notify the Board of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

7.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

7.1.3 ***Register of interests –*** The Chief Executive, through the Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

7.1.4 The register will be held by the Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the Board's commitment to openness and transparency the Board Secretary must take reasonable steps to ensure that the citizens served by the LHB are made aware of, and have access to view the LHB's Register of Interests. This may include publication on the LHB website. The LHB's Register of Interest can be accessed via:

http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Live%20register%2005-02-2015%20-%20publishing%20v2.pdf

7.1.6 ***Publication of declared interests in Annual Report*** – **Board members'** directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the LHB's Annual Report.

**7.2 Dealing with Members' interests during Board meetings**

7.2.1 The Chair, advised by the Board Secretary, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the LHB and the NHS in Wales.

7.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

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7.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

i The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

ii The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;

iii The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;

iv The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

7.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice-Chair, on behalf of the Board.

7.2.6 In all cases the decision of the Chair (or the Vice-Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

7.2.8 The Constitution Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

7.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a LHB Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Board Secretary.

**7.3 Dealing with officers' interests**

7.3.1 The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of LHB officers' interests in accordance with the Values and Standards of Behaviour Framework.

**7.4 Reviewing how Interests are handled**

7.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

**7.5 Dealing with offers of gifts[2] and hospitality**

7.5.1 The Values and Standards of Behaviour Framework adopted by the Board prohibits Board members and LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a

[2] The term gift refers also to any reward or benefit.

family member of a Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

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- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, ~~and sport,~~ cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

7.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

~~7.5.4~~

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## 7.6 Register of Gifts and Hospitality

7.6.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts and Hospitality to record offers of gifts and hospitality made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.

7.6.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts and hospitality, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts and hospitality are kept under active review, taking appropriate action where necessary.

7.6.3 When determining what should be included in the Register, individuals shall apply the following principles, subject to the considerations in Standing Order 7.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

7.6.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the LHB ;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.6.5 The Board Secretary will arrange for a full report of all offers of Gifts and Hospitality recorded by the LHB to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review

[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts and hospitality.

## 8. SIGNING AND SEALING DOCUMENTS

8.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board or Committee of the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

8.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

### 8.1 Register of Sealing

8.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

### 8.2 Signature of Documents

8.2.1 Where a signature is required for any document connected with legal proceedings involving the LHB, it shall normally be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

8.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the LHB any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

### 8.3 Custody of Seal

8.3.1 The Common Seal of the LHB shall be kept securely by the Board Secretary.

## 9. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

9.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

9.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

9.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

~~9.0.3~~

9.0.4 Assurances in respect of the functions discharged by WHSSC and EASC shall achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.5 above regarding the governance arrangements which should be agreed for each of the Joint Committees.

9.0.5 Arrangements for seeking and providing assurance is respect of any other services provided on behalf of or in association with the LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

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### 9.1 The role of Internal Audit in providing independent internal assurance

9.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

9.1.2 The Board shall set out the relationship between the Head of Internal Audit

(HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

### 9.2 Reviewing the performance of the Board, its Committees and Advisory Groups

9.2.1 The Board shall introduce a process of regular and rigorous self assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

9.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

9.2.3 The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the ~~Assembly~~ Welsh Government's Citizen Centred Governance Principles.

### 9.3 External Assurance

9.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the ~~Wales Audit Office~~Auditor General for Wales and Healthcare Inspectorate Wales.

9.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that

external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

9.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB implements any recommendations relevant to its business made by the National Assembly for Wales's ~~Audit Committee, the~~ Public Accounts Committee ~~or~~ and other appropriate bodies.

9.3.4 The LHB shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities under section 145 of and paragraph 17 to Schedule 8 of the Government of Wales Act 2006 (c.42).

## 10. DEMONSTRATING ACCOUNTABILITY

10.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the communities it serves and other stakeholders, including its officers and healthcare professionals.

10.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their community and other partners.

10.0.3 The Board shall also facilitate effective scrutiny of the LHB's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

10.0.4 The Board shall ensure that within the LHB, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

## 11. REVIEW OF STANDING ORDERS

11.0.1 The Board Secretary has arranged for ~~an equality~~ apprpriate impact

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assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board. The results of which were presented to the Board for consideration and action, as appropriate. ~~The Equality Impact Assessment (EIA) was undertaken when SOs were reviewed in May 2013. The EIA can be accessed via:~~

~~http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/EQIAs%20SO.pdf~~

11.0.2 These SOs shall be reviewed annually by the Audit Committee ~~[or equivalent]~~, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the equality impact assessment.

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# Schedule 1

## MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

**This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders**

# MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

**Introduction**

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

i) A Committee, e.g., Quality, Safety and Experience Committee

ii) A sub-Committee, e.g., the Equality, Diversity and Human Right sub-Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;

iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs established to take forward matters relating to specialist services; and

iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any ese terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the LHB.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the LHB's SOs.

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## DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs
- The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management
- Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility
- The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development
- The Board must take appropriate action to assure itself that all matters delegated are effectively carried out
- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes
- Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others
- The Board may delegate authority to act, but retains overall responsibility and accountability
- When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

## HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

### The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

### The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

### The Board Secretary

The Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of LHB functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

**The Audit Committee**

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

**Individuals to who powers have been delegated**

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the LHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary of their concern as soon as possible so that an appropriate and timely decision may be made on the matter.

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In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

## SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the LHB.

~~The Detailed Scheme of Delegation and Earned Autonomy Framework which captures the system of internal control can be accessed via:~~

~~(Insert Link to document)~~

## SCHEDULE OF MATTERS RESERVED TO THE BOARD[4]

| THE BOARD | | AREA | DECISIONS RESERVED TO THE BOARD |
|---|---|---|---|
| 1 | FULL | GENERAL | The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs[5] |
| 2 | FULL | GENERAL | The Board must determine any matter that will be reserved to the whole Board. These are: *Set out in sections 3-42 below;* |
| 3 | FULL | OPERATING ARRANGEMENTS | Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the LHB, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges |

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[4] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Assembly Government requirements

[5] Except for those decisions delegated to the Welsh Health Specialised Services Committee (WHSSC)

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| 4 | FULL | OPERATING ARRANGEMENTS | Approve, vary and amend:<br><br>▪ SOs;<br>▪ SFIs;<br>▪ Schedule of matters reserved to the LHB;<br>▪ Scheme of delegation to Committees and others; and<br>▪ Scheme of delegation to officers (The Detailed Scheme of Delegation and Earned Autonomy Framework).<br><br>In accordance with any directions set by the Welsh Ministers. |
| 5 | FULL | OPERATING ARRANGEMENTS | Approve the LHB's Values and Standards of Behaviour framework |
| 6 | FULL | OPERATING ARRANGEMENTS | Approve the LHB's framework for performance management, risk and assurance |
| 7 | FULL | OPERATING ARRANGEMENTS | Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities |
| 8 | FULL | OPERATING ARRANGEMENTS | Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements |
| 9 | FULL | OPERATING ARRANGEMENTS | Ratify in public session any instances of failure to comply with SOs |

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| 10 | FULL | OPERATING ARRANGEMENTS | Approve arrangements relating to the discharge of the LHB's responsibility as a bailee for patients' property |
| 11 | FULL | OPERATING ARRANGEMENTS | Approve policies for dealing with complaints and incidents |
| 12 | FULL | OPERATING ARRANGEMENTS | Approve individual compensation payments in line with SFIs |
| 13 | FULL | OPERATING ARRANGEMENTS | Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers |
| 14 | FULL | OPERATING ARRANGEMENTS | Approve proposals for action on litigation on behalf of the LHB |
| 15 | FULL | OPERATING ARRANGEMENTS | Authorise use of the LHB's official seal |
| 16 | FULL | ORGANISATION STRUCTURE & STAFFING | Ratify appointment and manage appraisal, discipline and dismissal of the Chief Executive |
| 17 | FULL | ORGANISATION STRUCTURE & STAFFING | Approve the appointment, appraisal, discipline and dismissal of the Executive Directors and any other Board level appointments, e.g., the Board Secretary |
| 18 | FULL | ORGANISATION STRUCTURE & STAFFING | Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee |
| 19 | FULL | ORGANISATION STRUCTURE & STAFFING | Approve, [arrange the] review, and revise the LHB's top level organisation structure and corporate policies |

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| 20 | FULL | ORGANISATION STRUCTURE & STAFFING | Appoint, [arrange the] review, revise and dismiss LHB Committees, including any joint-Committees directly accountable to the Board |
| 21 | FULL | ORGANISATION STRUCTURE & STAFFING | Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up by the Board |
| 22 | FULL | ORGANISATION STRUCTURE & STAFFING | Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups |
| 23 | FULL | ORGANISATION STRUCTURE & STAFFING | Approve the terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board |
| 24 | FULL | ORGANISATION STRUCTURE & STAFFING | Approve the arrangements relating to the discharge of the LHB's responsibilities as a corporate trustee for funds held on trust |
| 25 | FULL | STRATEGY & PLANNING | Determine the LHB's strategic aims, objectives and priorities |
| 26 | FULL | STRATEGY & PLANNING | Approve the LHB's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan |
| 27 | FULL | STRATEGY & PLANNING | Approve the LHB's Risk Management Strategy and plans |
| 28 | FULL | STRATEGY & PLANNING | Approve the LHB's citizen engagement and involvement strategy, including communication |

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| 29 | FULL | STRATEGY & PLANNING | Approve the LHB's partnership and stakeholder engagement and involvement strategies |
| 30 | FULL | STRATEGY & PLANNING | Approve the LHB's key strategies and programmes related to:<br>▪ Population Health Needs Assessment and Commissioning Plan<br>▪ The development and delivery of patient centred clinical services for their population<br>▪ Improving quality and patient safety outcomes<br>▪ Workforce and Organisational Development<br>▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)<br>▪ |
| 31 | FULL | STRATEGY & PLANNING | Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure) |
| 32 | FULL | STRATEGY & PLANNING | Approve new contracts for the LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the LHB's population Services |
| 33 | FULL | STRATEGY & PLANNING | Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions |
| 34 | FULL | PERFORMANCE & ASSURANCE | Approve the LHB's audit and assurance arrangements |
| 35 | FULL | PERFORMANCE & ASSURANCE | Receive reports from the LHB's Executive on progress and performance in the delivery of the LHB's strategic aims, objectives and priorities and approve action required, including improvement plans |
| 36 | FULL | PERFORMANCE & ASSURANCE | Receive reports from the LHB's Committees, groups and other internal sources on the LHB's performance and approve action required, including improvement plans |

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| 37 | FULL | PERFORMANCE & ASSURANCE | Receive reports on the LHB's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc) that raise issue or concerns impacting on the LHB's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate) |
| 38 | FULL | PERFORMANCE & ASSURANCE | Receive the annual opinion of the LHB's Chief Internal Auditor and approve action required, including improvement plans |
| 39 | FULL | PERFORMANCE & ASSURANCE | Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans |
| 40 | FULL | PERFORMANCE & ASSURANCE | Receive the annual opinion on the LHB's performance against *Doing Well, Doing Better: Standards for Health Services in* Wales (formally the Healthcare Standards) and approve action required, including improvement plans |
| 41 | FULL | REPORTING | Approve the LHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Assembly Government |
| 42 | FULL | REPORTING | Receive, approve and ensure the publication of LHB reports, including its Annual Report and annual financial accounts |

| **ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS** | |
|---|---|
| CHAIR | Chair of Remuneration and Terms of Service Committee<br>Chair of Integrated Health and Social Care Board<br>Chair of Spiritual Care Group<br>Public and Patient Involvement Champion (jointly with Chief Executive) |
| VICE CHAIR | Chair of Mental Health Legislation Committee<br>Chair of People, Performance and Delivery Committee<br>Member of Remuneration and Terms of Service Committee<br>Mental Health Champion |

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| ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS | |
|---|---|
| INDEPENDENT MEMBER – FINANCE | Chair of Audit Committee<br>Member of Quality, Safety and Experience Committee<br>Member of People, Performance and Delivery Committee<br>Member of Remuneration and Terms of Service Committee |
| INDEPENDENT MEMBER - INFORMATION COMMUNICATION & TECHNOLOGY | Member of People, Performance and Delivery Committee<br>Caldicott/Data Protection Champion (jointly with Medical Director)<br>Chair of the Information Governance sub-Committee and the Information Management and Technology sub-Committee |
| INDEPENDENT MEMBER – UNIVERSITY | Chair of Quality, Safety and Experience Committee<br>Member of Audit Committee<br>Patient Safety (Cleaning, Hygiene and Infection Management) Champion |
| INDEPENDENT MEMBER - THIRD (VOLUNTARY) SECTOR | Member of Quality, Safety and Experience Committee<br>Member of Mental Health Legislation Committee<br>Member of Charitable Funds Committee<br>Carers Champion<br>Equality and Human Rights Champion<br>Welsh Language Champion<br>Chair of the Equality, Diversity and Human Rights sub-Committee |
| INDEPENDENT MEMBER – ESTATES | Member of Audit Committee<br>Member of People, Performance and Delivery Committee<br>Design (Estates and Premises) Champion<br>Older People Champion |
| INDEPENDENT MEMBER - LOCAL GOVERNMENT | Member of Mental Health Legislation Committee<br>Member of Health and Safety Committee<br>Children and Young People Champion |

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| ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS | |
|---|---|
| INDEPENDENT MEMBER - LEGAL | Chair of Charitable Funds Committee<br>Chair of Health and Safety Committee<br>Member of Mental Health Legislation Committee<br>Member of Quality, Safety and Experience Committee<br>Member of Remuneration and Terms of Service Committee<br>Health and Safety Champion<br>Violence and Aggression Champion |
| INDEPENDENT MEMBER - COMMUNITY | Member of Quality, Safety and Experience Committee<br>Member of Mental Health Legislation Committee |
| INDEPENDENT MEMBER - TRADE UNION | Member of People, Performance and Delivery Committee<br>Member of Charitable Funds Committee<br>Member of Remuneration and Terms of Service Committee<br>Armed Forces and Veterans Champion |

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## DELEGATION OF POWERS TO COMMITTEES AND OTHERS[6]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, including the approval of policy documents and associated written control procedures in line with their individual remits and responsibilities.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- Audit Committee
- Charitable Funds Committee
- Health and Safety Committee
- Healthcare Professionals Forum
- Local Partnership Forum
- Mental Health and Capacity Legislation Committee
- People, Performance and Delivery Committee
- Quality, Safety and Experience Committee
- Remuneration and Terms of Service Committee
- Stakeholder Reference Group
- Welsh Health Specialised Services Committee
- Shared Services Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee Terms of Reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Board's Scheme of Delegation to Committees.

[6] As defined in Standing Orders

## SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The LHB SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the LHB's Scheme of Delegation to Officers.

The table below sets out those matters that the Board has agreed to delegate, whether supplementary delegations are allowable and the control documents that must be in place prior to supplier supplementary delegations being made.

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*The Detailed Scheme of Delegation and Earned Autonomy Framework is the title of the "authorisation matrix".

| Delegated matter | High level delegation | Further Delegation Allowable? | Control Documents required to be in place prior to further delegation of matters |
|---|---|---|---|
| Management of budgets | Directors | Yes | Financial delegations set out in Section 3. Further delegations subject to authorisation matrix*. |
| Management of cash and bank accounts | Director of Finance | Yes | Authorisation matrix. Financial policies & procedures |
| Approval of petty cash | Directors | Yes | Authorisation matrix. Financial policies & procedures |
| Reimbursement of patient monies | Directors | Yes | Authorisation matrix. Financial policies & procedures |
| Engagement of staff within funded establishment | Directors | Yes | Authorisation matrix. HR policies and procedures |
| Engagement of staff outside funded establishment | Chief Executive | Nominated deputy | In absence of Chief Executive |

| Delegated matter | High level delegation | Further Delegation Allowable? | Control Documents required to be in place prior to further delegation of matters |
|---|---|---|---|
| Staff re-grading and awarding of incremental points | Director of Workforce & OD | Yes | Written authority to suitably qualified HR staff |
| Approval of overtime | Directors | Yes | Authorisation matrix. HR policies and procedures |
| Approval of annual leave | Directors | Yes | Authorisation matrix. HR policies and procedures |
| Approval of compassionate leave | Directors | Yes | Authorisation matrix. HR policies and procedures |
| Approval of maternity and paternity leave | Directors | Yes | Authorisation matrix. HR policies and procedures |
| Approval of carers leave | Directors | Yes | Authorisation matrix. HR policies and procedures |
| Approval of leave without pay | Directors | Yes | Authorisation matrix. HR policies and procedures |
| Extension of sick leave on full or ½ pay<br>• Directors<br>• Other staff | Reserved for Board<br>Directors | Yes | Authorisation matrix. HR policies and procedures |
| Approval of study leave < £2k | Directors | Yes | Authorisation matrix. HR policies and procedures |
| Approval of study leave > £2k | Directors | No | |
| Approval of relocation costs | Director of Workforce & OD | Yes | Authorisation matrix. HR policies and procedures |
| Approval of lease cars & phones<br>• Directors<br>• Other staff | Reserved for Remuneration and Terms of Service Committee<br>Directors | No<br>Yes | Authorisation matrix. HR policies and procedures |

| Delegated matter | High level delegation | Further Delegation Allowable? | Control Documents required to be in place prior to further delegation of matters |
|---|---|---|---|
| Approval of redundancy, early retirement and ill-health retirement | Chief Executive | Yes | Authorisation matrix. HR policies and procedures |
| Dismissal of staff | Director of Workforce & OD | Yes | Authorisation matrix. HR policies and procedures |
| Management of clinical and other operational capacity | Directors | Yes | Authorisation matrix. Annual Operating Framework and operational plans |
| Approval to procure goods and services within budget | Directors | Yes | Standing financial instructions. Authorisation matrix. Procurement & finance policies and procedures. |
| Approval to procure goods and services outside of budget that would result in a budgetary overspend | Chief Executive | Yes | Authorisation matrix. Commissioning policies and procedures |
| Approval to commission healthcare services from other NHS bodies | Chief Executive | Yes | Authorisation matrix. Commissioning policies and procedures |
| Approval to commission healthcare services from voluntary sector | Chief Executive | Yes | Authorisation matrix. Commissioning policies and procedures |
| Approval to commission healthcare services from private and independent providers | Chief Executive | Yes | Authorisation matrix. Commissioning policies and procedures |
| Approval to enter into primary care contracts for GMS, dental, | Chief Executive | Yes | Authorisation matrix. Commissioning policies and procedures |

| Delegated matter | High level delegation | Further Delegation Allowable? | Control Documents required to be in place prior to further delegation of matters |
|---|---|---|---|
| ophthalmology and pharmaceutical services | | | |
| Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006 | Chief Executive | Yes | Authorisation matrix. Commissioning policies and procedures |
| Approval to amend the drugs formulary | Medical Director | No | |
| Approval to prescribe drugs outside the formulary | Medical Director | Yes | Prescribing policies and procedures |
| Authorisation of sponsorship | Directors | No | |
| Approval of clinical trials | Medical Director | Yes | Clinical policies and procedures |
| Approval of research projects | Chief Executive | Yes | Research policies & procedures |
| Management of concerns | Chief Executive | Yes | Complaints policies & procedures |
| Provision of information to the press, public and other external enquiries | Chief Executive | Yes | Communication policies & procedures |
| Approval of use of charitable funds | Charitable Funds Committee | Yes | |
| Investment of charitable funds | Director of Finance | Yes | Authorisation matrix. Financial policies & procedures |
| Approval to condemn and dispose equipment | Directors | Yes | Authorisation matrix. Disposal policies and procedures |
| Approval of losses and compensation (except for | Directors | No | Within authorised limits set by WG as detailed within the Annual Accounts Manual. |

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| Delegated matter | High level delegation | Further Delegation Allowable? | Control Documents required to be in place prior to further delegation of matters |
|---|---|---|---|
| personal effects) | | | |
| Approval of compensation for staff and patients personal effects<br>• Up to £1000<br>• £1,000 > £10,000<br>• £10,000 > £50,000<br>Over £50,000 | <br><br><br>Small Claims Panel<br>Director of Nursing<br>Chief Executive<br>Approval by WG | <br><br><br>No<br>No<br>No<br>No | |
| Approval of Clinical negligence and personal injury claims | Chief Executive | Yes | Authorisation matrix and within limits set by WG. |
| Approval of staff tenancy agreements | Directors | Yes | Authorisation matrix. HR policies and procedures |
| Approval of capital expenditure | Chief Executive / Director of Planning | Yes | Authorisation matrix and within limits set by WG. |
| Approval of capital expenditure | Chief Executive / Director of Planning | Yes | Authorisation matrix and within limits set by WG. |
| Approval to engage external building and other professional contractors | Director of Planning | Yes | Authorisation matrix and within limits set by WG. |
| Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements | Chief Executive | Yes | Authorisation matrix and within limits set by WG. |

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This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

**FINANCIAL DELEGATIONS**

**Contracts over £1m**

The UHB must gain written consent from the Welsh Government (WG) to enter into a contract where an individual contract exceeds £1m in any one financial year. There is also a requirement to notify the WG of contracts awarded between £250,000-£500,000 and £500,000-£1m. This requirement for consent or notification does not apply to any contract entered into pursuant to a specific statutory power and therefore does not apply to:

i. Contracts of employment between LHBs and their staff;
ii. Transfers of land or contracts effected by Statutory instrument following the creation of the LHB.
iii. Out of Hours Contracts; and
iv. All NHS contracts i.e. where one health service body contracts with another health service body.

These remain in the delegated authority of the LHB.

Each contract must be considered on a case by case basis and independent legal advice sought where appropriate.

Further detail regarding approval and notification arrangements are contained within the Standing Financial Instructions.

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**Framework for the delegation of financial commitments**

The following matrix sets out the framework for financial delegations to the Chief Executive, Directors and other delegated budget holders. All financial commitments above £0.5m must be approved by the Board either specifically or as part of the approval of the UHB's financial plan.

| Delegation | Delegated financial limit £'000 |
|---|---|
| Reserved for Board | >£500 |
| Chief Executive | 500 |
| Directors | 125 |
| Officers below Director level | Max 75 |

**The following principles apply to this framework:-**

- Financial limits can be reduced at the discretion of the Board.
- In an officer's absence, financial limits can be delegated in part or in total either generally or for specific items.
- Directors can limit delegated budget holders to less than £75k at their discretion.
- These limits apply to requisition authorisation, which is where the control lies.

- In exceptional circumstances the Chair may have delegated authority on behalf of the Board. Any use of delegated authority to the Chair must be included in the minutes of the next meeting of the Board.
- Each director has the responsibility of cascading the delegation within their area and ensuring that authorised signatories are in place. It may be appropriate for some areas of expenditure to be notified to the Board even if they are within the budget holder's limits.
- Further detail regarding these delegations is contained within the Detailed Scheme of Delegation and Earned Autonomy Framework.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

# Schedule 2

## KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

**This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders**

### LHB framework

The LHB's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs***
- ***Values and Standards of Behaviour Framework***
- ***Risk and Assurance Framework***
- ***Key policy documents***

agreed by the Board. These documents must be read in conjunction with the SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by: Contacting the Board Secretary via http://www.cardiffandvaleuhb.wales.nhs.uk/board-members

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### NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of LHB business are also issued in hard copy, usually under cover of a Ministerial Letter.

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|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | The Capital Ordering Authorisation Protocol | | | | | | | | |
| **Meeting:** | Audit Committee | | | | | | **Meeting Date:** | 26.02.19 | |
| **Status:** | **For Discussion** | | **For Assurance** | | **For Approval** | **x** | **For Information** | | |
| **Lead Executive:** | Executive Director of Finance | | | | | | | | |
| **Report Author (Title):** | Head of Financial Accounting and Services | | | | | | | | |

**SITUATION**

As defined in the Standing Financial Instructions, the Chief Executive is responsible to implement appropriate management and governance arrangements around the UHB's Capital Programme. To assist the Chief Executive with this task, the UHB has established a Capital Management Group, under the chair of the Director of Planning. This group meets monthly and will assist the Director of Planning in all areas of the UHB's capital programme and other asset management issues. This will include ensuring robust financial management and governance arrangements are in place in respect of the capital programme. The Capital Management Group has agreed to a revision of the capital ordering authorisation protocol to include the Deputy Chief Executive within IM&T authorisations, to reflect revisions to Executive Director responsibilities.

**REPORT**

**BACKGROUND**

To enact appropriate governance and management arrangements around the Capital Programme, the Capital Management Group produced and Published "The Capital Ordering Authorisation Protocol" in September 2014. This procedure was subsequently refreshed in September 2016 and December 2017. The attached draft has now been updated to reflect the current Governance Framework in place around placing expenditure orders for Capital Schemes. This has been updated to reflect changes to Executive Director portfolios.

**ASSESSMENT**

By implementing this procedure, this will help the UHB ensure that it maintains a robust capital governance regime in line with its standing financial instructions, standing orders and the requirements of The Welsh Ministers Guidance.

**ASSURANCE** is provided by:

- The attached procedure and revisions made have been approved by the Capital Management Group;
- The changes made reflect recently agreed Executive Director responsibilities.

**RECOMMENDATION**

The Audit Committee is asked to:

- **APPROVE** the protocol which will govern how the UHB places capital orders and request that the IHB's scheme of delegation is updated to include the Deputy Chief Executive for IM&T expenditure approvals.

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

| **Five Ways of Working (Sustainable Development Principles) considered**<br>*Please tick as relevant, click here for more information* | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Prevention | | Long term | x | Integration | | Collaboration | | Involvement | |

| | |
|---|---|
| **Equality and Health Impact Assessment Completed:** | Yes / No / Not Applicable<br>*If "yes" please provide copy of the assessment. This will be linked to the report when published.* |

| | |
|---|---|
| GIG CYMRU NHS WALES \| Bwrdd Iechyd Prifysgol Caerdydd a'r Fro \| Cardiff and Vale University Health Board | **Reference Number: UHB TBA**<br>**Version Number: 4**<br>**Next Review Date: October 2020**<br>**Previous Trust/LHB Reference Number: N/A** |

# Capital Ordering Authorisation Protocol

## Introduction and Aim

This protocol has been developed to ensure that the University Health Board (the UHB) has appropriate management and governance arrangements in place around the process by which orders are raised to commit capital expenditure.

The UHB's Standing Financial Instructions (SFI's) and Scheme of Delegation and Earned Autonomy Framework are the key policy documents for this area. This protocol; should be read in conjunction with the UHB's capital management procedure. This protocol provides further details on operational arrangements which underpin this

Each year the UHB receives a capital resource allocation from the Welsh Government (WG). The UHB has an annual statutory financial duty to ensure that its capital expenditure does not exceed this resource allocation. The funding comprises two elements:

- **Discretionary Capital.** This is a one off annual allocation given to the UHB by WG. As the title implies, the UHB is free to prioritise the sum allocated as it best sees fit.
- **Capital funding issued by WG for a specific purpose**. WG has a number of capital budgets (the All Wales Capital Building Programme, the Health Technology Fund, Invest to Save Funding) which the UHB can bid against in order to obtain capital funding which often, as a result of the size of the projects involved, cannot be accommodated from within the discretionary programme. Section 3.3 of this procedure outlines the principles such bids should follow and the governance regime that applies to their submission.

In addition to the above the UHB can internally generate capital funding by means such as property disposals or encouraging charitable donations.

## Objectives

This procedure sets out the management and governance arrangements that need to be in place in respect to the authorisation of capital orders. It recognises that a one fit for all process for capital orders is not appropriate  Specifically it addresses the following:

- The authorisation process which the UHB places follows when placing estates works orders for discretionary schemes.
- The authorisation process which the UHB places follows in placing orders for all emergency capital expenditure requirements.
- The authorisation process which the UHB follows in placing orders for

equipment (incl IM&T) for equipment only schemes.

- The authorisation process which the UHB follows in placing orders for All Wales Capital schemes.

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**Scope**

This procedure applies to all of our staff in all locations including those with Honorary Contracts who are involved in either bidding for, or the use of capital funding.

In addition to the responsibilities detailed within the protocol staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them.

| | |
|---|---|
| **Equality Impact Assessment** | An Equality Impact Assessment has not been completed. The UHB will, however ensure that an Equality Impact Assessment is undertaken annually when it is prioritising its capital programme. |
| **Documents to read alongside this Procedure** | Standing Financial Instructions<br>The UHB Scheme of Delegation<br>UHB Capital Management Procedure |
| **Approved by** | Capital Management Group |
| **Accountable Executives or Clinical Board Director** | Executive Director Of Finance/Executive Director of Planning |
| **Authors** | Head of Financial Accounting & The Business Manager (Capital, Estates & Facilities) |

**Disclaimer**

**If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**

**Summary of reviews/amendments**

| Version Number | Date of Review Approved | Date Published | Summary of Amendments |
|---|---|---|---|
| 1 | | September 2014 | This is a new protocol. |
| 2 | | September 2016 | Minor amendments to job titles |
| 3 | | December 2017 | The UHB's capital scheme of delegation was updated to include the Executive Director of Therapies, the Head of Procurement and the Head of Compliance and Discretionary Capital. |
| 4 | | March 2019 | The UHB's capital scheme of delegation was updated to include the Deputy Chief Executive within IM&T approvals. |

**Contents Page**



## 1.0 Introduction

As per the UHB's Scheme of Delegation and Earned Autonomy Framework, the Director of Capital, Estates and Facilities is the delegated budget holder responsible for ensuring that the UHB stays within its Capital Resource Limit on an annual basis.

While the Director of Capital, Estates and Facilities) will be the delegated budget holder for the capital programme as a whole, the Executive Director of Planning and Executive Director of Finance will delegate responsibility for individual capital schemes (including those funded directly by WG) to nominated budget holders. The below sections outline the processes budget holders must follow in order to get capital orders raised & approved.

Budget holders are reminded that any budgeted discretionary funds not required for their designated purpose(s) revert to the UHB Capital Contingency Budget, subject to any authorised use of virement and subject to the Board's scheme of delegation

In addition any likely overspending or reduction of income that cannot be met by virement must not be incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation

## 2.0 The Authorisation of Discretionary Funded Estates Works Orders

Capital requisitions up to £5,000 (incl VAT) may be approved by either the Head of Compliance and Discretionary Capital or the Head of Capital Planning.

Capital requisitions for values between £5,000 and £25,000 (incl VAT) may be approved by the Director of Capital, Estates and Facilities.

Where requisitions exceed £25,000 the following applies:

All orders are to be raised within procurement. In order for the order to be raised the relevant procurement officer will need to be e-mailed with the following confirmation(s) of approval:

- For orders higher than £25,000 but up to a value of £125,000 (incl VAT) a requisition form signed by the Director of Capital, Estates and Facilities plus a capital approval form (CAPR) signed by the Executive Director of Planning or the Executive Director of Finance.

- For orders higher than £125,000 but up to a value of £500,000 (incl VAT) a requisition form signed by the Director of Capital, Estates and Facilities plus a capital approval form (CAPR) signed by the Executive Director of Planning and the Chief Executive.

- For orders higher than £500,000 (incl VAT) a requisition form signed by the Director of Capital, Estates and Facilities) plus a capital approval form (CAPR) signed by the Chair on behalf of the Board

Note: this process encompasses equipment bought as part of a discretionary works scheme.

## 3.0 The Authorisation of Emergency Equipment Replacement Orders

As outlined in the UHB's Capital Management Procedure, where a clinical board needs to make an emergency request for capital to address an urgent medical equipment, IM&T,estates maintenance or statutory compliance issue then a standard form designed for this purpose needs to be completed. The forms are available from the Business Manager (Capital, Estates & Facilities). Once complete, for estates maintenance or statutory compliance issue the forms should be returned to the Business Manager (Capital, Estates & Facilities). In the case of urgent medical equipment bids, the forms should initially be sent to the Assistant Director of Therapies, who will review the bid before forwarding on to the Business Manager (Capital, Estates & Facilities). The Business Manager (Capital, Estates & Facilities) will advise the Director of Capital, Estates & Facilities on the level of contingency funding available to support the request The Director of Capital, Estates & Facilities will then forward the details of the bid (including the level of funding available to support it) to the Executive Director Of Therapies, the Chief Operating Officer and the Executive Director of Planning who will decide if the bid is to be supported or not.

In circumstances where the value of the equipment exceeds £0.125m (but not £0.5m) then additional authorisation would be required by the Chief Executive in line with the scheme of delegation

In respect of equipment bids supported as part of the above process, to enable an order to be raised the Assistant Director of Therapies must forward a signed requisition form to the relevant procurement officer, together with copies of the e-mails where authorisation has been given by the Executive Director of Therapies, The Executive Director of Planning, the Chief Operating Officer and where necessary The Chief Executive.

In the case of urgent IM&T bids, the forms should initially be sent to the Head of IM&T, who will review the bid before forwarding on to the Business Manager (Capital, Estates & Facilities). The process then follows that outlined for urgent medical equipment bids except that in respect of IM&T bids supported as part of the above process, to enable an order to be raised the Head of IM&T must forward a signed requisition form to the relevant procurement officer, together with copies of the e-mails where authorisation has been given by the Deputy Chief Executive, The Executive Director of Planning, the Chief Operating Officer and where necessary The Chief Executive

Note: In years in which the UHB's contingency for such items has been exhausted then the UHB will approach WG directly for the funding for such items. The Business Manager (Capital, Estates & Facilities) will be responsible for notifying the procurement team when this occurs and where it is the case the relevant procurement officer must obtain confirmation from either the Business Manager (Capital, Estates & Facilities) or The Head of Financial Accounting that the necessary WG funding has been obtained before an order can be placed.

## 4.0 The Authorisation of Equipment Orders to be placed for equipment only discretionary schemes

The responsibility for the delivery of these schemes will be delegated each year to nominated budget holders. As part of this the budget holder will be required to draw up a costed list of the items to be purchased. The total cost of this list must not exceed the annual budget designated to the scheme by the UHB's Board. Once the list is prepared it should be approved by the UHB Board in line with the UHB's scheme of delegation as follows:

For Non IM&T Schemes:

- For equipment schemes totalling up to a value of £25,000 (incl VAT) the list can be approved by the Director of Capital, Estates and Facilities.

- For equipment lists having a combined value of more than £25,000 but less than £125,000 (incl VAT) these can be approved by the Executive Director of Planning, The Executive Director of Therapies or the Executive Director of Finance.

- For lists with an overall value higher than £125,000 but up to a value of £500,000 (incl VAT) may be approved by the Executive Director of Planning and the Chief Executive.

- For equipment lists costing higher than £500,000 (incl VAT) approval by the Chair on behalf of the Board is required.

All orders are to be raised within procurement. In order for the order to be raised the relevant procurement officer will need to be e-mailed with approval in line with the above:

For IM&T Schemes:

- For equipment schemes totalling up to a value of £25,000 (incl VAT) the list can be approved by the Head of IM&T

Where requisitions exceed £25,000 the following applies:

All orders are to be raised within procurement. In order for the order to be raised the relevant procurement officer will need to be e-mailed with the following confirmation of approval.

- For equipment lists having a combined value of more than £25,000 but less than £125,000 (incl VAT) these can be approved by the Executive Director of Planning or the Deputy Chief Executive.

- For lists with an overall value higher than £125,000 but up to a value of £500,000 (incl VAT) may be approved by the Chief Executive on the recommendation of the Deputy Chief Executive.

- For equipment lists costing higher than £500,000 (incl VAT) approval by the Chair on behalf of the Board is required.

## 5.0 The Authorisation of Orders for All Wales Capital Funded Schemes

The initial Budget for such schemes shall be determined by the approval letter received from WG. The signing of the acceptance letter for the funding provided by the chief executive shall serve as authorisation to the Director of Planning and the Executive Director of Finance to appoint devolved budget holder to utilise the funding in the way intended:

In respect of contractor costs and the fees of external advisors, schedules should be obtained from the Health Board Cost advisors which reconcile to the WG approved sums. Copies of this schedule, the WG approval letter and a signed requisition by the budget holder need to be supplied to the relevant procurement officer in order for them to raise the appropriate orders. In respect of equipment, again a costed list of the items to be purchased should be produced by the budget holder. The value of this list should not exceed the value of equipment approved for the project by WG. Once in receipt of this list the relevant procurement officer can raise equipment orders on the written instruction of the budget holder.

The budget holder may choose to delegate some of the above tasks to members of their team. The relevant procurement officer may act on instruction from the person to whom the budget holder has delegated responsibility as long as they have been provided with written confirmation of the delegation by the budget holder.

Due to the nature of these schemes it may become necessary to vire funding between the different categories of expenditure within the one capital project. These virements can only be authorised by the project director (who will keep Capital Management Group and the Scheme's project Board briefed on the reason for and the effect of any such changes). Where this results in additional orders needing to be placed, the budget holder will advise the relevant procurement officer of the changes together with correspondence from Capital Management Group and the Project Board where the virements were discussed. As long as these virements are within the approved cost envelope of the scheme then this will allow the relevant procurement officer to place the additional orders on receipt of written instruction from the budget holder.

Occasionally the UHB may decide to allocate additional discretionary funds to a project to help it achieve its aims. Where this occurs the budget holder must again provide appropriate documentary evidence to support this decision to the relevant procurement officer (together with a list of what the additional funding is to be spent on). The UHB's scheme of delegation requires the following in respect of capital budgetary adjustments:

- Amendments greater than £1.0m require UHB Board approval
- Amendments greater than £0.5m; but less than £1m require Chief Executive Approval (based on the recommendation of CMG)
- Amendments up to £0.5m may be authorised by the Executive Director of Planning, Executive Director of Finance & Chief Operating Officer via the Capital Management Group.

These only apply to adjustments within the overall approved annual capital budget; any overcommitment on budget requires Board approval (or Chief Executive in emergency)

## 6.0 The Authorisation of Orders for Capital Schemes Funded outside of the Capital Resource Limit.

In certain instances funding will be contributed to capital schemes by external bodies. Before orders can be placed in respect of such funding, the relevant procurement officer must be provided with the following:

a) Written confirmation from the donating body of the sum to be donated.
b) Written confirmation from the Director of Finance that we are to take the money.
c) A costed list of items to be purchased from this money (which does not exceed in value the sum to be donated) – supplied by the budget holder.

Where this funding is contributing to the funding of an existing scheme, then the existing budget holder will be allocated this additional funding. Where the capital scheme is new and to be solely funded from this additional funding, the Executive Director of Finance and the Executive Director of Planning will appoint a budget holder.

Once in receipt of these, the relevant procurement officer should take advice on whether a VAT exemption certificate can used to avoid VAT being charged on any of the equipment. They may than place orders on receipt of a signed requisition from the budget holder.

## 7.0 Conclusion.

By implementing the above protocol; the UHB should ensure it has a robust governance regime in place for the authorisation of capital orders which is in line with its standing financial instructions, standing orders and the requirements of The Welsh Ministers Guidance.

# Cardiff and Vale University Health Board

# Claims Reimbursement

# Final Internal Audit Report

# 2018/19

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
| **Review reference:** | C&V-1819-02 |
| **Report status:** | Final Internal Audit Report |
| **Fieldwork commencement:** | 12th November 2018 |
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| **Auditor/s:** | Olubanke Ajayi Olaoye, Senior Internal Auditor |
| **Executive sign off:** | Ruth Walker, Executive Nurse Director |
| **Distribution:** | Angela Hughes, Assistant Director of Nursing |
| | Vicky Stuart, Head of Concerns |
| | Suzanne Wicks, Claims Manager |
| | Karen Lewis, Claims Manager |
| **Committee:** | Audit Committee |

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

## 1. Introduction and Background

The review of the claims reimbursement process was completed in line with the Internal Audit Plan. The review sought to provide the Health Board with assurance on compliance with Area for Assessment 23 of the Welsh Risk Pool (WRP) Concerns and Compensation Claims Management Standard.

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

## 2. Scope and Objectives

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

The purpose of the review was to provide assurance to the Audit Committee that the claims reimbursement process is in compliance with the requirements of the Welsh Risk Pool Standard.

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

- Appropriate and accurate completion and authorisation of Appendix U Cost Schedules by the Claims Manager.
- Appendix S Checklists are completed by the Claims Manager and signed by the Chief Executive and Nurse Director (or a delegated person); and forwarded to the Welsh Risk Pool.
- All claims submitted are accurately entered onto the DATIX Risk management Database.

## 3. Associated Risks

The potential risk considered in this review was as follows:

- Claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and are not appropriately authorised by Health Board senior management.

## OPINION AND KEY FINDINGS

## 4. Overall Assurance Opinion

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

identified risks associated with the objectives covered in this review.

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

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

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

The audit identified that the Health Board's claims reimbursement process is undertaken in compliance with Assessment Area 23 of the Welsh Risk Pool (WRP) Concerns and Compensation Claims Management Standard and the Organisational Claims Handling Policy and Procedure.

For the sample of reimbursed claims reviewed audit found that the above guidance and procedure had been followed.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Appropriate and accurate completion and authorization of Appendix U Cost Schedules | | | | ✓ |
| **2** | Appendix S Checklists are completed by the Claims Manager and signed and forwarded to the Welsh Risk Pool | | | | ✓ |
| **3** | All claims submitted are accurately entered onto DATIX | | | | ✓ |

### Design of Systems/Controls

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

### Operation of System/Controls

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

## 6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

**Objective: Appropriate and accurate completion and authorisation of Appendix U Cost Schedules by the Claims Manager**

The following area of good practice was noted:

- For the 16 claims reviewed, audit found that the Appendix U Cost schedules had been accurately completed and authorised by the Trust's Claims Manager.

There were no significant findings identified.

**Objective 2: Appendix S Checklists are completed by the Claims Manager and signed by the Chief Executive and Nurse Director (or a delegated person); and forwarded to the Welsh Risk Pool**

The following areas of good practice was noted:

- For the 16 claims reviewed audit found that the Appendix S schedules had been correctly completed. All schedules were signed and appropriately authorised.
- All 16 claims had been submitted to the Welsh Risk Pool for approval.
- Audit was also able to evidence confirmation of the payment approval of the reimbursement to the Health Board by the Welsh Risk Pool

There were no significant findings identified.

**Objective 3: All claims submitted are accurately entered onto the DATIX Risk Management Database**

The following area of good practice was noted:

- For the 16 claims reviewed audit found that all claims were accurately recorded on the Datix risk management database.
- Documents were electronically filed onto Datix

There were no significant findings identified.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

| Finding 1: Datix Claim File status Update (Operating effectiveness) | Risk |
|---|---|
| Currently the position of a Claimant's profile view status cannot be determined at a glance, however, Datix has the function to do so.<br>The front page of each claimant file on Datix has a drop box facility where the various options regarding the status of the file can be selected. This is not actively in use at present as the samples selected did not show their current position. | The current status of claims are not immediately apparent. |
| **Recommendation 1** | **Priority level** |
| Management should ensure that staff members complete the status section as a form of good practise. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| This will be audited through regular peer datix reviews of files by each claims manager | Claims Mangers / Complete |

| Finding 2: Reimbursement Test Finding (Operating effectiveness) | Risk |
|---|---|
| A sample of 16 reimbursed claims was selected for testing. All the claims were recorded on Datix. They also had their supporting Appendix U and S forms available for review.<br>However, the following minor issues were noted:<br>• 3/16 Appendix S forms were not dated by either the Responsible Body or Governance signatory<br>• 3/16 forms (2 Appendix U & 1 Appendix S) were not initially attached within Datix at the time of audit testing. | There is a lack of evidence to confirm the appropriate and timely authorisation of claims. |
| **Recommendation** | **Priority level** |
| Signatories should ensure that all documents are appropriately dated.<br>Management should ensure that all relevant documents are uploaded onto Datix on a timely basis for ease of access. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| There was no problem with any authorities in signing off the Appendix forms; these were minor errors all of which were rectified. From now on we will check all forms for dates and ensure that any interim or final forms are scanned/copied to Datix. | Claims Manager / Complete |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

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

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

 **Unsatisfactory** - The Board has **unsatisfactory** arrangements in place to secure governance, risk management and internal control, within those areas under review, which are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

### Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

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

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

# Cardiff and Vale University Health Board

# Performance Reporting Data Quality - Non RTT

## Final Internal Audit Report

## 2018/19

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
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| **Auditor/s:** | Ian Virgill, Deputy Head of Internal Audit<br>Kimberley Rowe, Principal Internal Auditor |
| **Executive sign off:** | Sharon Hopkins, Executive Director of Public Health |
| **Distribution:** | Andrew Nelson, Assistant Director Information and Performance. |
| **Committee:** | Audit Committee |

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

## 1. Introduction and Background

The review of Data Quality within the Performance Report has been completed as part of the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board (' The Health Board').

The Health Board's Performance Report sets out the level of performance against the Welsh Government Performance Framework and other priority targets.

In total, there are currently 66 performance measures included within the Performance Report and delivery against each of these is reported to each meeting of the Board.

A separate review of performance reporting against the Referral to Treatment Times (RTT) targets was completed as part of the 17/18 Internal Audit plan. This review therefore covers the non-RTT performance measures.

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

## 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 ensuring data Quality within the Performance Report, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the audit is to provide assurance over the accuracy of performance figures reported within the Health Board's Performance Report.

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

- The Health Board has appropriate and up to date documented procedures in place for the collation and reporting of performance data within the Performance Report;
- The data for inclusion within the Performance Report is gathered from reliable sources both within the Health Board and externally and has been subject to appropriate validation processes;
- Robust processes are in place for collating the recorded performance data and this is accurately reported within the Health Board's performance report; and
- The Performance report is presented to and reviewed by each meeting of the Board and includes appropriate and relevant narrative highlighting key issues.

### 3. Associated Risks

The potential risks considered in this review are as follows:

i. Inaccurate reporting of performance; and

ii. 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 Performance Reporting data quality - Non RTT is **Substantial assurance**.

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

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

The Health Board has appropriate procedures in place for the collation and accurate reporting of performance data to the Board; this review highlights some extra provisions to strengthen this current process.

The audit has made note that there are a number of NHS Delivery Measures that have not been included within the Board Performance Report and also a disparity between the Performance Report and those measures reported operationally throughout the Health Board via the Tier 1 Scorecard process. This is partly justified by the need to report deliverables and metrics agreed in the IMTP but also to maintain consistency by avoiding frequent changes to the report so trends can be analysed. However, the audit notes the importance of uniform reporting through the organisation, to the Board and externally to Welsh Government.

The data for inclusion within the Performance Report is gathered from various sources internally and externally to the Health Board that have been deemed appropriately validated.

The Performance Report is reviewed by each meeting of the Board, this review emphasises the need for reports to be presented in a format which is easy to appraise. However, the Performance Report in its current format has its limitations and has proven difficult to decipher.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Reporting Procedures | | | ✓ | |
| **2** | Data Sources & Validation | | | | ✓ |
| **3** | Accurate Collation | | | | ✓ |
| **4** | Board Presentation & Review | | | | ✓ |

** 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 Performance Reporting data quality - Non RTT.

### 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 Performance Reporting data quality - Non RTT.

## 6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

**Obj 1: The Health Board has appropriate and up to date documented procedures in place for the collation and reporting of performance data within the Performance Report.**

The following area of good practice has been noted:

- There is documented, up to date methodology for each of the processes for uploading data into the Business Intelligence System. The BIS team maintain a metric schedule which lists the responsible officer for each of

the Tier 1 Scorecard metrics and the status of the collation.

The following significant finding has been identified:

- There are a number of NHS Delivery Measures that are not included in the Cardiff and Vale Performance Report and similarly there are differing measures within the Tier 1 Scorecard. This means that performance is being measured and reported differently externally and internally to management and Executives. Where measures are the same, there is consistency in the figures reported.

**Obj 2: The data for inclusion within the Performance Report is gathered from reliable sources both within the Health Board and externally and has been subject to appropriate validation processes.**

The following areas of good practice have been noted:

- Data is collated by a variety of sources and is validated by those with the appropriate knowledge and expertise; and
- Data input into BIS for the Tier 1 Scorecards and subsequent inclusion in the Performance Report has passed through appropriate control checks for completeness.

No significant findings have been identified.

**Obj 3: Robust processes are in place for collating the recorded performance data and this is accurately and appropriately reported within the Health Board's performance report.**

The following areas of good practice have been noted:

- 12/15 measures tested were found to be accurately supported by source documentation. 2 were found to have minor discrepancies. However, these inaccuracies are deemed insignificant, as they would not change the RAG status or trends reported to the Board.

  For the remaining measure relating to hip fractures, no evidence was provided to audit to support. However, the reported figure had not changed the trend or RAG status previously reported therefore the lack of movement does not highlight a misrepresentation risk. Assurance can therefore be provided over the accuracy of the Performance Report; and
- Where measures are also reported to the NHS Wales Executive Board, these were tested for consistency with the Performance Report. Of the four identified measures, three were found to be inconsistent. The differences are likely due to timing of reporting and the disparity was deemed insignificant, as there is no impact to the RAG status or trend. Assurance can therefore be provided over the consistency of figures reported externally and internally.

No significant findings have been identified.

**Obj 4: The Performance report is presented to and reviewed by each meeting of the Board and includes appropriate and relevant narrative highlighting key issues.**

The following areas of good practice have been noted:

- The Performance Report was found to be presented at all Board meetings by an appropriate Executive;
- A summary of the report is presented, with supporting commentary for those measures that have either a marked improvement or deterioration of RAG status;
- A table summarising the RAG status score for each policy objective is also provided;
- Detailed commentary supplements the performance report for areas prioritised by the Board or where there have been noted deteriorations and improvement drives. This information provides useful context for the table of measures;
- The minutes evidence that the Performance Report is being reviewed and discussed in detail, and there are resulting actions; and
- In the months tested, Reasonable Assurance was provided to the Board that the UHB was making progress in delivering its Delivery Plan for 2018/19 by achieving compliance with a number of the performance measures.

No significant findings were identified.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

| Finding 1 - Performance Report vs National Framework vs Scorecard (Operating effectiveness) | Risk |
|---|---|
| The audit has noted that there are a number of NHS Delivery Measures included in the NHS Wales Delivery Framework and Reporting Guidance that have not been included in the C&V Performance Report. The Performance and Information team explained that this is because the delivery measures are continually changing and the performance report needs to maintain consistency with the 3 year IMTP Delivery Plan. There is also a disparity between the Tier 1 Scorecard which is used to report performance internally to management and the Performance Report presented to the Board.<br><br>Work has been undertaken by the BIS Team to align the National Framework and the Tier 1 Scorecard, but has been limited to a comparison between the two reporting mechanisms.<br><br>Despite this, where measures are the same, there is consistency in the figures reported. | Inaccurate reporting of performance; and<br><br>Issues are not effectively identified, reported and addressed. |
| **Recommendation** | **Priority level** |
| Consideration should be given to aligning the Performance Report and Tier 1 scorecard to the NHS Delivery Measures. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Discussions at a national level are happening between Welsh Government and the NHS in Wales to ensure that the Health Boards are sighted on the data being submitted to Welsh Government to report on the Q&D framework targets. This is not the case at the moment and there is no mechanism other than via the NHS | Assistant Director – Information and Performance |

| | |
|---|---|
| Wales performance report for the UHB to be sighted.<br><br>The UHB's performance report is intended to provide an indication to our board as to the level of progress we are making in delivering our strategic, tactical and short term operational priorities. As performance measures for some of these are not included in the quality and delivery framework there is then a trade-off to be considered between increasing the number of measures reported, enabling the board to focus on the key areas of interest at that period of time, and the resources required to service this.<br><br>The UHB is again considering the measures that will be reported to board and will take into consideration this recommendation that the board needs to be sighted on performance against the WG Q&D framework in this review. | |

| **Finding 2 - Performance Report Reference Matrix (Control design)** | **Risk** |
|---|---|
| The Performance Report working spreadsheet is not currently set up as a referenced matrix with Standard Operating Procedures (SOPs) and data sources linked. Therefore, the collation of performance data for inclusion within the Performance Report is reliant on the tacit knowledge of the current team and future reporting could be jeopardised by the absence of members of the current performance and information team. | Inaccurate reporting of performance; and<br><br>Issues are not effectively identified, reported and addressed. |
| **Recommendation** | **Priority level** |
| The Performance Report working spreadsheet should be linked to data sources and SOPs in order to aid collation and ensure the on-going robustness of the process. | **Low** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| As identified above – not all the data is available to achieve this.<br>The UHB is actively contributing, via membership of WG & NHS Wales committees to changing and improving data flows and making the required data available. | Assistant Director – Information and Performance. |

| Finding 3 - Presentation of Performance Report (Operating effectiveness) | Risk |
|---|---|
| It is noted that the current format of the Performance Report presentation is difficult to view as all 67 measures are reported on a singular portrait page.<br>This was identified and noted in the minutes for the September Board meeting for reconsideration. | Issues are not effectively identified, reported and addressed. |
| **Recommendation** | **Priority level** |
| Consideration should be given to re-formatting the Performance Report to improve usability. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Accept | Board Secretary / Assistant Director – Information and Performance |

# 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.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>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 & Vale University Health Board

# Renal IT System

# Final Internal Audit Report

# 2018/19

## Private and Confidential

## NHS Wales Shared Services Partnership

## Audit and Assurance Service

**Contents** **Page**



| | |
|---|---|
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| **Final report issued:** | December 2018 |
| **Auditors:** | Martyn Lewis |

| | |
|---|---|
| **Executive sign off:** | Chief Operating Officer |
| **Distribution:** | |
| **Committee:** | Audit Committee |

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

**Please note:**

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

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

## 1. Introduction and Background

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

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

## 2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place for the management of the Renal IT System (VitalData), in order to provide reasonable assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review is to provide assurance that data held within the Renal system is accurate, secure from unauthorised access and loss and that the system is used fully.

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

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

## 3. Associated Risks

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

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

## OPINION AND KEY FINDINGS

### 4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Renal IT System 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 VitalData system is a well managed system used in a coordinated way across Wales. The system architecture has a high level of resilience built in and support contracts are in place for both hardware and software. There is also a continuity plan for the system, however this has not been tested. Access to the system is granular and well controlled, with good controls over key data entry fields and extensive use of lists and there are a number of data quality reports in place.

There were areas of identified weaknesses, in particular the database and operating system software are out of date, unsupported, and contain known critical vulnerabilities. User access also had some issues with the current password length not complying with policy and there were users with access who have left the UHB. In addition although users appreciate the system there is no local forum for users to share knowledge and take ownership of the system.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Governance of the System | | | | ✓ |
| **2** | Database | | ✓ | | |
| **3** | Input Control | | | ✓ | |
| **4** | Access Control | | | ✓ | |
| **5** | Outputs and Interfaces | | | | ✓ |
| **6** | Audit Trail | | | | ✓ |
| **7** | Continuity | | | ✓ | |

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

### Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for the Renal IT System.

### Operation of System/Controls

The findings from the review have highlighted ten issues that are classified as weakness in the operation of the designed system/control for the Renal IT System.

## 6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

**Objective 1: An appropriate governance process is in place for the system.**

The following areas of good practice were noted:

- there is a contract in place with Vitalpulse for provision of the system and maintenance etc. together with an accompanying SLA;
- invoices received are monitored for consistency with the contract;
- the Renal IT team meet on a regular basis to discuss developments etc.;
- there is a national (Wales) VitalData group;
- there is a (recently) set up formalised change request process;
- the system is fully used by the UHB; and
- there is good knowledge sharing and coordination of system administrators.

The following significant finding was identified:

- there is no local user group or similar within the UHB. As a result users do not have a forum to share knowledge, concerns, improvements etc. This may result in the system not being used to its fullest potential.

**Objective 2: Appropriate control is maintained over the database.**

The following area of good practice was noted:

- In general, control over the database is good.

The following significant finding was identified:

- The system is running on out of date and unsupported software for both the server operating system and the database. Both old versions have a number of vulnerabilities, of which some are rated as critical.

**Objective 3: All input is authorised, complete, accurate, timely and input once only.**

The following areas of good practice were noted:

- there is a good level of input control for data, with mandatory fields, format checks and limits imposed on many fields; and
- a set of user guides is available.

- standing data is maintained by system administrators appropriately; and
- the system has reports available to monitor data quality.

The following significant finding was identified:

- although the system has input controls in place, testing and discussion with users identified areas where these could be improved.

**Objective 4: Proper control is exercised over access to application systems.**

The following area of good practice was noted:

- access level is granular and based on job function and data class;
- accounts with system administrator privileges are appropriately restricted;
- in general allocation of privileges is secure;
- user accounts are locked after a set number of failed login attempts; and
- user accounts time out after a set period of inactivity.

The following significant findings were identified:

- reviewing access controls indicated 2 issues, with the minimum password length set to 6 and not all users having an enforced password change.
- testing a random sample of 15 leavers identified that 5 users still had access, including people who had left 12m ago. A review of last login date indicated that there were 177 users who haven't logged in in over 1 year.
- there are a number of generic logins. The majority have read only access, which is appropriate, however some have enhanced access privileges and are consultant or nurse equivalent accounts. The use of these will mean a lack of accountability over data entry.

**Objective 5: Controls ensure the accuracy, completeness, confidentiality and timeliness of output, reports and interfaces**.

The following areas of good practice were noted:

- the status of interfaces is monitored
- reports are available to users, along with a report writing functionality

There were no significant findings identified within this objective.

**Objective 6: A complete audit trail is maintained which allows an item to be traced from input through to its final resting place.**

The following area of good practice was noted:

- there is an auditing tool available which tracks the update of screens.

There were no significant findings identified within this objective.

**Objective 7: Appropriate business continuity arrangements are in place which include backing up copies of data and programs, storing and retaining them securely, and recovering applications in the event of failure**.

The following area of good practice was noted:

- there is a maintenance contract in place for the server hardware;
- there is a resilient architecture in place with data replicated to DR (disaster recovery) server;
- There is a business continuity / disaster recovery plan in place; and
- backups are taken on a regular basis.

The following significant findings were identified:

- although backups are taken, these have not been tested. This is exacerbated as recent changes to the backup regimen have meant that the logs provided to system administrators have not been available. As such administrators have not been able to confirm the expected files and sizes and so will not be able to confirm that backups are working fully as expected.

- there is a DR plan in place for the VitalData system, a review of this highlighted the following issues:

    - the plan has not been tested, as such there is no guarantee it will work as planned;
    - although the plan notes the contract in place and refers to contacting support, the details of who to contact and how are not contained in the document;
    - the plan also does not provide for communication with user departments and escalation of issues.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

| Priority | H | M | L | Total |
|---|---|---|---|---|
| **Number of recommendations** | **1** | **7** | **2** | **10** |

| Finding 1–Out of Date Software (Operating effectiveness) | Risk |
|---|---|
| The system is running on out of date software for both the server operating system and the database:<br>-The UNIX version is 6.1 (sp5). Support for this version ceased April 2017 and there are a number of vulnerabilities in this version, with 5 of these being critical.<br>- The MySQL database is version 5.1.51. Support for this version ceased in December 2013 and there are a number of vulnerabilities in this version, with 1 being critical.<br><br>The use of old, unsupported software leads to an increased risk of unauthorised access to data, loss of data and malicious activity. | Loss of processing / data. |
| **Recommendation** | **Priority level** |
| Both UNIX and MySQL should updated to a more recent, supported version. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Early investigations have taken place between Vitalpulse and Summerside. Monies will need to be found to either see how viable the MySQL version 5.7 is with a more recent AIX version. It may not be compatible and a Windows or Linux infrastructure (Live and DR) will need to be considered.<br><br>Whilst the appropriate Hardware and Software vendor companies, who are contractually obliged to support and maintain the renal IT infrastructure | Renal Systems Analyst<br>June 2019 |

| | |
|---|---|
| (Summerside Computers Ltd and Vitalpulse Ltd respectively) review and consider the viable options available, we are unable to action any immediate change, either as a HB or as part of the WRCN. We will continue to monitor and review until a suitable solution is identified and can be implemented. | |

| **Finding 2– Access Controls (Operating effectiveness)** | **Risk** |
|---|---|
| reviewing access controls indicated 2 issues:<br>- Although the system has a required minimum password length, this is set to 6, however the UHB IT security Policy requires 8.<br>- Not all named users have a forced change of password set within the system. | Inappropriate access to system / data. |
| **Recommendation** | **Priority level** |
| The minimum password length should be set to 8 and all users have a forced password change enacted. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The minimum length has now been amended to 8.<br><br>With regard to forced change, this will be required when VitalData v1.7 is implemented across Wales this financial year. v1.7 has Active Directory authentication, which will mean Users will be required (and forced) to change | Renal Systems Analyst<br>April 2019 |

| | |
|---|---|
| their VitalData password every 90 days – the same as is required with User's everyday NADEX domain login. | |

| **Finding 3– Backups (Operating effectiveness)** | **Risk** |
|---|---|
| Although backups are taken, these have not been tested. This is exacerbated as recent changes to the backup regimen have meant that the logs provided to system administrators have not been available. As such administrators have not been able to confirm the expected files and sizes and so will not be able to confirm that backups are working fully as expected. | Loss of processing / data. |
| **Recommendation** | **Priority level** |
| The backups should be subject to periodic testing. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| This has been brought to the attention of the IT Server Team but is outside of the Directorate's direct control. We will continue to seek an appropriate response. | Renal Systems Analyst<br>April 2019 |

| Finding 4– Disaster Recovery (Operating effectiveness) | Risk |
|---|---|
| There is a DR plan in place for the VitalData system, a review of this highlighted the following issues:<br>- The plan has not been tested, as such there is no guarantee it will work as planned;<br>- Although the plan notes the contract in place and refers to contacting support, the details of who to contact and how are not contained in the document;<br>- The plan also does not provide for communication with user departments and escalation of issues.<br><br>As such the plan is heavily reliant on the knowledge of the system administrator(s). Should these be unavailable the organisation would be significantly hampered in recovery. | Loss of processing / data. |
| **Recommendation** | **Priority level** |
| The DR plan should be revised to include contact details of support organisations, user departments and management.<br><br>The DR plan should be tested and subject to subsequent review. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Dialogue with the Vendor parties has already started regarding the failback process. Action is underway to test and resolve, and identify an appropriate timetable for follow-up to ensure regular review. The BCP will be revised with immediate attention | Renal Systems Analyst<br>April 2019 |

| Finding 5– User Management (Operating effectiveness) | Risk |
|---|---|
| Testing a random sample of 15 leavers identified that 5 users still had access, including people who had left 12m ago. A review of last login date indicated that there were 177 users who haven't logged in in over 1 year. | Inappropriate access to system / data. |
| **Recommendation** | **Priority level** |
| A review of users should be undertaken to ensures that leavers access is revoked. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Action has been taken as identified and a process implemented to regularly review leavers. This will ensure access is revoked at the earliest opportunity. | Renal Systems Analyst<br>April 2019 |

| Finding 6– Generic Users (Operating effectiveness) | Risk |
|---|---|
| There are a number of generic logins. The majority have read only access, which is appropriate, however some have enhanced access privileges and are consultant or nurse equivalent accounts. The use of these will mean a lack of accountability over data entry. | Inappropriate access to system / data. |
| **Recommendation** | **Priority level** |
| Generic accounts should not be used for data entry. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Agreed, On request, Auditor provided a list of affected accounts and these have been reviewed. | Renal Systems Analyst<br>Complete |

| Finding 7– Data Entry Controls (Operating effectiveness) | Risk |
|---|---|
| Although the system has input controls in place, testing and discussion with users identified areas where these could be improved e.g.:<br>- In the APD screens the format for the number of hours does not allow decimals despite half hours being used as a treatment regime;<br>- The volume for medication in CAPD allows high values which are clinically inappropriate e.g. 20l where 2-3l is a normal dose;<br>- Venous pressure allows very high values;<br>- Pulse allows too low values;<br>- Medication allowed a quantity of 1000g.<br><br>Although the risk of clinical error is low due to staff training, the possibility for incorrect data entry, particularly in the case of bulk entry of data from forms leads to a reduction in the data quality within the system. | Inaccurate data held in system. |
| **Recommendation** | **Priority level** |
| The local user group should seek to identify fields which could benefit from improved entry controls. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Communication with users is ongoing and agreed changes will be actioned where appropriate. | Renal Systems Analyst<br>June 2019 |

| Finding 8– User Group (Operating effectiveness) | Risk |
|---|---|
| There is no local user group or similar within the UHB. As a result users do not have a forum to share knowledge, concerns, improvements etc. This may result in the system not being used to its fullest potential. | The UHB is not maximising the benefits from the system. |
| **Recommendation** | **Priority level** |
| A local user group should be established with leads from each of the user departments with the remit to:<br>- Share knowledge over how departments use the system;<br>- Identify areas where improvements to design or functionality could be made;<br>- Identify areas where additional training should be provided to users.<br>- identify areas where poor or late data entry has impacts on downstream departments. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Partially agree. There is an all Wales VitalData Group to which Users can feed into via their Renal IT lead or via each Health Board Clinical IT Lead. As the VitalData system is use within four out of the five Renal Units in Wales any developments or suggestions to change are to benefit all the renal community and a Request for Change process is in place in relation to any system improvements.<br>In Cardiff, local drop-in How-To sessions were established but with little buy-in; they were soon disbanded. | Renal Systems Analyst<br>June 2019 |

| | |
|---|---|
| Further consideration of an appropriate User involvement process is required and appropriate action based on feedback will be implemented. | |

| **Finding 9– Database (Operating effectiveness)** | **Risk** |
|---|---|
| From reviewing the MySQL database configuration, 2 minor issues were identified:<br>- The ROOT account has not been renamed. (audit notes that the password has been changed)<br>- The default anonymous account appears to still exist. (audit notes that privileges have been restricted) | Inappropriate access to system / data. |
| **Recommendation** | **Priority level** |
| The ROOT account should be renamed and the anonymous account deleted. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The anonymous account was deleted Oct 2018.<br><br>The ROOT account will be kept as such to maintain consistency in the database. | Renal Systems Analyst<br>Complete |

| Finding 10– Logging (Operating effectiveness) | Risk |
|---|---|
| Currently logging is turned off within the database. Best practice would entail this being enabled to allow for tracking of actions and ensure compliance with legislation such as GDPR and the NIST directive. | Inaccurate data held in system. |
| **Recommendation** | **Priority level** |
| The UHB should consider enabling logging | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Database enables logging of every action, be it viewing, editing, deleting etc. all stored in an Activity Log table, where identification of Users can be analysed. The Activity audit facility can be used for system screens, or in the case of the binary logs, can focus on specific screen fields. | Renal Systems Analyst<br>Complete |

## 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.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

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

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

# Cardiff and Vale University Health Board

# Contract Compliance

## Final Internal Audit Report

## 2018/19

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



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**Auditors:** Ken Hughes, Principal Auditor
Ian Virgil, Deputy Head of Internal Audit

**Executive sign off:** Bob Chadwick, Director of Finance

**Distribution:** Claire Salisbury, Head of Procurement
Rhian Lye, Deputy Head of Procurement

**Committee:** Audit Committee

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

## 1. Introduction and Background

The review of Contract Compliance within the UHB was completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board.

The UHB's Standing Orders (SO's) & Standing Financial Instructions (SFI's) require that the purchase of all goods and services be subject to competition in accordance with good procurement practice and relevant legislation, making reference to minimum thresholds for quotes and competitive tendering arrangements.

Although the review focused on the elements of the contracting process undertaken by the Health Board, it was necessary to communicate with NHS Wales Shared Services Partnership (NWSSP) staff as part of the review.

The relevant lead Executive Director for the audit was the Executive Director of Finance.

## 2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of Contract Compliance in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of systems objectives were being managed appropriately.

The purpose of the review was to establish whether the Health Board has adequate processes in place for ensuring compliance with the rules around carrying out competitive tendering and awarding commercial contracts.

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

- Robust processes are in place to ensure that all relevant employees and independent members are aware of and comply with the contracting process and have access to the Health Board's policies, procedures and guidance as required;
- The purchase of goods and services valued over the relevant financial thresholds is appropriately carried out via the contracting process and in accordance with the Health Board's policy, SOs, SFIs and relevant legislation; and
- Robust processes are in place for monitoring compliance with the contracting process and any instances of non-compliance are highlighted and reported to appropriate management / Health Board Committee for action.

## 3. Associated Risks

The potential risks considered in the review were as follows:

- The Health Board does not comply with contract law; and
- The Health Board does not receive value for money.

## 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 Contract Compliance 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 Health Board has a range of documented Procurement and Contracting guidance in place for staff and Independent Members, and this is readily available via the Cardiff & Vale Intranet. Advice and guidance is also available from the Procurement Team, and this was recognised by the majority of staff as the first port of call if they required assistance or had any procurement queries.

There are well established processes and procedures in place for the ordering of goods and services, and robust monitoring processes are undertaken by the Procurement Team to identify non-compliant expenditure. Consequently our audit found that much of the Trust's expenditure was covered by a contract or Framework agreement.

However testing identified a significant number of instances where staff could not provide evidence that they had obtained quotations prior to raising purchase orders, and one instance where a full tender exercise should have been undertaken. The Trust cannot therefore demonstrate that all purchases achieve

value for money or that suppliers are always able to compete for the provision of goods and services on a fair and equal basis.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Staff and IM's have access to relevant guidance and HB policies and procedures and are aware of the contracting process. | | | ✓ | |
| **2** | The purchase of goods and services is carried out via the contracting process and in accordance with SO's and SFI's. | | | ✓ | |
| **3** | Compliance with the contracting process is robustly monitored and instances of non-compliance are reported to management / Health Board for action. | | | | ✓ |

** 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 a weakness in the system control/design for Contract Compliance.

### Operation of System/Controls

The findings from the review have also highlighted three issues that are classified as weaknesses in the operation of the designed system/control for Contract Compliance.

## 6. Summary of Audit Findings

The key findings are reported in the Management Action Plan in Appendix A.

**Objective 1: Robust processes are in place to ensure that all relevant employees and independent members are aware of and comply with the contracting process and have access to the Health Board's policies, procedures and guidance as required.**

The following areas of good practice were noted:

- A comprehensive Procurement Guide and Procurement Decision Tree had been drawn up by Procurement Services. The Guide has a section covering contracts;
- An annual Procurement Services Business Plan had been drawn up setting out how services would be delivered across NHS Wales;
- A Procurement Strategy was in place for the period 2017 to 2022;
- All key procurement documentation had been made available to staff in January 2019 via the procurement pages on the C & V intranet;
- The Procurement Team provides advice and guidance on the contracting processes to both staff and Independent Members;
- Procurement training is periodically provided to Independent Members.

The following significant finding was identified for this objective:

- Staff awareness levels of the contracting process were poor.

**Objective 2: The purchase of goods and services valued over the relevant financial thresholds is appropriately carried out via the contracting process and in accordance with the Health Board's policy, SOs, SFIs and relevant legislation:**

The following areas of good practice were noted:

- There is documented, up to date guidance for staff that is available on the C & V intranet;
- Standing Orders and Standing Financial Instructions are available to staff on the C & V intranet;
- Advice and guidance on all aspects of procurement is provided by the Procurement Team;
- Catalogue items are uploaded to Oracle where there are contracts or framework agreements in place;
- Invoices with no Purchase Order number will not be paid;
- Compliance with the contracting process is monitored by the Procurement Team; and

- A contracts register is maintained detailing all contracts and Framework Agreements in place.

The following significant findings were identified for this objective:

- Testing identified significant expenditure to a contractor that had been awarded on the basis of a single quotation that should have been subject to a full tender exercise;
- Staff were not always able to provide evidence that they had obtained quotations prior to raising purchase orders.

**Objective 3: Robust processes are in place for monitoring compliance with the contracting process and any instances of non-compliance are highlighted and reported to appropriate management / Health Board Committee for action:**

The following areas of good practice were noted:

- There is a comprehensive Procurement Guide that is readily available to all staff that sets out the procurement processes in place;
- Advice and guidance on the procurement processes is readily available from the procurement team;
- Expenditure is subject to ongoing monitoring for compliance throughout the year by the Procurement Business Manager (Compliance & Sourcing);
- The Business Managers for each area undertake deep dive expenditure reviews annually to identify common non-catalogue expenditure;
- All instances of non-compliance identified are reported to the C & V Audit Committee via the Procurement Compliance Report.

No significant findings were identified for this objective.

## 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** | **1** | **2** | **4** |

| Finding 1 - Lack of Competition (Operation) | Risk |
|---|---|
| In accordance with Procurement Procedures, Standing Orders and Standing Financial Instructions, staff responsible for purchasing goods or services on behalf of the Trust are required to achieve value for money and ensure that all suppliers can compete on a fair and equal basis.<br><br>Testing of a sample of invoices identified expenditure of £98k for the first 6 months of 2018/19 to a contractor engaged by the Estates Department to undertake anti ligature works at Llandough hospital. The work was awarded on the basis of a single quotation for an hourly rate for the provision of labour. We were informed that this was done to ensure funding awarded by the Welsh Government in November 2017 was spent by the year end or it would be lost.<br><br>However the work has continued into 2018/19 and is ongoing and expenditure has continued into 2018/19. We also note that expenditure includes materials and not just labour, and that other larger elements of work from the same funding were tendered prior to the 2017/18 year-end. Based on expenditure incurred during 2017/18 and the current year to date the award of anti-ligature work should also have been subject to a full tender exercise. | The failure to tender for works over £25k contravenes the Trust's procurement procedures, SO's and SFI's and could expose the Trust to accusations of favouritism and legal challenge from other contractors. There is also no assurance that the Trust has achieved value for money. |

| Recommendation 1 | Priority level |
|---|---|
| Capital & Estates staff should be formally reminded of the requirement to comply with Procurement procedures and ensure all work awarded achieves value for money and contractors are able to compete for work on a fair and equal basis.<br><br>Identified non-compliance with the above requirement should be reported to the Audit Committee through the Procurement Compliance Report. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Procurement Services has put in place a system to identify additional expenditure sub £5k, and are working with Estates Services to tender a Framework for these services to ensure competition and governance is managed.<br><br>Capital & Estates staff are reminded to comply with Procurement Procedures.<br><br>All non-compliance is reported to Audit Committee. | Claire Salisbury<br><br>August 2019 |

| Finding 2 - Lack of Evidence of Quotations - (Operation) | Risk |
|---|---|
| A random sample of 10 invoices under £5k in value was selected for testing to ensure that a quotation had been obtained prior to raising the Purchase Order. Staff were unable to provide evidence that a quotation had been obtained for 2 of the 10 invoices tested.<br><br>Delays in uploading catalogues from agreed contracts to Oracle were also identified during testing. | Non-compliance with procurement procedures.<br><br>Failure to obtain value for money. |
| **Recommendation 2** | **Priority level** |
| Staff raising purchase orders should be reminded of the requirement to obtain quotations and retain evidence of such, prior to raising orders in accordance with procurement procedures.<br><br>The uploading of catalogue items to Oracle for new contracts should be undertaken on a timely basis. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Procurement Services will continue to support, provide training, guidance and reinforce SFI's to all departments. | Claire Salisbury<br><br>Continuous |

| Finding 3 - Awareness of Contracting Process - (Control Design) | Risk |
|---|---|
| Awareness of the contracting process is promoted through the production of a comprehensive Procurement Guide, Procurement Decision Tree, Procurement Services Business Plan and 5 year Procurement Strategy. These were made available to staff on the Cardiff and Vale intranet in January 2019. Standing Orders and Standing Financial Instructions were also available to staff via the C & V intranet, and support, advice and guidance was also available from the Procurement Business Manager and the procurement team.<br><br>A survey of a sample of 100 Cardiff and Vale staff was undertaken as part of the audit to gauge awareness of the contracting process and in particular the thresholds for obtaining single / multiple quotes and undertaking a full tender exercise. Both the response rate and results of the survey were disappointing and overall showed a very poor understanding of the Health Board's contracting processes.<br><br>It was also identified during discussions with senior procurement staff that procurement is not included in the corporate induction programme. | Non-compliance with procurement procedures.<br><br>Failure to obtain value for money. |
| **Recommendation 3** | **Priority level** |
| An overview of the procurement process should be included in the Corporate staff induction programme. This could take the form of a summary guidance sheet that could be handed out to new employees and / or a presentation to new employees by the procurement team. | **Low** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| Procurement Services will provide a summary guidance sheet to the Induction Team for the Health Board. | Claire Salisbury<br>April 2019 |

| Finding 4 - Procurement Services Business Plan (Operation) | Risk |
|---|---|
| A Procurement Services Business Plan for 2017/18 had been produced setting out how Procurement Services were going to help NHS Wales deliver world class health and social services. This was also available to all C & V staff via the C & V intranet, but was out of date. It is unclear whether the out of date Business Plan had been posted in error or an updated Business Plan had not been produced. | Non-compliance with procurement procedures.<br>Failure to obtain value for money. |
| **Recommendation 3** | **Priority level** |
| The Procurement Guide should be reviewed and updated as necessary. The current year's Procurement Services Business Plan should be posted to the intranet if available. An up to date Procurement Services Business Plan should be drawn up for 2019/20 and made available to all staff via the procurement section of the C & V UHB intranet. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Since the C&V intranet was tested, the revised Business Plan has been approved by NWSSP and updated on the C&V website in January. | Claire Salisbury – Jan 2019 (Completed) |

## 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.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>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

# Clinical Diagnostic and Therapeutic Clinical Board – Bank, Agency & Overtime Spend

## Final Internal Audit Report

## 2018/19

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
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| **Auditor/s:** | Ian Virgill, Johanna Butt |
| **Executive sign off:** | Mat Temby, Director of Operations |
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| **Committee:** | Audit Committee |

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

## 1. Introduction and Background

The review of bank, agency and overtime spend within the Clinical Diagnostic and Therapeutic (CD&T) Clinical Board was completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board.

All National Health Service organisations rely on a level of temporary and / or additional staff resources, in order to maintain service continuity. The inherent nature of providing health services, with the variations in demand, capacity and workforce availability dictate that such expenditure is unavoidable. However, areas can influence the demand for and cost of this additional staffing through the development and utilisation of robust governance and control processes.

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

## 2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the CD&T Clinical Board for the management of bank, agency and overtime spend, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the review was to establish if bank, agency and overtime usage is effectively justified, verified and authorised and the subsequent payments are correctly processed and authorised.

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

- Appropriate documented processes and procedures are in place for the booking of bank and agency staff and the utilisation of overtime;
- Bank and agency staff are only requested after all other possible forms of cover have been investigated;
- All requests for bank and agency staff are supported by appropriate justification and authorisation;
- Bank and agency staff are obtained from the most cost effective providers;
- All completed bank and agency shifts are effectively verified and authorised prior to payment at the correct rate;
- Requests for overtime are supported by effective justification and are appropriately authorised prior to being worked;
- Completed overtime is appropriately paid at the correct rate; and

- Accurate and timely reports on bank, agency and overtime usage and costs are produced and distributed to appropriate staff and groups / committees within the Health Board. Reports are subject to effective scrutiny and actions are taken where required.

As part of the review, detailed testing was undertaken within the following 5 departments:

- Cellular Pathology;
- Medical Biochemistry;
- Occupational Therapy;
- Physiotherapy; and
- Dietetics.

## 3. Associated Risks

The potential risks considered in this review were as follows:

- Financial loss due to unnecessary usage and / or incorrect payment of bank, agency and overtime.
- Issues relating to bank, agency and overtime are not identified or addressed.

## OPINION AND KEY FINDINGS

## 4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with CD&T CB – Bank, Agency & Overtime Spend 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. |

We found the use of bank, agency and overtime within the Clinical Board to be justified, with valid reasons for utilisation which included; cover for vacant posts to ensure safe service delivery, different initiatives including Winter Pressure; 'A Perfect Day'; provision of a seven day service; clearing waiting time initiatives; covering maternity leave and clearing backlogs.

At the time of the review the Clinical Board had decided to source all its agency workers through 'Medacs' which it considers to be the most efficient and cost-effective method of sourcing agency staff as Medacs are on-site at University Hospital Wales.

All departmental delegated budget holders are provided with monthly reports from the Finance Team which include budget reports and supplementary finance reports which detail variances on staffing. Delegated budget holders present at the Directorate Performance Review meetings and the Finance Delivery Group meetings when required which includes reasons for any adverse variances and any staffing issues.

The Clinical Board does not have a documented Standard Operating Procedure detailing the process to follow for booking and authorising bank and agency staff and utilising overtime. We acknowledge that for our sample of departments, managers were clear on the process within their own departments. However, the Clinical Board may benefit from introducing clear guidelines and standard documentation to ensure that there is a standardised and consistent approach within the Clinical Board.

Our review of a sample of worked and paid overtime sessions identified instances of non-compliance with the requirement for a 30 minute unpaid break along with issues around the correct recording of additional hours worked by part time staff.

However, at the time of our review, we acknowledge that the costs associated with bank, agency and overtime were not excessive within the Clinical Board.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Appropriate and Documented Process/Procedure | | | ✓ | |
| **2** | Bank and Agency Requests | | | | ✓ |
| **3** | Justification and Authorisation for use | | | | ✓ |
| **4** | Bank and Agency Providers | | | | ✓ |
| **5** | Verification/Authorisation prior to payment | | | ✓ | |
| **6** | Justification/Authorisation of overtime | | | | ✓ |
| **7** | Overtime paid at correct rate | | ✓ | | |
| **8** | Reporting Bank/Agency/Overtime usage | | | | ✓ |

** 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 two issues that are classified as weakness in the system control/design for CD&T CB – Bank, Agency & Overtime Spend.

### 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 CD&T CB – Bank, Agency & Overtime Spend.

## 6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

**Objective 1: Appropriate documented processes and procedures are in place for the booking of bank and agency staff and the utilisation of overtime.**

The following areas of good practice were noted:

- All of the 5 departments sampled had generally effective processes in place for the booking of bank and agency staff and the utilisation and authorisation of overtime.

The following significant finding was noted:

- The Clinical Board does not have a standard documented procedure in place that details the process for the booking of bank and agency staff and the utilisation and authorisation of overtime. However, we acknowledge that for the sample of departments within the Clinical Board we visited, managers were aware of the process followed within their department but this was not always formally documented.

**Objective 2: Bank and agency staff are only requested after all other possible forms of cover have been investigated.**

The following areas of good practice were noted:

- The use of bank and agency staff is only requested when other forms of cover have been investigated which includes advertising vacant posts.
- The Dietetics department has clear guidance in place for managing annual leave to ensure that adequate arrangements can be put in place to minimise any disruption to the service and patient care.
- The Medical Biochemistry department uses its substantive staff to cover bank shifts which ensures that the staff used are appropriately competent to undertake the duties required and the requirement to provide any training to undertake the duties.

There were no significant findings noted.

**Objective 3: All requests for bank and agency staff are supported by appropriate justification and authorisation.**

The following areas of good practice were noted:

- Reasons for using bank and agency were found to be appropriately justified. These included clearing backlogs, covering maternity leave, backfill any gaps resulting from 'work, life, balance' working

arrangements. Participation in initiatives such as Winter Pressure and Lung Prehab.

- When departments are required to participate in initiatives such as Winter Pressure these schemes are in addition to their normal establishment. Given that the departments are already carrying vacancies the only way to participate is with the use of bank, agency and overtime. These initiatives are not permanent and as such it would not be appropriate as a substantive post.
- There was evidence of appropriate agreement being in place for the use of bank, agency and overtime to support the relevant initiatives.

There were no significant findings noted.

**Objective 4: Bank and agency staff are obtained from the most cost effective providers.**

The following areas of good practice were noted:

- The Clinical Board has communicated to departments that from October 2018 onwards Agency staff will be sourced from 'Medacs' as this is considered to be a more cost effective and efficient sourcing solution for the Health Board. A representative for 'Medacs' is based on-site at University Hospital Wales site.
- Where the Health Board has used agency staff these have been from suppliers on the NHS Framework.
- Bank staff are sourced and paid through the temporary staffing department within the Health Board. Bank Staff are paid at the same rate of pay for the banding of the substantive post that they are being assigned to. The hourly payment is equivalent to the Agenda for Change pay scales for the duties that the bank worker is required to undertake.
- The Medical Biochemistry department uses its substantive staff to work to cover bank shifts rather than have substantive staff accumulating large amounts of 'time off in lieu' which would exacerbate any effects of carrying vacant posts within the department.

There were no significant findings noted.

**Objective 5: All completed bank and agency shifts are effectively verified and authorised prior to payment at the correct rate.**

The following areas of good practice were noted:

- Our review of a sample of bank timesheets confirmed that the shifts are effectively authorised prior to payment which includes comparison against the individual's patient caseload.
- The Medical Biochemistry department uses 'Rosterpro' which interfaces with ESR payroll. The authoriser checks that the shift was worked against the laboratory attendance sheets and only then the rota is locked down and can be submitted for payment. Our review of 'Rosterpro' screen shots against the laboratory attendance sheets confirmed that the shift had been worked.

The following significant finding was noted:

- We requested evidence of agency timesheets from the Cellular Pathology department however evidence of timesheets and authorisation of agency timesheets were not provided. We acknowledge that the department was being inspected by the HTA at the time of our review. The department only had one agency worker. At the time of our review the agency worker had been informed that the contract would be terminated as the backlog had reduced.

**Objective 6: Requests for overtime are supported by effective justification and are appropriately authorised prior to being worked.**

The following areas of good practice were noted:

- The use of overtime was justified and are the same reasons documented for the use of bank and agency staff detailed in 'Objective 3' above.
- Departments are required to participate in initiatives and as such the departments are asked to provide details of staffing required to participate in the initiatives rather than departments requesting authorisation.

There were no significant findings noted.

**Objective 7: Completed overtime is appropriately paid at the correct rate.**

The following areas of good practice were noted:

- With the exception of the specific issue highlighted below, we found that the sampled overtime sessions were appropriately paid to staff at the correct rate.

The following significant finding was noted:

- Our review of a sample of overtime claim forms found that a 30 minute unpaid break was not always included where the individual had worked over six hours. This is a requirement under the Working Time Regulation.

**Objective 8: Accurate and timely reports on bank, agency and overtime usage and costs are produced and distributed to appropriate staff and groups / committees within the Health Board. Reports are subject to effective scrutiny and actions are taken where required.**

The following areas of good practice were noted:

- The Clinical Board Accountants provide delegated budget holders with Monthly Finance / Budget Reports that they are required to review. These reports include staffing costs and any adverse or favourable variances this ensures that delegated budget holders are aware of costs associated with staffing.
- The CD&T CB Finance Delivery Group meet monthly and delegated budget-holders are expected to attend and provide an update if they are not meeting their Cost Reduction Programme (CRP) target. This, where appropriate would include any staffing issues that may impact on the achievement of the target. Our review of minutes for the group confirmed that delegated budget holders attend and where required present to the group.
- CD&T CB Directorate Performance Review meetings are held monthly and delegated budget holders are asked to present a report on the department's performance which may include a review of staffing issues impacting the department.

There were no significant findings noted.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

| Priority | H | M | L | Total |
|---|---|---|---|---|
| **Number of recommendations** | **1** | **2** | **1** | **4** |

| Finding 1 – Overtime Payments (Control design) | Risk |
|---|---|
| We selected a sample of overtime payments and obtained copies of the overtime claim forms for the payments selected. The following issue was noted:<br>• The Working Time Regulations require that an individual should not work longer than 6 hours without a break. The Health Board's Working Time Policy states that a minimum 30 minute break should be taken and this should be unpaid. Review of a sample of overtime claim forms within the Cellular Pathology and Dietetics departments confirmed that where staff are working over 6 hours of overtime, an unpaid break is not always recorded. This results in non-compliance with the Regulations and Health Board policy and an overpayment to the individual in respect of the 30 minute break. | Financial Loss due to incorrect payment of overtime. |
| **Recommendation** | **Priority level** |
| The Clinical Board should develop a process to ensure that all overtime sessions worked in excess of 6 hours include a clearly documented 30 minute unpaid break. This process should then be communicated to all relevant managers and consistently implemented in the future. | **High** |
| **Management Response** | **Responsible Officer / Deadline** |
| All departments have received a communication instructing them to amend their current processes to include a documented 30 min break. This was done in advance of the production of a new Standard operating procedure which will include this guidance and relevant recording mechanisms as per finding 2 | Director of Operations<br>Completed |

| Finding 2 - Standard Operating Procedures (Control design) | Risk |
|---|---|
| The CD&T Clinical Board does not have any standard documented procedure / guidance notes in place which detail the process to follow when booking bank, agency and utilisation of overtime.<br><br>However, discussions with the five sampled departments within the CD&T Clinical Board confirmed that they all had generally effective processes in place but these were not documented in all cases. Of the five departments reviewed, the following is noted:<br><br>Medical Biochemistry and Dietetics had documented the process for the purpose of the audit.<br><br>Physiotherapy had a 'high level' flowchart in place.<br><br>Cellular Pathology and Occupational Therapy did not have any documented process in place. | Potential financial loss due to unnecessary usage and / or incorrect payment of bank, agency and overtime. |
| **Recommendation** | **Priority level** |
| The Clinical Board should consider producing a Standard Operating Procedure detailing the process to follow when booking bank, agency and utilisation of overtime, in order to ensure that there is a consistent approach throughout the Clinical Board. | **Medium** |

| | |
|---|---|
| As a minimum, Individual directorates should ensure that their own processes are formally documented in order to ensure consistent application and effective continuity in the event of staff changes / absence. | |
| **Management Response** | **Responsible Officer / Deadline** |
| CD+T will review the current processes in place across departments to produce an overarching SOP to be utilised across departments. Where there are individual practices in place that are necessarily bespoke they can remain and will be referenced within the procedure | Business Partner for Workforce and OD<br>30/3/19 |

| **Finding 3 – Authorisation of Agency timesheets (Operation)** | **Risk** |
|---|---|
| We reviewed the general ledger for the Cellular Pathology department which confirmed that it included payments made to Maxxima Ltd in respect of Agency Healthcare Scientists.<br>In October 2018 we requested evidence that the agency shifts for April – August 2018 had been appropriately authorised prior to payment. As at January 2019 no evidence had been provided to evidence that the shifts had been appropriately authorised prior to payment. We acknowledge that the department was being inspected by the Human Tissue Authority (HTA) at the time of our review.<br>From our initial discussions we understand that the Cellular Pathology department only had one agency worker who had been informed that their contract would be terminated as the microtomy backlog had reduced. | Financial loss due to unnecessary usage and / or incorrect payment of bank, agency and overtime. |

| Recommendation 3 | Priority level |
|---|---|
| The department should ensure that all agency shifts worked are appropriately authorise prior to payment and evidence of authorisation should be retained. | **Medium** |
| **Management Response 3** | **Responsible Officer/ Deadline** |
| The management team associated with this department has been requested to provide the relevant recording to the clinical board for review and the need for this on an ongoing basis will for part of the SOP. | Cellular Pathology Service Manager<br>15/3/19 |

| Finding 4 – Correct completion of pay-cards (Operation) | Risk |
|---|---|
| The departments are required to submit pay-cards to the Payroll department in order for individuals to be paid overtime. We reviewed the pay-cards submitted by the directorates from April 2018 - July 2018. The following is noted:<br>Under Agenda for Change arrangements, individuals working under 37.5 hours should be paid plain time and any hours worked above their contracted hours should be categorised as plain time additional hours up to 37.5 hours before overtime is paid at time and a half. The pay-card details the individuals contracted hours. | Financial Loss due to incorrect payment of overtime. |

| | |
|---|---|
| Our review of a sample of pay-cards within the Cellular Pathology department confirmed that they included some instances of individuals whose contracted hours are below 37.5 hours but have overtime hours recorded and no plain time additional hours. These hours may be incorrectly classed as overtime which would result in an overpayment to the individual with them being paid time and a half instead of plain time.<br><br>Review of the individual's pay slips confirmed that Payroll had correctly processed the hours as plain time rather than overtime and so no overpayment had actually occurred. The incorrect recording of the time on the pay-cards still created the risk that overpayments could occur. | |
| **Recommendation 4** | **Priority level** |
| Where staff work less than the Agenda for Change hours of 37.5 hours any additional hours worked must be recorded as 'Additional Hours' on the Pay Card returned to Payroll Delegated Budget Holders should review the pay-cards submitted to Payroll to establish whether additional hours have been incorrectly classed as overtime. | **Low** |
| **Management Response 4** | **Responsible Officer/ Deadline** |
| This will form part of the SOP, and a reminder email will be sent to all departments | Director of Operations<br><br>Complete |

## 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.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

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

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Cardiff and Vale University Health Board

## Cardiff and Vale University Health Board

# Kronos Time Recording System - Estates

## Final Internal Audit Report

## 2018/19

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

Contents **Page**



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**Auditor/s:** Ken Hughes, Principal Auditor
Ian Virgill, Deputy Head of Internal Audit

**Executive sign off:** Abigail Harris, Director of Planning

**Distribution:** Geoff Walsh, Director of Capital, Estates & Facilities
Ian Fitsall, Estates Manager
Gareth Simpson, Estates Manager
Dave Burnett, Administration Manager

**Committee:** Audit Committee

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

## 1. Introduction and Background

A review of the Kronos time recording system within the Estates Department has been completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Health Board.

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

An Internal Audit of the Estates Timesheets process was undertaken in January 2016 that highlighted a number of significant issues resulting in an overall assurance rating of No Assurance. A detailed follow-up review completed in December 2016 confirmed that a number of the agreed management actions had been completed resulting in an overall assurance rating of Reasonable Assurance.

During the follow-up audit it was identified that the Estates Department had been trialling the Kronos time recording system within the Maintenance Department that it was envisaged would address the outstanding issues and further strengthen the time management 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 management of the Kronos time recording system in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The scope of the audit was to establish whether the Kronos time recording system currently being piloted within UHW is designed and operating effectively to ensure the appropriate management of staff rotas and time recording.

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

- The department had effective processes and procedures in place for the drawing up of appropriate staff rotas and these are accurately recorded within the Kronos system;
- Actual time worked by Estates staff was accurately recorded within the Kronos system and appropriately authorised by the relevant Supervisors;
- The controls in place ensured that all staff were working their contracted hours;
- Any overtime usage was appropriate, authorised and accurately recorded within the Kronos system; and
- The recorded rotas and time worked within the Kronos system were accurately entered into the ESR system to ensure correct payments were made to staff.

## 3. Associated Risks

The potential risks considered in the review were as follows:

- Rotas did not ensure effective service provision or that staff worked their contracted hours and had appropriate breaks;
- Unnecessary usage of overtime; and
- Rotas and time were not accurately recorded leading to errors in payments.

## 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 Kronos time recording system is **Reasonable Assurance.**

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

The pilot of the Kronos Workforce Ready (WFR) system has been running since July 2016 and was set up by the Estates Service Improvement Programme Team in conjunction with the system suppliers Kronos. A Business Case was prepared prior to running the pilot that set out the project objectives, expected costs and benefits and considered other options, but recommended piloting the Kronos system.

The audit has identified that controls are in place for the recording and management of Estates staff time, which represents an improvement from the position at the time of the previous audit. However a number of the controls relate to manual processes operating alongside the Kronos system.

The pilot, which was expected to last 6 months, has now been running for over 2 years. However the system is still not fully functional with a number of key issues still to be resolved; the main issue being the failure to develop

and implement an automatic interface between Kronos and ESR which is crucial to the successful implementation of the system and its rollout across the remainder of the Estates Department.

There has also been no regular monitoring or reporting of progress of the pilot to Estates Senior Management, and to date no evaluation of the suitability of the system for the Estates Department has been undertaken.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | The department has effective processes and procedures for the drawing up of rotas and these are accurately reflected within the Kronos system | | | ✓ | |
| **2** | Actual times worked by Estates staff is accurately recorded within the Kronos system and appropriately authorised by the relevant supervisors | | | ✓ | |
| **3** | The controls in place ensure that all staff work their contracted hours | | | | ✓ |
| **4** | Any overtime is appropriate, authorised and accurately recorded within the Kronos system | | | ✓ | |
| **5** | The recorded rotas and time worked within the Kronos system are accurately entered into the ESR system to ensure correct payments to staff | | | ✓ | |

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

### Design of Systems/Controls

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

### Operation of System/Controls

The findings from the review have also highlighted two issues that are classified as weaknesses in the operation of the designed system / control.

## 6. Summary of Audit Findings

The key findings are reported in the Management Action Plan at Appendix A.

**Objective 1: The department has effective processes and procedures for the drawing up of rotas and these are accurately reflected within the Kronos system:**

The following areas of good practice were noted:

- Staff rotas were drawn up by Estates Management and were subject to periodical review; and
- There were eight rotas in place that provided round the clock coverage.

The following significant finding was identified under this objective:

- The pilot, which was expected to last 6 months, has now been running for over 2 years. There has also been no regular monitoring of the pilot and to date no evaluation of the suitability of the system for the Estates Department has been undertaken.
- Eight of the employees included in the pilot were working one of the five M & E Rotas (A to E) which included paid breaks.

**Objective 2: Actual times worked by Estates staff is accurately recorded within the Kronos system and appropriately authorised by the relevant supervisors:**

The following areas of good practice were noted:

- Individualised timesheets recorded the scheduled start and finish times of each shift;
- Staff were required to clock in at the start of their shift and clock out at the end of their shift;
- The Kronos system automatically calculated the actual hours worked and deducts any scheduled breaks; and
- Supervisors had the facility to amend the start and finish times on the Kronos system prior to authorising timesheets.

The following significant findings were identified under this objective:

- Some staff were clocking in up to an hour and a half before the start of their shift.

**Objective 3: The controls in place ensure that all staff work their contracted hours:**

The following areas of good practice were noted:

- Rotas were set up to ensure full time staff worked 37.5 hours per week;
- Actual hours worked each week recorded on the Kronos system alongside the scheduled hours; and
- Timesheets were subject to checking and authorisation by supervisors prior to payment.

No significant findings were identified under this objective.

**Objective 4: Any overtime is appropriate, authorised and accurately recorded within the Kronos system:**

The following areas of good practice were noted:

- The start and finish times for any overtime worked could be recorded on the Kronos timesheets; and
- Supervisors could approve or reject any overtime when authorising timesheets.

The following significant finding was identified under this objective:

- Not all of the sample of overtime tested had been claimed and authorised on employee timesheets within the Kronos system.

**Objective 5: The recorded rotas and time worked within the Kronos system are accurately entered into the ESR system to ensure correct payments to staff:**

The following areas of good practice were noted:

- All staff are set up on ESR to receive their basic pay automatically each week or month;
- Additional overtime and standby hours worked are entered into the Rosterpro system by Estates Admin staff, and these are uploaded to ESR via an automatic interface.

The following significant findings were identified under this objective:

- To date it has not been possible to create an automatic interface between Kronos and ESR; and

## 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** | **4** | **1** | **6** |

| Finding 1 - Monitoring, Reporting & Evaluation of Kronos Pilot (Operating effectiveness) | Risk |
|---|---|
| There has been no regular monitoring or formal reporting of progress of the pilot to Estates Senior Management, and to date no evaluation of the suitability of the system for the Estates Department has been undertaken. At the time of the audit it was unclear who had responsibility for this.<br><br>The pilot, which was expected to last 6 months, has now has been running for over 2 years. However the system is still not fully functional with a number of key issues still to be resolved. These include:<br>• the lack of an automatic interface between Kronos WFR and ESR;<br>• the system is not recording all overtime worked; and<br>• none of the system's standard management reports have been set up or tested. | The outcome of the Kronos system is not effectively evaluated. |
| **Recommendation 1** | **Priority level** |
| Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system. | **High** |

| | |
|---|---|
| A timescale should be set for the final evaluation of the system. This should include a recommendation as to whether or not the system should be rolled out across the rest of the Estates Department. | |
| **Management Response** | **Responsible Officer/ Deadline** |
| Since the initial audit fieldwork, CEF have identified a senior lead for reviewing the KRONOS system with a view to identifying what elements of the system are effective, areas which require further attention/training, link to ESR etc. A review date completion is set for June 2019 following which the Service Board will evaluate the system. | Business Manager<br>June 2019 |

| Finding 2 - Paid Breaks (Operating effectiveness) | Risk |
|---|---|
| It was identified during testing that the five M & E Rotas (A to E) are all based on staff being paid their full shifts with no deductions for breaks. This includes shifts of up to 8 hours long. Currently eight maintenance staff included in the Kronos pilot are working these shifts and benefitting from paid breaks. The remaining 44 maintenance staff included in the pilot do not receive paid breaks.<br><br>Paying full shifts of more than 6 hours without an unpaid break contravenes the requirements of the Health Board's Working Time policy.<br><br>This issue has been raised previously in our report issued in January 2016 where management acknowledged that no formal agreement existed for Estates staff to receive paid breaks. At that time management had also completed discussions with Trade Unions and had agreed to address the issue of paid breaks jointly with HR. | Non-compliance with Health Board policy. |
| **Recommendation 2** | **Priority level** |
| Management should review the current M & E Rotas to establish if the practice of paying staff for their breaks can be stopped. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The Estates Department is currently in the process of consultation with staff on modernisation of the department including changes to the shift patterns which would eliminate the need to pay staff for breaks. However until this is resolved | |

| | |
|---|---|
| the risk associated with enforcing an unpaid meal break for shifts outside normal hours is considered high. In so much that if an emergency (eg electrical failure) occurs when the shift electrician is on an unpaid break they could refuse to respond and put the service at risk. | |

| Finding 3 - Automatic Interface - Kronos to ESR (Design Weakness) | Risk |
|---|---|
| ESR is set up to automatically pay all staff on the pilot their basic pay of 37.5 hours per week or 162.95 hours per month. Enhancements such as payments for overtime, standby and call-out and any adjustments to basic pay such as unpaid leave are processed through the Rosterpro system by manual data entry. This then updates ESR via an automatic interface.<br>As part of the pilot the system providers have been asked to develop an automatic interface between Kronos and ESR so that data for worked enhancements does not have to be manually input to Rosterpro. This is crucial to the successful implementation of the system and its rollout across the remainder of the Estates Department. However, to date the automatic interface between Kronos and ESR has not been developed or implemented. | Increased costs due to inefficient use of staff time and potential errors in manual input. |
| **Recommendation 3** | **Priority level** |
| The development of an automatic interface between Kronos and ESR is a key factor in determining whether Kronos should be rolled out across Estates. A timetable and deadline should therefore be set for the development and introduction of a suitable interface between Kronos and ESR. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Refer to Management Response to Finding 1; which includes investigating the interface with ESR. Interface has now been developed and is currently being tested. | Business Manager<br>June 2019 |

| Finding 4 - Overtime (Design Weakness) | Risk |
|---|---|
| A sample of timesheets for 10 staff was tested to ensure overtime was appropriate, authorised and accurately recorded within the Kronos system. Not all of the sample tested had claimed overtime on their timesheets for the period reviewed.<br><br>It is acknowledged that a separate manual process was in place for recording and authorising this overtime but there is no record of the overtime claimed on the Kronos system. Overtime claims processed this way would also not be included in any future automatic interface between Kronos and ESR.<br><br>It was also noted that although the Kronos system can record the start and finish time for overtime and its approval or rejection, there is no field to record the reason why the overtime was worked. | Overtime worked is not fully recorded and authorised within the Kronos system. |
| **Recommendation 4** | **Priority level** |
| Where overtime has been worked this should be reflected in the start and finish times recorded in Kronos, and should be authorised on the timesheets.<br><br>Management should investigate the feasibility of including a 'reason for overtime' or Notes field on timesheets with the system providers so that in future all overtime can be claimed and authorised on individual timesheets. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| The issue will be considered as part of the system review although all overtime is authorised and recorded therefore the risk is low. Kronos has been updated to include overtime reasons. | Business Manager<br>June 2019 |

| Finding 5 - Early and Late Clock-ins (Design Weakness) | Risk |
|---|---|
| A sample of three weekly paid and seven monthly paid staff was selected and tested to ensure they had worked their assigned hours in line with the shifts in their rotas. All staff had worked their assigned number of hours. However 2 staff were regularly clocking in up to 1.5 hours before the start of their shift and one employee was regularly clocking in some 30 minutes late and staying 30 minutes after the end of his shift to make up his hours.<br><br>Where staff clock in up to 27 minutes before the start of their shift the system will round up the start time to the scheduled start time. Where staff clock in more than 27 minutes before their scheduled start time the system will require the supervisor to approve or reject the additional time as overtime. Where this is rejected the supervisor should manually adjust the start time to the scheduled start time, although this was not being done. Testing also identified a significant number of days where staff had not clocked in or out but no reason for absence or explanation for no clock in / out times had been recorded on the timesheet. | Time is not accurately recorded within the Kronos system. |

| Recommendation 5 | Priority level |
|---|---|
| Staff should be instructed to clock in no more than 27 minutes before the start of their shift. Where staff do clock in more than 27 minutes before the start of their shift, supervisors should amend the timesheet start time to the scheduled start time if the additional time is not to be paid as overtime. Supervisors should update timesheets with reasons why staff have not clocked in or out of the system prior to authorising them, for example annual leave, special leave, unpaid leave, working off site, system down etc.<br><br>Supervisors should amend shift start and finish times on Kronos where it has been agreed that staff can work alternative shift patterns. Disciplinary action should be taken against staff that are persistently late and fail to work their assigned shift pattern. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Staff clock in on arrival on site but are not paid from this point, unless authorisation is given for overtime. Staff will be advised not to clock in as suggested and this will be monitored but the risk associated with this practice is considered low. | Business Manager<br><br>June 2019 |

| Finding 6 - Manual Data Entry (Design Weakness) | Risk |
|---|---|
| ESR is set up to automatically pay all staff on the pilot their basic pay of 37.5 hours per week or 162.95 hours per month. Enhancements such as payments for overtime, standby and call-out and any adjustments to basic pay such as unpaid leave are then processed through the Rosterpro system by manual data entry. This then updates ESR via an automatic interface.<br><br>However Estates Admin staff have also been manually inputting all basic hours from Kronos timesheets into Rosterpro as well as the enhancements. This has no impact on pay as only the enhancements are included in the interface with ESR. It was identified during discussions with Admin staff that this generates a significant number of queries that are raised with Supervisors because basic hours are not always fully recorded on the Kronos timesheets. | Increased costs due to inefficient use of staff time. |
| **Recommendation 6** | **Priority level** |
| Estates Admin staff should be instructed to only input hours for enhancements into Rosterpro, i.e. overtime, standby and callout, plus any adjustments to basic pay.<br><br>The Kronos WFR system is being used primarily as a time and attendance recording system. Supervisors should therefore be instructed to ensure that timesheets accurately record the attendance and absences of all staff under their control. | **Low** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| Supervisors are fully aware of their responsibilities in respect of recording absence and attendance. Senior Managers will reiterate the process. | Senior Managers<br>June 2019 |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

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

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

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

### Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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