



A meeting of the Aneurin Bevan University Health Board Audit Committee will be held on Thursday 18th July 2019, commencing at 1:30pm in the Executive Meeting Room, Conference Centre, Health Board Headquarters, St Cadoc's Hospital, Caerleon

AGENDA

1	Private Discussions – 1:30pm			
	1.1	Committee members to have private discussions with External Audit	Verbal	Committee Members and External Audit
2	Preliminary Matters - 2:00pm			
	2.1	Apologies for Absence	Verbal	Chair
	2.2	Declarations of Interest	Verbal	Chair
	2.3	Draft Minutes of the Meeting held on 3rd April 2019	Attachment	Chair
	2.4	Action Sheet	Attachment	Chair
	2.5	Audit Recommendation Tracker Report	Attachment	Board Secretary
3	External Audit – 2:30pm			
	3.1	WAO Progress Update	Attachment	Wales Audit Office
	3.2	Report from WAO requiring consideration – Clinical Coding	Attachment	Wales Audit Office
4	NWSSP Audit & Assurance - Internal Audit & Specialist Service Unit – 3:00pm			
	4.1	Internal Audit Progress Report	Attachment & Presentation	Head of Internal Audit
	4.2	Internal Audit Report – of Limited Assurance – Medical Staffing	Attachment	Head of Internal Audit and Executive Lead Paul Buss/ Stephen Edwards
5	Governance and Assurance – 4.00pm			
	5.1	Update on Governance, Financial Control Procedures and Technical Accounting Issues	Attachment	Assistant Director of Finance (Financial Systems & Services)/ Board Secretary
	5.2	Financial Control Procedures (FCP's) For Approval	Attachment	Assistant Director of Finance (Financial Systems & Services)

	5.3	Losses and Special Payments Report	Attachment	Assistant Director of Finance (Financial Systems & Services)
6	Date of Next Meetings			
	Business Meeting: Thursday 10 th October 2019 at 1.30pm in Seminar Room 4, Headquarters, St Cadoc's			Chair

	Supplementary Papers Reasonable Assurance Internal Audit Reports submitted this period: • Risk Management – Reasonable • Health and Care Standards – Reasonable • Well Being of Future Generations Act – Reasonable – 1 high level recommendation • Clinical Futures Gateway Review – Reasonable • Cyber Security – Reasonable • GDPR Regulations – Reasonable • Clinical Futures IT Workstream – Reasonable • Use of Digital Technology Fit for the Future Advisory Report – Reasonable • Organisational Development and Training – Reasonable • HSDU Project – Reasonable • Capital Systems – Reasonable • Water Safety – Reasonable – 1 high level recommendation • Grange University Hospital Open Book Audit – Reasonable • Grange University Hospital Project Audit – Substantial • Annual Quality Statement – Approved

Aneurin Bevan University Health Board

Minutes of the Audit Committee held on Wednesday 3rd April 2019, in Conference Rooms 1 & 2, Headquarters, St Cadoc's

Present:

Catherine Brown	-	Chair, Independent Member (Finance)
Shelley Bosson	-	Independent Member (Community)

In Attendance:

Danielle O'Leary	-	Committee Secretariat
Richard Bevan	-	Board Secretary
Glyn Jones	-	Director of Finance
Judith Paget	-	Chief Executive
James Quance	-	Head of Internal Audit, NWSSP
Stephen Chaney	-	Deputy Head of Internal Audit, NWSSP
Terry Lewis	-	Wales Audit Office
Dave Wilson	-	Wales Audit Office

In Attendance for Specific Items:

Martyn Edwards	-	Head of Counter Fraud
Dr Paul Buss	-	Medical Director
Kate Hooton	-	Assistant Director of Organisational Learning
Nick Wood	-	Director of Primary, Community and Mental Health
Scott Lavender	-	PPV Manager, Shared Services
Sara Jeremiah	-	PPV Manager, Shared Services

Apologies:

Katija Dew	-	Independent Member (Third Sector)
Gabrielle Smith	-	Wales Audit Office
Martine Price	-	Director of Nursing
Dr Sarah Aitken	-	Director of Public Health

Audit 0304/01 Welcome and Introductions

The Chair welcomed members to the meeting and thanked all members for their attendance. The Chair commented that given the small amount of members of this Committee, it would be useful to have more members to ensure the Committee would be quorate when it met. It was agreed that this request would be fed in to discussions with the Chair of the Health Board with regard to the future Committee structure.

ACTION: Board Secretary

Audit 0304/02 Apologies for Absence

Apologies for absence were noted.

Audit 0304/03 Declarations of Interest

There were no declarations of interest to note.

Audit 0304/04 Minutes of Previous Meeting

The minutes were agreed as a true and accurate record.

Audit 0304/05 Action Log

A query was raised in relation to action **1701/09 GP Out of Hours/Urgent Primary Care Services**. The Committee suggested that because this specific action related to standards, it should also be monitored via the Quality and Patient Safety Committee. However, it was further agreed that when the review of the Committee structure was taking place, appropriate consideration would be given to a mechanism that would review and monitor performance, quality and financial compliance.

ACTION: Board Secretary

Audit 0304/06 Annual Counter Fraud Bribery and Corruption Report for 2018/19

The Committee received the annual report from the Head of Counter Fraud. It was noted that the report demonstrated that there had been a deficit in relation to the number of days actually attributed to the Counter Fraud work. The Committee was assured that despite the deficit of days,

attributed to sickness absence within the department, Counter Fraud had delivered on all legal aspects and responsibilities.

The Committee thanked the Head of Counter Fraud for the plan and commended the department on delivering on the targets despite the limited resource available to them.

The Committee discussed the resourcing of the Counter Fraud Team going forward and recommended that the National Counter Fraud Service role needed to be encompassed within the future plans. The Committee encouraged a resourcing plan to ensure sustainability for the Counter Fraud Team as it was recognised that this was a specialised area. It was agreed that the Health Board would explore the National approach on recruiting to this area and seek to create a natural career path. The Director of Finance agreed to liaise with the Counter Fraud Steering Group who made National recommendations.

ACTION: Director of Finance

Assurance was provided to the Committee in respect of the Standards and it was noted that there was a robust mechanism in place within the Health Board for testing the compliance in this area.

The Committee queried if awareness within the Procurement Department should be higher than described within the report. It was agreed that the Head of Counter Fraud would seek a position from counter parts within Shared Services and share areas of best practice.

ACTION: Head of Counter Fraud

Audit 0304/07 Annual Counter Fraud Work Plan for 2019/20

The Committee noted and endorsed the Counter Fraud Work Plan for 2019/20.

Martyn Edwards left the meeting.

Audit 0304/08 WAO Progress Report

The Committee received a progress update from Wales Audit Office. The Committee was provided with an update on the upcoming WAO reports:

- The Clinical Coding follow up review had now been prepared and finalised.
- Orthopaedics Review was currently underway and data collection was ongoing.
- The financial plan was on target and as planned. The plan was continuing to be updated as individual reports came through.
- A thematic review on quality governance arrangements and on the Well Being of Future Generations Act (WBoFGA) was due to be undertaken.
- A report on expenditure of agency staff was finalised in January 2019.
- A report on Intermediate Care Fund (ICF) was due in Spring 2019.
- Primary Care Services in Wales report had been finalised and was due to be discussed later in the meeting.

The Committee noted the progress report.

Audit 0304/09 Approval of WAO Audit Plan and Fee

The Committee received the report that outlined the WAO Audit Plan and detailed the WAO Annual Audit Fee.

The Committee noted that the fee was broadly the same as it was last year with an overall 2% reduction on the previous year's fee. It was noted that the fee was kept under review and the audit team had remained unchanged for the last year.

The Committee queried the overall fee level in light of the pressure on all of us to look for better value ways of delivering outcomes and particularly asked whether WAO were sure that the cost of the Structured Assessment represented value for money for the taxpayer and how they assessed that. It was agreed that these comments would be feedback to the WAO Central Team, alongside the Committee's thanks for the work that had been undertaken to develop the Audit Plan.

ACTION: Wales Audit Office

Audit 0304/10 Annual PPV Report

The Committee received the Annual PPV Report and noted the current position. The Committee was advised that the



PPV Team was going through a period of review by a risk analyst to establish a 'traffic light' system to provide further assurance in future. It was anticipated that this new system would be ready for presentation to the Committee in 6 months' time.

ACTION: PPV Manager/Secretariat

The Committee was advised of the significant training and development work that had been undertaken within GP Practices in relation to anomalies over the last few months. It was reported that good links with Practice Managers had been forged and the Committee commented that it was encouraging to see the outreach work that had been undertaken.

It was explained that where anomalies were identified, a re-visit would then take place 12 months after the anomaly had occurred. This would be a routine visit however, additional anomalies could be identified. The Committee was assured that the PPV Team had no concerns in relation to any Practices within the Health Board area.

The Committee thanked the PPV for their helpful report and endorsed the approach of reviewing a longer trend analysis in future reports.

Scott Lavender and Sara Jeremiah left the meeting.

Audit 0304/11 2018 Structured Assessment

The Committee received the Structured Assessment and the level of detail was acknowledged. Wales Audit Office confirmed that the management response had been received from the Health Board that addressed all recommendations that had been made within the report.

WAO drew attention to the governance aspect of the report and commented that the Committee review which was due to take place imminently should be used to address the some of the specific issues raised in the report particularly in terms of the support for Committees. The Board Secretary reported that he had agreed with the Chair and Chief Executive for a re-structure of the Corporate Services Department that would take place over the summer. The Board Secretary confirmed that he would be seeking to scope a Risk Manager role within the team and interim cover

arrangements would include some individuals 'acting' up into roles.

The Committee responded that the Board Secretary's comments were very reassuring and agreed that the Health Board should prioritise resource especially around risk. Sufficient time and resource should also be allocated to the review of the Committees of the Board to ensure less duplication and to provide an overview of the Health Board business to the Board.

The Committee queried the good level of assurance given to Clinical Audit within the report especially as the Committee had received limited assurance reports from Internal Audit. It was noted that Clinical Audit remained a significant area of concern for the Committee and this would be reflected in the Committee Assurance Report to the Board.

ACTION: Secretariat

The Committee queried the mechanism for tracking the transfer of resources from Secondary to Primary Care and if there was scope within the Internal Audit work programme to explore this further in Quarter 3. The Head of Internal Audit replied that there was some contingency time built in to the Internal Audit work plan every year. It was agreed that the Head of Internal Audit would review the capacity to undertake an additional audit and report back to Committee members with a plan.

ACTION: Head of Internal Audit

The Committee commented that the Structured Assessment appeared to have taken a long time to be finalised and queried if there had been an issue around management responses. It was acknowledged that there had been a focus on both sides to ensure the report gave a fair and accurate picture of the organisation. Therefore, this process had taken a little longer than expected.

The Committee concluded that the report was very helpful to the organisation and the specifics and data were improved in comparison to last year. It was acknowledged that better timeliness would also help to strengthen the report going forward.

Audit 0304/12 2018 Annual Audit Report

The Committee received the report for information. A formal thanks was extended to Dave Wilson, WAO as this was his final meeting as he was due to leave his current role within WAO.

Audit 0304/13 Internal Audit Progress Report

The Head of Internal Audit provided the Committee with a progress update. It was noted that Internal Audit was on track with regard to the number of audits that were currently in process.

Members noted that although the Clinical Futures report was rated as reasonable assurance, there was one aspect that was assessed as being limited assurance. This was in relation to engagement around Clinical Futures and posed a risk to the delivery of the programme. It was suggested that the re-refresh of the Health Board's IMTP would be helpful in resolving the outstanding issues in relation to Clinical Futures engagement.

The Committee discussed the financial risks associated with Clinical Futures and it was commented that if the Estates Strategy was implemented, this would help to reduce the financial risks associated with the delivery of Clinical Futures.

Audit 0304/14 Approval of Internal Audit Plan

The Committee was presented with the Internal Audit Plan for approval. The plan was balanced alongside the risks of the organisation and had been through due process in its development.

The committee were concerned that management responses to audit recommendations continue to take too long to be agreed in some cases, potentially leaving the organisation at risk of control failures for longer than appropriate. They were also concerned that some responses were so lengthy as to be unclear, and asked that each response be clearly prefaced by the terms Agreed, partially agreed or disagreed. They drew attention to the excellent responses to the recent discharge planning audit which could be used as an exemplar of good practice.

ACTION: Internal Audit

The Chief Executive gave assurance that the importance of prompt and clear responses to audit recommendations had been reinforced with the Executive Team.

The Committee approved the Internal Audit Plan.

Audit 0304/15 Clinical Audit Follow Up Report

The Committee received the report and noted that it was a follow up report from 2016/17.

The Health Board agreed with all recommendations and findings within the report and it was confirmed that it was seeking to implement them in accordance with stipulated timeframes.

Following significant discussion at the last Committee meeting, improvements had been made and the Medical Director was confident that the next iteration of this report would not be assessed as Limited Assurance. The Medical Director described the main areas of improvement and the following points were noted:

- Recruitment and structural changes had taken place to address some of the key recommendations and areas of concern.
- The development of an Improvement and Assurance Strategy was underway.
- A programme of meetings had been scheduled to better align Clinical Audit with the high level Quality and Patient Safety Assurance Framework.
- Clinical Audit Strategy and Policy had been approved by the Quality and Patient Safety Operational Group (QPSOG). Further work was anticipated in respect of the overall framework for Clinical Audit. The next stage of this work was due to complete in September 2019.

It was confirmed that the results of all National and Health Board wide Clinical Audits were to be reported to the Quality and Patient Safety Committee.

The Medical Director suggested that further work on the governance around the reporting mechanisms for Clinical



Audit needed to be clarified as part of the Quality and Safety Assurance Framework.

The Committee commented that it was pleased to hear that focused attention was being paid to this critical area. The recommendations within this report would continue to be monitored via the Executive Team through the Audit Recommendation Tracker document.

Dr Paul Buss and Kate Hooton left the meeting.

Audit 0304/16 Primary Care Services

The Committee received the WAO report on Primary Care Services and the Director of Primary, Community and Mental Health Services was present to answer any questions.

It was commented that the management response was comprehensive and the Health Board was confident that it could meet all of the recommendations. Some recommendations had already been implemented and an update on recommendation 1 (shift of resource to Primary Care) was due to be presented to the Finance and Performance Committee (FPC) on 1st May 2019. The FPC would also be given the opportunity to review the methodology that the Health Board had used at that meeting.

The Committee discussed recommendation 2, Oversight of Primary Care, within the report. It was noted that there was a good focus on Primary Care at the Public Partnerships and Well Being Committee (PPWBC) and as an integrated organisation, further overarching reports would include elements of Primary Care in future. It was agreed that this would be made very clear in agenda setting meetings and committee work planning processes for the PPWBC going forward.

ACTION: Board Secretary/Secretariat

The Committee acknowledged the importance of Primary Care in its own right and the level of focus that it is given at a Board level. Since the Chief Operating Officer role had been split, the Director of Primary Care, Community and Mental Health Services now had more time to provide further structure and focus within Primary Care. It was agreed that a strengthened focus on Primary and

Community Care should be included overall in all Board papers going forward.

ACTION: Executive Team

The Committee thanked WAO for the report and commented that the recommendations were very clear.

Audit 0304/17 Update on Governance, Financial Control Procedures and Technical Accounting Issues

The Committee received the report and noted the proposed changes to the Scheme of Delegation.

The Committee approved the report and the proposed changes.

Audit 0304/18 Recovery of Overpayments to Employees Policy

The Committee approved the Policy however, it was agreed that the letter in Appendix 1 would be re-worded.

ACTION: Assistant Director of Finance

Audit 0304/19 Losses and Special Payments Report

The Committee received the report. It was noted that the numbers in relation to the Welsh Risk Pool (WRP) were significant therefore were there mechanisms the Health Board had in place to ensure learning from these instances. It was confirmed that significant work was undertaken in the Putting Things Right Team in relation to organisational learning from litigation.

The Committee noted the report for information.

Audit 0304/20 Risk Management Review and Link to Assurance Framework

The Board Secretary presented the Committee with an update on the Risk Management Review. The Board Secretary thanked Jeff Brown, Director, JBPS Advisory Solutions Limited, for the work undertaken for the organisation. This had been the most comprehensive work on risk management since the inception of the Health Board in 2009.

Following receipt of the report, an action plan had been developed and was supported by the Executive Team and Head of Internal Audit. Key to the implementation of the action plan was the restructuring of the current Corporate Services Team to encompass a Risk Manager role to centrally manage and review risk. The Board Secretary was confident that subject to the recruitment of the Risk Manager role, the action plan was achievable.

The Board Secretary had received constructive feedback from Independent Members on the 'risk on a page' format and assurance mapping. The Committee was advised that work was underway to develop a business masterplan for the Board and Sub-Committees of the Board.

The Committee supported the Action Plan and thanked the Board Secretary and Jeff brown for the work that had been undertaken.

Audit 0304/21 Audit Recommendation Tracker Report

The Committee received the report and commented that the content of the report had significantly improved, however, that further traction was still required in relation to management responses.

The Committee agreed that as a general point, recommendations should include a realistic timescale to ensure the Health Board had enough time to implement the recommendation.

ACTION: Board Secretary/Head of Internal Audit

Audit 0304/22 Date of Next Meeting

The next meeting to receive the Draft Annual Accounts is on Thursday 9th May 2019 at 1:30pm in Conference Room 3, Headquarters, St Cadoc's Hospital.

Audit Committee
17th January 2019
Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the Audit Committee and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the Audit Committee these actions will be taken off the rolling action sheet.)

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 1701/18	WAO and Internal Audit High Level Tracker The Audit Committee to receive an assurance update with regard to the HIW recommendation monitoring arrangements from the Quality and Patient Safety Committee.	Board Secretary	July 2019	A verbal update will be provided at the Committee following the Executive team's approval of a new process and supporting arrangements.

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 0304/01	Welcome and Introductions It was agreed that it would be helpful to have more Committee Members to ensure the Committee was quorate at future meetings. Board Secretary to include this request when completing the re-structure of the Committees.	Board Secretary	May 2019	A paper outlining the proposed Committee structure was presented to the May 2019 Board and approved. The proposal encompassed more members for the Audit Committee.
Audit 0304/05	Action Log Further consideration to be given in relation to a mechanism for reviewing and monitoring performance, quality and financial elements in one place.	Board Secretary	May 2019	This was considered as part of the Committee structure review and changes made. A report outlining the proposed structure was approved by the Board in May 2019.

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 0304/06	Annual Counter Fraud Bribery and Corruption Report for 2018/19 The Director of Finance and Performance agreed to liaise with the Counter Fraud Steering Group in relation to National recommendations around recruitment and career paths in Counter Fraud.	Director of Finance and Performance	July 2019	Update to be reported to July Audit Committee.
	It was agreed that Counter Fraud awareness should be higher than currently reported in Procurement. The Head of Counter Fraud agreed to seek a position from counter parts within Shared Services and share areas of best practice.	Head of Counter Fraud	October 2019	Update to be reported to October Audit Committee under the Counter Fraud item.
Audit 0304/09	Approval of WAO Audit Plan and Fee Comments with regard to value ways of delivering outcomes and how this was assessed to be feedback to the wider team at WAO.	Wales Audit Office	Immediately.	The comments were fed back to the Directors at WAO.

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 0304/10	Annual PPV Report The new traffic light system to be presented to the Committee in 6 months' time.	PPV Manager/Secretariat	October 2019	Item registered on the Committee forward work programme.
Audit 0304/11	2018 Structured Assessment The Committee asked for their concerns in relation to Clinical Audit to be raised in the Committee assurance report to the Board.	Secretariat	Completed.	Item raised as a concern within the assurance report presented to the May 2019 Board meeting.
	It was agreed that the Head of Internal Audit would assess the additional capacity in quarter 3 to conduct a further audit in relation to mechanisms for tracking transfers of resources from Secondary care to Primary Care.	Head of Internal Audit	Quarter 3	Contingency days are available to undertake additional work to the approved plan should this be required. Consideration will also be given to whether it may be appropriate to include this as an objective within the budgetary control audit due to be undertaken in Quarter 3.
Audit 0304/14	Approval of Internal Audit Plan It was agreed that each management response to internal audit recommendations was to be clearly prefaced by the terms Agreed, partially agreed or disagreed.	Head of Internal Audit	Immediately	This is being implemented from 2019/20 onwards.

Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Audit 0304/16	Primary Care Services (WAO Report) Overarching reports to all Committees of the Board to include elements of Primary Care in future and this would be made clear in agenda setting meetings.	Board Secretary/Secretariat	Immediately.	Complete. This has been communicated to the Secretariat Team to ensure Primary Care is raised at agenda setting meetings.
	It was agreed that a strengthened focus on Primary and Community Care should be included overall in all Board papers going forward.	Executive Team	Immediately.	Complete. Message cascaded to the wider Executive Team.
Audit 0304/18	Recovery of Overpayments to Employees Policy It was agreed that the letter in Appendix 2 would be re-worded.	Assistant Director of Finance	Immediately.	Complete.
Audit 0304/21	Audit Recommendation Tracker Report It was agreed that as a general point, recommendations should include a realistic timescale to ensure the Health Board had enough time to implement the recommendation.	Board Secretary/Head of Internal Audit	Immediately.	Discussions have been ongoing with Internal Audit, Executive Team colleagues to ensure that responses are timely, realistic and accurate.

 Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board		Audit Committee 18 th July 2019 Agenda Item: 2.5	
Aneurin Bevan University Health Board			
High Level Audit Recommendations Tracker			
Executive Summary			
At the Audit Committee Meeting in April 2018, it was agreed that the current Audit recommendations Tracker would be fully reviewed by the Executive Team. This was undertaken in readiness for the July 2018 Audit Committee Meeting and has been reported to each committee meeting since that time. Further refinement of the tracker has been undertaken over recent months and good progress has been noted with the redevelopment and the reporting against recommendations. This report provides the Audit Committee with an update on the progress with the tracker. Thirty four recommendations are currently covered by the tracker. This has increased since the last report given that the recommendations of the WAO Structured Assessment have been added to the tracker. It was agreed that the Tracker would be submitted to each Audit Committee Meeting and that the categorisations used would be changed to better indicate progress. It was also agreed that the source of the reports i.e. Internal Audit or Wales Audit Office would be shown for each action. This report provides information on the current status of the recommendations following extensive review by the Executive leads and also at an Executive Team meeting. The tracker indicates those recommendations in the opinion of the Executive Team that have been completed and are proposed to be taken off the tracker, those that have made significant progress but are still not fully complete and those where some progress has been made but a number of factors still remain which prevents the action being fully completed. There are also recommendations that are yet to reach their deadline date and others that are proposed to be withdrawn as they regarded as no longer applicable.			
The Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views		✓	
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Richard Bevan, Board Secretary			
Report Author: Lucy Bennett, Executive Assistant			
Report Received consideration and supported by :			
Executive Team		Committee of the Board	
		[Committee Name]	
Date of the Report: 10 th July 2019			
Supplementary Papers Attached: June 2019 Audit Tracker Update			

Purpose of the Report

To present to the Audit Committee for compliance and assurance purposes the tracking database of the current agreed high level recommendations for Internal Audit and also Wales Audit Office recommendations.

Background and Context

The Audit Committee agreed in 2014 that in order to closely monitor progress with the programme of internal audits reports undertaken at the Health Board and the subsequent organisational responses to recommendations, that a tracking arrangement would be established, which would be monitored by the Executive Team. A detailed tracking database was set-up initially to record the progress of all the recommendations contained in each of the Internal Audit reports completed since the establishment of the Health Board.

The Committee subsequently agreed that the Wales Audit Office (WAO) report recommendations should also be included within the tracker in order to provide assurance that those recommendations were also being progressed, monitored and completed.

There are currently 34 recommendations within the database, as per the table below:

Red	13	Some progress, but outside the target deadline.
Green	8	The Action has been completed and it is proposed that the action is withdrawn from the tracker.
Blue	2	This recommendation is assessed as no longer applicable and should be withdrawn.
Purple	11	Action yet to reach its target date.

Eight high level actions have been assessed by the Executive Team as completed and are proposed to be withdrawn from the tracking database with the agreement of the Audit Committee. Two recommendations have been assessed as no longer applicable and it is proposed they should be withdrawn with agreement of Internal Audit and the Audit Committee.

Further work is underway to ensure that the remaining actions on the database are completed as agreed.

Recommendation

The Audit Committee is asked to note this report and green recommendations can be withdrawn from the database.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational actions for audit activity are key elements of the Health Board's overall assurance arrangements.
Financial Assessment, including Value for Money	There may be financial consequences of individual actions however there is no direct financial impact associated with this report at this stage.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are highlighted within the individual actions and assurance requirements contained within this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality issues associated with this report at this stage, but equality impact assessment will be a feature of the work being undertaken as part of the actions.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The actions will be aspects of the delivery of key priorities in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	WBFGA considerations are included within the consideration of individual actions.
Glossary of New Terms	None
Public Interest	Report to be published in public domain

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
1. (IA)	Medicines Homecare Services Management Arrangements Audit <i>October 2015</i>	The clinical check requires a Pharmacist to review the current list of drugs prescribed to a patient to confirm that the newly prescribed drug will not affect the patient adversely when taken in combination with the patient's existing prescription. While the clinical check forms an integral part of the homecare process for Tecifera, no clinical check is undertaken for the other 7 drugs delivered through the homecare service. We understand that, due to the large number of patients receiving homecare drugs, there is not sufficient Pharmacist resource available to undertake all of the required checking.	March 2016	Director of Primary, Community and Mental Health	Update June 2019 KPIs report received from homecare companies demonstrate the following improvement in compliance. In May 2019, there were 271 prescriptions processed of which 34% did not receive a clinical check compared with May 2018 where 207 prescriptions processed of which 54% did not receive a clinical check. Mechanisms now in place to receive regular KPIs and this will be monitored by the Homecare committee.	The Audit Committee at its April 2019 meeting agreed to keep this item on the tracker as Amber until the report is received as planned in April 2019 and KPIs are reported. Executive Team Status – July 2019: It was agreed that the report and KPIs have now been received. Arrangements in place for regular review of KPIs and escalation arrangements in place if required. It is proposed that the recommendation can now be removed from the tracker.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
7. (IA)	IT Access and Environmental Controls <i>February 2017</i>	All server rooms should have appropriate equipment installed to enable the effective combat of fire. Equipment should also be regularly maintained and inspected in line with the manufacturer's guidance.	May 2017	Director of Planning, Digital and IT	June 2019 Update: Following a review of the remediation proposal by the fire officer, a quote from Minor Works is expected before mid July allowing the team to proceed and schedule the amendments with minor works to complete this recommendation.	Executive Team Status – July 2019: Good progress made. However, the one remaining element means the action cannot be fully completed at this stage. The Executive Team will monitor progress with finalisation of the required minor works to complete this recommendation it is anticipated that this will be able to be removed at the next review.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
13. (IA)	Theatres May 2017	Management should undertake a complete review of the current arrangements in place with regards to loan equipment and ensure that there are effective controls in place to mitigate the risks associated with this area, such as: • establishing a documented procedure/process for loaning equipment from suppliers or loaning kit out to other Hospitals/Health Boards; • implementing a tracking mechanism to monitor the location and status of loan equipment; • consider a recharge mechanism for loan equipment in order to recoup costs and balance potentially excessive expenditure; and • ensure that there is effective budgetary control concerning loan equipment to ensure that value for money is achieved and costs to the HB are minimised where possible.	September 2017	Director of Operations	June 2019 Update: A flow chart with a revised process and procedure in respect of internal loan kit transfers between sites has been developed and is being implemented. Dedicated staff have been identified at each site to be responsible for this process, delivering a more robust record of what is being loaned where and assurance that replacement stock is being ordered to the correct site. The Directorate has in place a mechanism to audit the success of this process aligned to the Omnicell Project. The process for external loan kit requesting is currently under review with a view to producing a standard SOP to be used in all sites. Omnicell have committed to developing the functionality for loan kit tracking and the requirements for such a function have been gathered by relevant individuals in ABUHB and fed back to the company. It is likely that the functionality will take 12 months to complete. This process should negate the need for the Loan Kit Co-ordinator, however the Directorate is considering a fixed term post to manage the process in the interim period. The Omnicell project will also consider within its remit the value of loaning vs purchasing stock, thus saving loan and carriage costs.	Executive Team Status – July 2019: The Executive Team noted that significant progress had been made with the response to these recommendations. However, some elements of the recommendations are still required to be fully completed. Whilst material progress has been made with this recommendation since the last report. It is suggested that it remains red to reflect the current position, but this will be able to be removed at the next review (as the assessment was that enough progress has been made to have reduced this to an amber status).

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
16. (IA)	Private Patients and Overseas Visitors <i>May 2017</i>	R2 - All the individuals should be trained to ensure the appropriate information is recorded. They should be provided with the procedures to be followed based on the latest legislation. These procedures should be uploaded to the intranet. The Health Board should review the resources allocated to overseas patients' administration to ensure that all the required information is captured and that they are billed appropriately.	June 2017	Director of Operations	June 2019 Update: The Overseas Visitor Policy has been updated and is available on the intranet. The training package has been completed based on the policy. We are still awaiting the first draft of the online training package for review and expected this to be available to us w/c 8th July 2019. In the meantime 13 training sessions have been held around the Health Board and a number are booked over the next few weeks and will continue until the online training is available. The resources in the department have also been reviewed.	Executive Team Status – July 2019: To be agreed Policy now approved – progress made with the on-line training package. Classroom style training has now been undertaken and further rolled-out. A review of resources has been undertaken. Given the progress made against the recommendations. It is proposed that the recommendation can now be removed from the tracker.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
20. (IA)	Clinical Audit May 2017	R3 - An effective mechanism for the identification and follow-up of actions arising from a clinical audit undertaken locally and nationally, should be implemented as soon as possible, in order to provide assurance that effective action is being undertaken to mitigate clinical risk.	November 2017	Medical Director	June 2019 Update: The Medical Director has set up a Quality Improvement Leaders Group, with the leaders of ABCi, Value Based Healthcare, Clinical Audit and Research and Development and Innovation. This Group is developing new ways of using clinical information for improvement, and from this will develop a Quality and Patient Safety Improvement Strategy and Assurance Framework. It will incorporate a review of known clinical risks, so that its focus is on major clinical risks for the Health Board. From this, the Executive Team will assess the level of clinical audit required by the organisation and determine how this will be implemented through a Clinical Audit plan. In 2019-20, whilst the Strategy and Framework are in development, the Quality and Patient Safety Operational Group has discussed the risks and recommended the key issues to be addressed by a Health Board programme of Clinical Audit. The Group has an overview of Divisional risks as well as concerns raised through Putting Things Right and is well placed to make recommendations. From the recommendations and the National Clinical Audit and Outcome Review Plan (NCAORP), a Programme of Clinical Audit is being developed, which will be taken to key Committees for agreement and monitored by the Clinical Effectiveness Group.	Executive Team Status – July 2019: The Executive Team has assessed that good progress has been made since the last report in April 2019. However, it has agreed that the assessment level will remain red until the new arrangements have been embedded. It is anticipated that this could be moved to a green status at the next review.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
35 (IA)	Medical Equipment and Devices <i>February 2018</i>	Registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details. The register format should be consistent and overseen centrally, with periodic reviews/scrutiny completed.	No deadline stated in the report	Medical Director	Update June 2019 A new clinical effectiveness and audit group has been set up under a newly appointed Assistant Medical Director for this purpose. The group has key divisional clinical representatives nominated to attend and will use its position to identify key areas for improvement and to highlight those issues that will also be reported to QPSOG. This will include the finalisation and monitoring of registers. There is ongoing work with procurement leads and other Health Board teams and the new devices group (led by Director of Therapies and Health Science) to identify how a prospective inventory for newly acquired devices can be achieved whilst maintaining a log of key equipment at ward based and directorate level. IT systems are being explored.	Executive Team Status – July 2019: This was previously taken off the tracker, due to assessed progress however, it was agreed by Executive Team that it would be added back on to the tracker until actions had been fully completed. It is anticipated that this will be in position to be moved to green at the next review.
77 (WAO)	Structured Assessment <i>2017</i>	R4 - Internal control The Health Board should ensure that clinical audits provide assurance within an assurance framework, linked to the organisation's strategic objectives	End of May 2018	Medical Director	Update June 2019: this is linked to the previous item 20 (IA). The update is the same.	Executive Team Status – July 2019: The Executive Team has assessed that good progress has been made since the last report in April 2019. However, it has agreed that the assessment level will remain red until the new arrangements have been embedded. It is anticipated that this could be moved to a green status at the next review.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
85 (IA)	Estates Assurance (Fire Safety)	R6 The review/updating of local fire policies/procedures, fire manuals and risk assessments will be appropriately monitored and managed. (O)	July 2018	Director of Therapies and Health Science	June 2019 Update: The Health Board Fire Safety Team have been successfully recruited and have completed all of the overdue fire risk assessments that were due up to and including May 2019. A sustainable plan has been developed to ensure the programme of fire risk assessments within Health Board premises is achieved within the required timescales. The fire management dashboard which monitors compliance with fire risk assessments, local policies and fire manuals is regularly monitored by the Fire Safety Team and the Health Board Fire Safety Committee.	Executive Team Status – July 2019: The Executive Team was satisfied that this work had been completed. It is proposed that the recommendation can now be removed from the tracker.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
86 (IA)	IT Service Management	R1 Formal SOPs should be developed for operating the service desks that cover the following key items: - objectives; - definition of types of calls and routing of these; - roles and responsibilities; - process for recording and monitoring calls received; - service level targets and metrics; - process for handling calls received; and - classification and prioritisation scheme. Formal SOPs should be developed for change control. Formal SOPs should be developed for release and deployment management.	October 2018	Director of Planning, Digital and IT	June 2019 Update: The ICT Service Manager has started in post on 17th June 2019 and has made good progress in developing a GAP analysis and initial framing of SOPs. An improvement plan will be completed by the end of July 2019 and a clear timeline for the finalisation of SOPs will be agreed.	Executive Team Status – July 2019: The Executive Team noted the good progress that has been made. However, as the original timescale had now passed, this remained red. It is anticipated that this action plan and SOPs will be completed by September 2019. The Executive Team will keep the position monitored and expect this to have been assessed at green when reported to the Audit Committee in October 2019.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
87 (IA)	IT Service Management	R2 Informatics should seek to identify the Informatics service needs of the organisation. This should be done by identifying customers' desired outcomes and recognition of value and should include an assessment of customer need, impacts recovery objectives etc. Services should be designed/restructured to appropriately match these needs and the services provided should be recorded in a service catalogue.	October 2018	Director of Planning, Digital and IT	June 2019 Update: The ICT service manager has begun a stakeholder mapping exercise and a series of structured interviews with the immediate stakeholder group.	Executive Team Status – July 2019: The Executive Team noted the progress that has been made and that this work was ongoing. However, the original timescale had now passed and it was agreed that this remained red. It is anticipated that this action will be completed by September 2019. The Executive Team will keep the position monitored and expect it to be assessed as green at the next report to Audit Committee.
88 (IA)	IT Service Management	R3 Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	October 2018	Director of Planning, Digital and IT	June 2019 Update: The ICT Service Manager has commenced post and is developing the improvement plan for internal review by the end of July 2019.	Executive Team Status – July 2019: The Executive Team noted the progress that has been made and that this work was ongoing. However, the original timescale had now passed and it was agreed that this remained red. It is anticipated that this action will be completed by September 2019. The Executive Team will keep the position monitored and expect it to be assessed as green at the next report to Audit Committee.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
93 (IA)	Management of Balance Sheet Assets	We recommend that the Health Board introduces tagging/identity marking of all relevant assets in order to facilitate the identification and physical verification of assets against the asset register.	March 2019	Director of Finance	June 2019 Update: The capital team have investigated the options available for implementing asset tagging for capital assets. These have been developed into a shortlist of options following site visits and in liaison with other departments within the Health Board. A preferred option is emerging but the capital team will be undertaking a further site visit to ensure the functionality and benefits of implementation as intended is achievable. The preferred option will be presented to Executive Team within the next 2 months.	Executive Team Status – July 2019: The Executive Team noted the good progress that has been made and that this work was ongoing. However, the original timescale had now passed and it was agreed that this would be reported as red. It is anticipated that this action will be completed by September 2019. The Executive Team will keep the position monitored and expect it to be assessed as green at the next report to Audit Committee.
94 (IA)	Patient Discharge Process	Consideration should be given to updating the Discharge Policy with a timescale for setting an estimated date of discharge (EDD). For example, another Health Board advise this should be set within 24-48 hours.	January 2019	Director of Operations Director of Nursing Medical Director	June 2019 Update: A new Discharge policy has been reviewed by Executive Team in June 2019. A few final amendments are being made and will be ratified by Executive Team during July 2019.	Executive Team Status – July 2019: Significant work has been undertaken against this recommendation. The policy is to be approved by Executive Team by the end of July 2019. It is proposed that the recommendation can now be removed from the tracker.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
94 (IA)	Patient Discharge Process	EDD's are often written on ward boards, however this information is not kept. EDD's assigned on board rounds must be captured on CWS for recording keeping and audit purposes – this should sit as a role for ward clerk.	November 2018	Director of Operations	June 2019 Update: Scheduled Care/Unscheduled Care are now allocating EDD on CWS. Compliance is monitored by DMTs but also measured at bimonthly Discharge Improvement Board.	Executive Team Status – July 2019: The Executive team considered that this recommendation is now complete and should be assessed as green and withdrawn from the tracker.
		EDD will be added to paediatric discharge pro forma and discussed at ward manager level for dissemination to nursing staff.	December 2018	Director of Operations	June 2019 Update: The Director of Operations has discussed this recommendation with Paediatric Department and it is has been agreed that EDDs are not relevant to this specialty and it has therefore been agreed that they will not be implemented.	Executive Team Status – July 2019: The Executive Team considered this update and agreed with the assessment and therefore propose that the recommendation is withdrawn from the tracker.
		Mental Health and Learning Disabilities to review expectations for EDD across wards, due to the variation in average length of stay.	March 2019	Director of Operations	June 2019 Update: The Director of Operations has discussed this recommendation with Mental Health and Learning Disabilities and it is has been agreed that EDDs are not relevant to this specialty and it has therefore been agreed that they will not be implemented.	Executive Team Status – July 2019: The Executive Team considered this update and agreed with the assessment and therefore propose that the recommendation is withdrawn from the tracker.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
96 (IA)	Clinical Futures Service Redesign	A plan should be developed to ensure that all clinical model assumptions (as part of recommendations 2 & 4), variables, requirements and business cases are appraised, with a clear timeline set out for a final position over: • which models will be fully/partially funded; • total bed numbers; • workforce requirements; • risks and interdependencies; and • any other key attributes.	End of March 2019 – Phase 1	Director of Planning, Digital and IT	June 2019 Update: Service models agreed by the Board at the end of March 2019 to agree recruitment timelines with Finance.	Executive Team Status – July 2019: The Executive Team agreed that this recommendation had been completed with the approval of the clinical models by the Board in March 2019. It is proposed that the recommendation can now be removed from the tracker.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
96 (IA)	Clinical Futures Service Redesign		End of September 2019 – Phase 2	Director of Planning, Digital and IT	As set out in the actions of January 2019 Delivery Board, the programme has conducted the following process to reach firm recommendations in the time given: • Broad agreement of process/principles/ methodology/investment themes to utilise. • Construction of a common service model proforma to present to the panel to ensure an objective analysis and prioritisation of models. • Clinical Futures team conducted close working with services, finance, workforce to finalise key areas of models in a uniform format ready for the panel. • Papers finalised in advance of the panel and pre-briefings given. • Panel formed and took place over a two day period to analyse and prioritise the cases for investment. Follow up/clarification sought were appropriate and panel agreement on priority order and recommendations. The outcome of this 2 day panel concluded with a prioritised list of models highlighting which models (or elements of models) would be endorsed and which would not at this time. A comprehensive paper has been produced to show clearly to the Delivery Board what this means for costs, benefit opportunities, risks and	At the time of review the deadline was not yet reached.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
96 (IA)	Clinical Futures Service Redesign				beds. This will be presented to the 4th March Delivery Board and then the 27th March UHB Main Board on the current plan. It is expected that any further investment will also be dealt with via this method later in the year as required with modification of the models, as and when they arise.	
		- There should be a documented trail of what is required for each action identified from the Challenge and Support process, including risks and interdependencies – i.e. everything required to achieve a final version of the clinical model. - The documented output should inform the details of the plan referenced within recommendation 1 above.	End of April 2019	Director of Planning, Digital and IT	June 2019 Update: Service messaging documents have been developed for each service with a plan on a page. A comprehensive guide to services and the service models in essence a one version of the truth document has been developed and will continue to be updated. This work is ongoing.	Executive Team Status – July 2019: The Executive Team noted that good progress had been made with documented tracking mechanisms in place for actions etc. It was anticipated that this recommendation would be assessed as green at the next review.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
97 (WAO)	Structured Assessment 2018	R1 Governance The Health Board should: ensure board member induction and training meets the needs of Independent Members;	December 2019	Board Secretary	Update June 2019: The Health Board has already introduced a new Induction and training programme for 2018/2019. Several elements of this have been completed. The programme will be completed during 2019. The Health Board is also participating in the redesign of the national NHS Wales Induction Programme.	At the time of review the deadline was not yet reached.
		explore the reasons for the increase in complaints from patients and service users as part of the service improvement plan for Putting Things Right; and	December 2019	Acting Director of Nursing	Update June 2019: The Health Board has appointed new leadership for the Putting Things Right Team. The Health Board has undertaken a thematic review of the reasons for the increase in formal complaints and developed an improvement plan. Progress is being closely monitored by the Executive Team and the Quality Patient Safety Committee. A new Assistant Director of Organisational Learning has been appointed and will take up post in early August. The Improvement Plan is being progressed and monitored.	At the time of review the deadline was not yet reached.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
97 (WAO)	Structured Assessment 2018	Clarify perceptions around interoperability of the Board committees.	May 2019	Board Secretary	June 2019 Update: A new committee structure was approved at the Board in May 2019. Implementation has begun since the 1 st July 2019. New terms of reference are being developed for approval by the Board in September 2019.	Executive Team Status – July 2019: The Executive Team noted the progress and decisions that had been made, but agreed to leave the recommendation on the tracker, assessed as red, due to the timescale having passed. However, it is anticipated that the recommendation will be assessed as green at the next report. This will give time for the new Committee structure to be embedded and this will allow for the interoperability of the Committees to be fully assessed.
98 (WAO)	Structured Assessment 2018	R2 National Fraud Initiative The Health Board should put in place an action plan to ensure that the matches it receives in future NFI exercises are reviewed and where necessary investigated in a timely manner. We expect the Health Board to: commence review of the data-matches as soon as possible following the release of the next NFI matches in January 2019;	March 2019	Director of Finance and Performance	June Update 2019 ABUHB review of the 2019 NFI data matches commenced on their release particularly payroll to payroll data matches and trade creditor standing data matches. There was a delay from the NFI in releasing trade creditor matches which in turn, delayed the review. The first data set matches were released on 1 st March 2019 and the trade creditor matches followed on 31 st May 2019.	Executive Team Status – July 2019: The Executive Team considered that this recommendation had now been responded to. It is proposed that the recommendation can now be removed from the tracker.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
98 (WAO)	Structured Assessment 2018	in addition to reviewing all the high priority matches recommended for review, carry out a review of a sample of the remaining data-matches; and	March 2019	Director of Finance and Performance	June Update 2019 High priority matches are subject of initial review and samples of remaining matches will be undertaken afterwards. The total number of data matches amount to 5,645, of which, 943 are marked as high priority.	Executive Team Status – July 2019: The Executive team noted the progress that had been made and agreed to leave this recommendation on the tracker at this stage with the anticipation that it would be withdrawn at the next review.
		ensure that where data-matches have been reviewed, the NFI web application is updated to clearly record how matches were reviewed and the outcomes of those reviews.	March 2019	Director of Finance and Performance	June Update 2019 High priority actions completed and updated. Other matches being updated. Updating of outcomes on NFI is conducted as a matter of routine and this is an ongoing practice.	Executive Team Status – July 2019: The Executive Team considered that this recommendation could be assessed as green due to the routine monitoring in place. It is proposed that the recommendation can now be removed from the tracker.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
99 (WAO)	Structured Assessment 2018	R3 Information Governance - The Health Board should improve its information governance arrangements by: - improving compliance with the information governance training programme to reach the national rate of 95%;	March 2020	Director of Planning, Digital and IT	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bi-monthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	At the time of review the deadline was not yet reached.
		improving performance against information access targets for the Freedom of Information Act and Data Protection Act to reach the statutory targets	March 2020	Director of Planning, Digital and IT	The Health Board during 2018/19 has already improved its compliance with statutory targets and will continue with this focus for 2019/2020.	At the time of review the deadline was not yet reached.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
99 (WAO)	Structured Assessment 2018	strengthening the focus of the Information Governance Committee to overseeing delivery of informatics strategic plans rather than operational matters.	March 2020	Director of Planning, Digital and IT	The Information Governance Committee agenda is focused on strategic plans around informatics and is evidenced by agenda items. This will also be highlighted in the revised Terms of Reference. A draft Digital Transformation strategy was circulated in March 2019 with initial feedback incorporated. This has led to the engagement of an external consultancy to assist with developing the strategy further. The work has progressed and a draft Digital Strategy is being submitted to the Health Board for approval in July 2019.	At the time of review the deadline was not yet reached.
100 (WAO)	Structured Assessment 2018	R4 Informatics The Health Board should address weakness in its use of informatics, specifically concerning: the resource constraints within the Informatics Department to improve the resilience of the ICT infrastructure and replace ageing hardware and software;	Completed.	Director of Planning, Digital and IT	June 2019 Update: The Cyber Team Leader commenced post in February 2019 followed by the Officers in March and April 2019. More recently in June the Band 6 posts were appointed and these will commence in late July 2019. The systems engineers started in October 2018 and have made excellent progress with server patch compliance. This team has the focus to deliver a policy and underlying service that keeps ICT assets secure and up to date as well as informing future plans.	Executive Team Status – July 2019: This has been completed. It is proposed that the recommendation can now be removed from the tracker.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
100 (WAO)	Structured Assessment 2018	completing and approving the digital transformation strategy by the end of 2019	December 2019	Director of Planning, Digital and IT	Further work was undertaken to align with the IMTP, an updated version has now been drafted and Health Board approval will be sought.	At the time of review the deadline was not yet reached.
		oversight of national system risks and their impact on the organisation	December 2019	Director of Planning, Digital and IT	ABUHB continues to engage with both Welsh Government and NHS Wales Informatics Service. Welsh Government have conducted a review of governance following the WAO report. The Health Board is actively engaged in this and other resultant actions including an architecture review.	At the time of review the deadline was not yet reached.
		strengthening cyber security control arrangements and resourcing by establishing a specialist team, resilience and incident response plans; and	December 2019	Director of Planning, Digital and IT	As stated above key appointments have now been made against a number of positions relating to cyber security. Work is being completed on key personnel policies plans and underlying services. The team operational model is under development and will be internally reviewed in July 2019.	At the time of review the deadline was not yet reached.
		updating its ICT disaster recovery plans and test these to ensure they work as intended.	March 2020	Director of Planning, Digital and IT	Work is ongoing with the newly recruited team in compliance with NISD. A Task and Finish group is currently prioritising and planning continuity arrangements led by the Emergency Planning Team. Infrastructure level failover and failback of 81 systems was undertaken in April/May 2019 respectively. Specific application testing and evaluation of this is an on-going task.	At the time of review the deadline was not yet reached.

Audit Recommendations – June 2019

No.	Report title and date reported to Audit Committee	High Level Recommendation	Deadline	Responsible Officer	Management Response – Update on Current Progress	STATUS
101 (WAO)	Structured Assessment 2018	R5 Asset Management The Health Board should take steps to improve the management of its non-estate assets by: - agreeing an asset strategy; and - ensuring there are suitable asset registers to support the management of assets.	Reviewed every three months – Annual review March 2020	Director of Planning, Digital and IT	Under GDPR organisations must hold an Information Asset Register. IT holds an Asset Register linked to all IT equipment held by ABUHB. The Information Governance unit holds the information asset register, within the asset register we collect the following: - Patient/Personal Identifiable Information - Staff Records - Non patient/personal identifiable information System used throughout the health board	At the time of review the deadline was not yet reached.



Archwilydd Cyffredinol Cymru
Auditor General for Wales

3.1

External Audit Progress Report – **Aneurin Bevan University Health Board**

Audit Committee Meeting – July 18, 2019

Date issued: July 2, 2019

Reference: 648A2018-19

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

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This document was prepared by Terry Lewis and Gabrielle Smith.

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About this document

- 1 This document is intended to help the Audit Committee of Aneurin Bevan University Health Board to monitor the progress of external audit work. All finalised reports are presented to the Committee for information and consideration.
- 2 Progress in relation to both financial and performance audit work is presented, as well as information on the Auditor General's planned programme of NHS related studies and publications.

Progress against 2018 audit plan

- 3 **Exhibit 1** provides an update on progress against the performance audit projects identified in the 2018 audit plan, which are either complete or ongoing.

Exhibit 1: progress against previous audit plans

Topic	Details	Status	Executive lead
2018 financial and performance audits			
Clinical coding: follow-up review	This work considered the extent to which the Health Boards has made progress to address areas for improvement and recommendations made in our 2014 report.	Complete – on the agenda	Glyn Jones
Orthopaedics - follow-up review	This work will consider the extent to which the Health Board has made progress to address areas for improvement and recommendations made in our 2015 report.	Set up meeting complete and onsite fieldwork scheduled between July to September; reporting late autumn	Claire Birchall
Follow-up work against previous recommendations	This work will track progress made by the Health Board to address our recommendations on:	Onsite fieldwork interviews between July and August	Nick Wood

Topic	Details	Status	Executive lead
	- District nursing services (2014/2015) - Medicines management in acute hospitals (2015) - GP out-of-hours services (2017)		

Progress against the 2019 audit plan

- 4 **Exhibit 2** provides an update on progress against the 2019 audit plan with most audit work not yet underway.

Exhibit 2: progress against the 2019 audit plan

Topic	Details	Status	Executive lead
Financial audits			
2019 Audit Plan	The plan sets out the financial and performance audit work to be carried out in 2019-20.	Complete	Glyn Jones
Financial accounts audit work	All our work to support the audit of the financial statements was completed by May 2019.	Complete	Glyn Jones
Audit of Financial Statements Report (ISA 260)	This report was presented to the Committee at its meeting on 28 th May and the Board meeting on 30 th May 2019.	Complete	Glyn Jones
Opinion on Financial Statements	The Auditor General gave his audit opinion on the financial statements on June 11, 2019.	Complete	Glyn Jones

Topic	Details	Status	Executive lead
Charitable Funds	Our work on the Charitable Funds is scheduled for August/September 2019.	Not started	Glyn Jones
2019 Annual Audit Report	This report will summarise our financial and performance audit work during 2019.	Not started	To be confirmed
Performance audits			
Structured Assessment	Structured Assessment will continue to assess the robustness of the arrangements for corporate and financial governance, as well as progress against previous issues and recommendations.	Terms of reference issued; fieldwork July to September	To be confirmed
Thematic review - quality governance arrangements	This audit will consider the Health Board's quality governance arrangements and reporting how these underpin the work of the Quality and Patient Safety Committee.	Not started - due to start late autumn	To be confirmed
Thematic review - Well Being of Future Generations (Wales) Act 2015	This work will consider the Health Board's overall corporate approach to applying the 'Sustainable Development Principle' and 'Five Ways of Working'.	Onsite fieldwork phase underway	Sarah Aitken
Locally focused audit project	The precise focus of this work is yet to be agreed but will be reflected in regular	Not started	To be confirmed

Topic	Details	Status	Executive lead
	updates to the Committee.		

NHS-related national reports and Good Practice Exchange events

- 5 [Exhibit 3](#) provides information on national value for money studies and other publications directly relevant to NHS organisations published by the Auditor General since the Committee last met or which he intends to publish in the coming year. Any recommendations arising from national studies (or related reports by the National Assembly's Public Accounts Committee) that are relevant to the Health Board will be reported to the Committee where appropriate.
- 6 Our [Good Practice Exchange](#) (GPX) helps public services improve by sharing knowledge and good practice. Events are held where knowledge can be exchanged face to face or via webinars and podcasts. The main areas of work relate to financial management, public sector staff and governance.

Exhibit 3: NHS-related national reports

Report topic	Publication date
NHS Wales Finances Data Tool An interactive data tool that enables users to look at trends in NHS Wales finances, such as revenue funding and savings, at an all Wales level or individual NHS bodies.	June 2019
Counter-Fraud Arrangements in the Welsh Public Sector: An Overview for the Public Accounts Committee This report focuses on the impact and scale of fraud in the Welsh public sector and provides an overview of counter-fraud arrangements in place, including those in NHS Wales.	June 2019
A review of the Integrated Care Fund	July 2019
Primary Care Services in Wales	Autumn 2019

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3.2

Clinical Coding Follow-up Review— **Aneurin Bevan University Health Board**

Audit year: 2018

Date issued: May 2019

Document reference: 1183A2019-20

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The person who delivered the work was Delyth Lewis.

Contents

Despite a high level of accuracy, coding completeness is a significant issue and the profile and use of coded data to support improvement has not increased since our previous work. Although reasonable progress has been made in implementing our previous recommendations, some issues remain unresolved.

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Summary report

Introduction

- 1 Clinical coding involves the translation of written clinical information (such as a patient's diagnosis and treatment) into a code format. A clinical coder will analyse information about an episode of patient care and assign internationally recognised standardised codes¹.
- 2 Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day-to-day management information used within the NHS and is used in many different systems and presented in different formats. It can be used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.
- 3 Coding departments within Welsh NHS bodies are required to satisfy standards set by the Welsh Government on the completeness and accuracy of coded data. Performance against these standards form part of NHS bodies' annual data quality and information governance reporting.
- 4 During 2014-15, the Auditor General reviewed the clinical coding arrangements in all relevant NHS bodies in Wales. That work pointed to several areas for improvement such as the accuracy of coding, the quality of medical records and engagement between coders, clinicians and medical records staff.
- 5 We also found that NHS bodies routinely saw clinical coding as a back-office role, often with little recognition of the specialist staff knowledge and understanding needed. In addition, not all health bodies understood the importance of clinical coding to their day-to-day business.
- 6 In October 2014, we reported our findings for Aneurin Bevan University Health Board (the Health Board) and concluded that 'whilst there had been a good level of investment in clinical coding, a range of weaknesses in the clinical coding arrangements and processes were significantly reducing the accuracy of clinical coded data. More specifically, we found that:
 - the Health Board recognised the importance of clinical coding but resources may have been insufficient, stronger links with health records were needed and the Board needed to focus more on complying with national targets;
 - the effectiveness of the clinical coding process was undermined by a low level of clinical engagement, slow access to, and poor quality of, medical records and lack of routine validation and audit; and
 - clinical coded data was used appropriately and met national standards for validity and consistency but some coding was inaccurate, timeliness had

¹ For diagnoses, the International Classification of Diseases 10th edition (ICD-10), and for treatment, the OPCS Classification of Interventions and Procedures version 4 (OPCS).

deteriorated and the Board was unaware of the inaccuracies or their implications.

- 7 We made recommendations focused on:
 - improving the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process;
 - strengthening the management of the clinical coding team to ensure that good quality clinical coding data is produced;
 - strengthening engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised; and
 - building on the good level of awareness of clinical coding at the Board to ensure members are fully informed of the Health Board's clinical coding performance.
- 8 As part of the Auditor General's 2018 audit plan at the Health Board, we have examined the progress made in addressing the recommendations set out in the **2014 Review of Clinical Coding** and any resulting improvement in clinical coding performance.
- 9 In undertaking this work, we have:
 - reviewed documentation, including reports to the board and committees;
 - asked the Health Board to self-assess its progress so far;
 - analysed clinical coding data sent to Welsh Government;
 - sought board member views² on their understanding of clinical coding; and
 - interviewed staff to discuss progress, current issues and future challenges.
- 10 We summarise our findings in the following section. **Appendix 1** provides specific commentary on progress against each of our previous recommendations.

Our findings

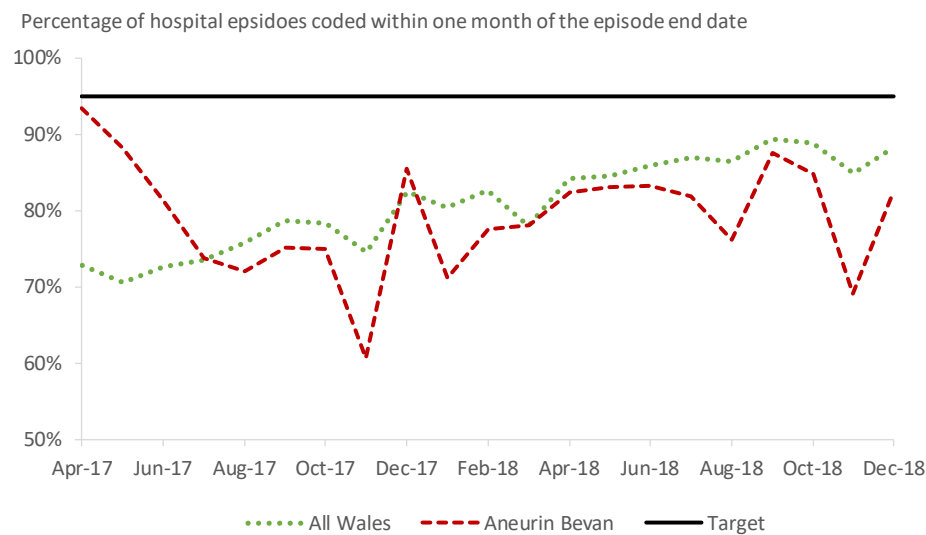
- 11 Our overall conclusion is that **despite a high level of accuracy, coding completeness is a significant issue and the profile and use of coded data to support improvement have not increased since our previous work. Although reasonable progress has been made in implementing our previous recommendations, some issues remain unresolved.**

² Some questions relating to clinical coding were included in the board member survey which formed part of our 2018 Structured Assessment work. A total of 17 responses out of a possible 23 responses were received.

While the accuracy of the clinical coded data remains high, the completeness figures are below national targets and the Health Board carries a significant backlog

- 12 The Welsh Government has two coding-related Tier 1 targets which NHS bodies are required to meet. These relate to completeness and accuracy.
- 13 Each year, NHS bodies send data to the Welsh Government showing their performance against the Tier 1 target for **completeness**. The target is that 95% of hospital episodes should have been coded within one month of the episode end date. NHS bodies need to meet this target monthly rather than at the end of each financial year, which was previously the case. **Exhibit 1** shows that the Health Board's completeness has worsened significantly since 2017 with performance regularly below the all-Wales position, and the Welsh Government target.

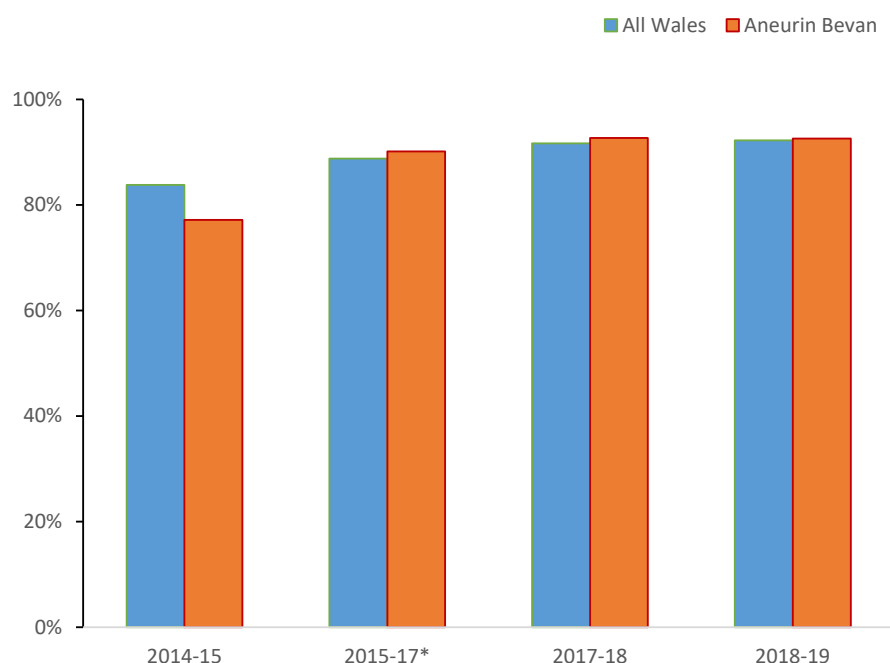
Exhibit 1: percentage of episode coded within one month of the episode end date



Source: Wales Audit Office analysis of information on clinical coding completeness submitted to the Welsh Government.

- 14 Each year, the NHS Wales Informatics Service (NWIS) Standards Team assess the **accuracy** of clinical coding by reviewing a sample of coded episodes against patients' medical records. Health Boards are expected to show annual improvement. In 2018, NWIS found that accuracy for the primary diagnosis, secondary diagnosis, primary procedure, and secondary exceeded recommended thresholds. Overall clinical coding accuracy improved at the Health Board from 77% in 2015 to 93% in 2017 with overall accuracy unchanged in 2018 (**Exhibit 2**).

Exhibit 2: percentage of episodes coded accurately



Source: NWIS, Clinical Coding Audit Report for Aneurin Bevan University Health Board

* Note that due to capacity within the NWIS clinical coding team, a single accuracy review was undertaken during the period 2015-16 and 2016-17.

- 15 In our previous work, we reported that at the end of February 2014, there were roughly 12,500 hospital episodes that had not been coded within the required timeframe. As part of our fieldwork, we requested the backlog position for the year ending 2017-18, to understand the extent to which episodes are not coded within the one-month timeframe. The Health Board reported a significant backlog of 46,638 episodes still to be coded. This is nearly four times the number of un-coded episodes in 2014. Based on a standard workload of 30 episodes per day, we estimate that it would take one person five to six years to clear the backlog. The Health Board's own estimate is that it needs an additional eight coders to clear the coding backlog and achieve and sustain the 95% completeness target.

Clinical coding has a low profile and the Health Board is not using coded data to support improvement

- 16 In 2014, we found that not all NHS bodies understood the wider importance of clinical coding to their business. Furthermore, they were missing opportunities to use this information more extensively, for example by:
- assessing the number of patients on clinical pathways; and
 - providing comparative activity data to evaluate productivity, quality and performance.
- 17 The profile of the clinical coding team is relatively low within the Health Board. This is probably most notable from where the coding teams are situated, with some located off the main hospital site in unsuitable accommodation. They have no access to cleaning services and are facing monthly generator black outs and system outages. Being situated away from clinical areas also does not help with the visibility of coders to clinical staff, however, the coding team has introduced more awareness sessions for medical staff to meet with coding staff.
- 18 Our follow-up work found that the coding team are rarely asked for coded data to support service improvement. The coding team attend mortality review meetings where coded data is used but it can be difficult to obtain an accurate picture when there is a backlog of data and completeness targets are not met.
- 19 There is a clear management structure for the coding function up to Board level. However, not all performance information on coding performance is presented to the Board. Currently performance against completeness against the IMTP target and national target is reported but the accuracy figure and backlog position are not currently reported at Board level.

The Health Board has made reasonable progress on our previous recommendations, but issues around medical records and reporting coding performance at Board level are yet to be resolved

- 20 **Exhibit 3** summarises the status of our 2014 recommendations.

Exhibit 3: progress status of our 2014 recommendations

Total number of recommendations	Implemented	In progress	Not started	Superseded
15	8	7	0	0

Source: Wales Audit Office.

- 21 Our follow-up work has found that the Health Board has made reasonable progress against our 2014 recommendations, although several recommendations are still in progress.
- 22 The quality of medical records has not improved since our audit work in 2014, despite the clinical coding and medical records department being proactive in holding sessions for clinical and nursing staff on the importance of good record keeping. Coding staff told us that a large proportion of their time is spent tracking down loose notes or refiling notes into a logical order. The Medical Records team have identified issues at ward level, namely ward clerks have little or no training on the importance of good medical record keeping and the tracker tool on Myrddin. Medical records have recently carried out an audit of ward processes and clinical behaviours in relation to the Health Record. This has taken place at the same time as the annual Health and Care Standards audit across all wards at the Health Board. The findings and recommendations from both audits were to be combined and reported to the Director of Nursing. At the time of our audit, the results were not yet available. Access to medical records for coders also remains an issue. Although coders generally have good access, delays can occur if they do not have access to the scanned records. Problems can also occur when accessing records pertaining to deceased patients prior to them going to the complaints department.
- 23 Good progress has been made on our 2014 recommendations on clinical coding resources. The Health Board is unique in having both a qualified auditor and a qualified trainer in the coding team. As a result, there is a good programme set up of regular audits for each coder and follow-up with subsequent training as needed. However, there has been a high turnover of staff, high levels of sickness, and recruitment freezes, which has affected the completeness of coding and there is a significant backlog as a result. The coding department also are still not using the latest version of Medicode, due to issues in the national rollout across Wales.
- 24 The coding team's engagement with medical staff is improving but is still relatively irregular. Coding staff tend to contact medical secretaries or more senior coders to resolve coding queries. The same applies to involving medical staff in validation. Coders have started to have regular meetings with certain specialities, but this is only on a small scale. There have, however, been improvements in the training for medical staff and coders have a regular slot on junior doctor induction programmes and hold training sessions with individual specialties.
- 25 Since our previous review in 2014 there has been significant change in board membership. Although the Coding Manager and Medical Director meet every six weeks to discuss how to improve reporting on patient outcomes using the coded data, there is very little which gets reported to Board on coding. The level of awareness amongst board members has also declined. The full board survey results are available in [Appendix 2](#).

Recommendations

- 26 The Health Board needs to continue to implement our previous recommendations where these remain incomplete. These are set out in [Exhibit 4](#).
- 27 In undertaking this work, we have also made two new recommendations. These are set out in [Exhibit 5](#).

Exhibit 4: outstanding recommendations from 2014

2014 recommendations not yet complete	
Management of Medical Records	
R1	Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. The Health Board should: a) raise the importance of good quality records throughout the Health Board; c) put steps in place to ensure that coders have early access to medical records; and e) improve compliance with the medical records tracker tool within the Myrddin Patient Administration System.
Clinical Coding Resources	
R2	Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. The Health Board should: b) revisit staffing levels across the teams, with a particular focus on the hours allocated to retrieval officers; and e) work with NWIS to ensure that the Health Board is using the latest version of Medicode.
Engagement with medical staff	
R3	Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include: c) engaging medical staff in the validation process.
Board engagement/resources	
R4	Building on the good level of awareness of clinical coding at the Board to ensure members are fully informed of the Health Board's clinical coding performance. At a minimum, this should include the Health Board's compliance with the Welsh Government targets.

Source: Wales Audit Office.

Exhibit 5: new recommendations

2019 Recommendations	
Clinical Coding Resources	
R1	To support retention of qualified clinical coders, the Health Board should: a) ensure the workplace accommodation is suitable and safe; b) ensure the workplace facilities are commensurate with other departments; and c) explore flexible working for staff.
Management of Medical Records	
R2	The Health Board should: a) review the way that medical records are managed at ward level; b) ensure ward clerks are released to attend training on records management relevant to their role; c) ensure ward clerks have adequate time allocated for records management.

Appendix 1

Health Board progress against our 2014 recommendations

Exhibit 6: assessment of progress

Recommendation	Status	Target date for implementation	Summary of progress
Management of medical records			
R1 Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include:			
a) raising the importance of good quality records throughout the Health Board	In progress		The clinical coding teams at Royal Gwent and Nevill Hall reported that the quality of medical records has not improved since our last audit in 2014. Records are frequently misfiled, missing loose notes or contain unclear diagnoses which are difficult to code. Clinical coding support officers are spending a large proportion of their time finding loose notes for coders. An issue with the filing of records for deceased patients has been identified. There is a lack of urgency to find the loose notes to ensure the medical record is complete.
b) reinforcing the Royal College of Physician standards for Records Management across the Health Board;	Implemented		Both medical records and clinical coding staff hold regular training and induction sessions for clinicians, nursing staff and divisional leads. At these sessions, guidance from the Royal College of Physicians on the importance of keeping good medical records is provided to staff attending the session.
c) putting steps in place to ensure that coders have early access to medical records;	In progress		Coders generally have early access to medical records although there can be delays if they do not have access to the scanned documents first. Staff also identified problems obtaining deceased patient notes before they are sent to the complaints department.

Recommendation	Status	Target date for implementation	Summary of progress
Management of medical records			
R1 Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include:			
d) improving compliance with the medical records tracker tool within the Myrddin Patient Administration System;	In progress		Medical records have completed a series of audits across all wards including a review of ward clerk knowledge at the two main hospital sites. They found the biggest issue is with a lack of training on the importance of good record keeping for ward clerks. Ward clerks reported to the medical records team that they had not received training on the Myrddin system to track records. The training is available, but they are not being released from the wards to attend. The medical records department has recently produced a report for the Director of Nursing, which seeks to address concerns on the management of medical records at ward level. At the time of our audit, the report was not available.
e) strengthening the links between medical records and coding by inviting coding representation on the Health Records Committee; and	Implemented		The relationship between medical records and clinical coding is good. Coders have a standing agenda item at the monthly PRISM (Patient Records and Information Services Managers) meeting which feeds into the Health Board's Health Records Committee.
f) ensuring that the experience of coders in using the digitalised health record is considered as part of the digitalisation pilot.	Implemented		Clinical coding staff were included in meetings prior to the implementation of the digitalised health record (DHR). Some of their initial ideas were not able to be incorporated but there are ongoing meetings with the business change manager and project manager to discuss coders' concerns.

Recommendation	Status	Target date for implementation	Summary of progress
Clinical Coding Resources			
R2 Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include:			
a) ensuring an appropriate level of time is allocated for mentoring and checking the work of others, particularly amongst the Band 4 staff;	Implemented		A training plan is in place for all new starters to the coding team with trainees allocated a band 4 mentor to check their work, which is incorporated into their work programme.
b) revisiting staffing levels across the teams, with a particular focus on the hours allocated to retrieval officers;	In progress		There have been issues with recruiting coding staff as some posts were frozen in 2012. These posts have recently been released and recruited to, but this has contributed to the negative backlog position they are now in. The Health Board's proximity to the English border has meant it has had difficulty retaining qualified coders, who are approached by private organisations that can offer home working and more attractive salaries. To reduce the coding back log, as well as achieve the 95% completeness target, the Health Board estimates they require an additional eight coders. The Health Board is currently awaiting confirmation of the activity figures forecasted for the new Grange Hospital before submitting a business case for additional resources.
c) using the additional auditor capacity to develop a rolling programme of clinical coding audit across the Health Board;	Implemented		Each coder receives an individual audit as part of an annual rolling audit programme run by the Health Board's approved clinical coding auditor. These audit reports are then brought together into an overview report. Between April 2017 and March 2018, 520 coded episodes were audited.

Recommendation	Status	Target date for implementation	Summary of progress
Clinical Coding Resources			
R2 Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include:			
d) revisiting the role of the clinical coding co-ordinator to ensure that responsibilities are comparable across the four members of staff; and	Implemented		Since our last audit, the four co-ordinator posts have become more structured. The Health Board is in the unique position of having both a qualified auditor and qualified trainer. In addition, they have line managers for each main site at the Royal Gwent and Nevill Hall.
e) working with NWIS to ensure that the Health Board is using the latest version of Medicode.	In progress		The Health Board has yet to upgrade to version 5.9 as there have been issues with upgrading at other health boards. Once the issues have been resolved the Health Board will implement the latest version.
Engagement with medical staff			
R3 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include:			
a) raising awareness of the clinical coding process adopted by the Health Board through training sessions for medical staff, as well as attendance at appropriate meetings;	Implemented		The coding team provides clinical coding awareness sessions for medical and nursing staff. These sessions also provide an opportunity for coders to ask medical staff questions relating to the particular speciality. The coding team also has a regular slot as part of the induction training for junior doctors.
b) encouraging clinical coders to be more visible to consultants, for example, by seeking clarification from them on episodes of care of patients; and	Implemented		Coders are encouraged to engage with medical consultants and any queries are usually routed through the coding managers or through medical secretaries in the first instance. Attendance at awareness sessions, as referred to above, also provides opportunities for coders to be more visible to consultants and to ask questions or seek clarification.

Recommendation	Status	Target date for implementation	Summary of progress
Engagement with medical staff			
R3 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include:			
c) engaging medical staff in the validation process.	In progress		The clinical coding trainer meets with one of the vascular consultants quarterly to ensure accuracy and the Health Board would like to roll out this approach to more specialties to involve more medical staff in the validation process.
Board Engagement/Resources			
R4 Build on the good level of awareness of clinical coding at the Board to ensure members are fully informed of the Health Board's clinical coding performance. At a minimum, this should include the Health Board's compliance with the Welsh Government targets.	In progress		Clinical coding performance is reported to the Board via the integrated performance dashboard. Although the national target for clinical coding completeness is 95%, the Health Board is working to achieve a minimum completeness of 80% according to the IMTP dashboard. Meanwhile, the percentage of clinical coding accuracy is not reported to the Board. We surveyed all Board members about their understanding of clinical coding. We received a 74% response rate. There were mixed views, for example, one board member reported not having heard of the coding function while another had recently met with the Head of Coding. Board members reported that they were not satisfied with the information they received on the robustness of clinical coding arrangements at the Health Board. The majority reported that they would find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information.

Source: Wales Audit Office.

Appendix 2

Results of the board member survey

Responses were received from 17 of the board members in the Health Board. The breakdown of responses is set out below.

Exhibit 7: Rate of satisfaction with aspects of coding

	How satisfied are you with the information you receive on the robustness of clinical coding arrangements in your organisation?		How satisfied are you that your organisation is doing enough to make sure that clinical coding arrangements are robust?	
	This Health Board	All Wales	This Health Board	All Wales
Completely satisfied	–	6	–	5
Satisfied	3	34	6	40
Neither satisfied nor dissatisfied	11	46	8	46
Dissatisfied	3	10	2	4
Completely dissatisfied	–	–	1	1
Total	17	96	17	96

Exhibit 8: rate of awareness of factors affecting the robustness of clinical coding

	How aware are you of the factors which can affect the robustness of clinical coding arrangements in your organisation?	
	This Health Board	All Wales
Full awareness	1	26
Some awareness	9	50
Limited awareness	6	17
No awareness	1	3
Total	17	96

Exhibit 9: level of concern and helpfulness of training

	Are you concerned that your organisation too readily attributes under performance against key indicators to problems with clinical coding?		Would you find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information?	
	This Health Board	All Wales	This Health Board	All Wales
Yes	–	8	15	77
No	16	84	2	19
Total	16	92	17	96

Exhibit 10: additional comments provided by respondents from the Health Board

Additional comments
- Not sure what clinical coding is, I have heard it referred to and I think I recall one audit report that mentioned it, but I am not sure of its significance in terms of assessing progress against the organisation's objectives. - I have met with the Head of Coding and understand the constraints and risks, and what is being undertaken to address this

Appendix 3

Management response

Exhibit 10: management response

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	Clinical Coding Resources To support retention of qualified clinical coders, the Health Board should: a) ensure the workplace accommodation is suitable and safe; b) ensure the workplace facilities are commensurate with other departments; and c) explore flexible working for staff.	To retain existing clinical coders and ensure working environment is suitable.	Yes	Yes	A full review of clinical coding will be undertaken as part of the impact assessment for the new Grange University hospital, this will include an accommodation review. Qualified experienced clinical coders are essential in ensuring consistent high quality clinical coding. The HB has a good track record in consistently delivering this.	Complete review by March 2020.	Assistant Director of Performance & Information

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	Management of Medical Records The Heath Board should: a) review the way that medical records are managed at ward level; b) ensure ward clerks are released to attend training on records management relevant to their role; and c) ensure ward clerks have adequate time allocated for records management.	Improve the standard of medical records at ward level.	Yes	Yes	The ward clerk role is managed by the individual ward sisters and staff are not trained in records management currently. There is a requirement for the staff to be released to attend the Record Awareness sessions and this requires to be made a mandatory element of their training portfolio as well as WPAS training on records tracking.	31 December 2019	Director of Nursing to mandate

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INTERNAL AUDIT PROGRESS REPORT 2019/2020

18 July 2019 Audit Committee

**NHS Wales Shared Services Partnership
Audit and Assurance Service**

INTERNAL AUDIT PROGRESS REPORT 2019/2020



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INTERNAL AUDIT PROGRESS REPORT 2019/2020

4.1

1. INTRODUCTION

- 1.1** The purpose of this report is to highlight the completion of reporting to the Audit Committee in respect of the 2018/19 Internal Audit Plan and progress against the 2019/20 Internal Audit Plan at 11 July 2019.

2. COMPLETION OF REPORTING IN RESPECT OF THE 2018/2019 INTERNAL AUDIT PLAN

- 2.1** The following final reports were issued to the Health Board since the Audit Committee meeting in April 2019 and were included in the 2018/19 Head of Internal Audit Opinion:

AUDIT ASSIGNMENT	ASSURANCE RATING
Risk Management	Reasonable
Health and Care Standards	Reasonable
Well-being of Future Generations Act	Reasonable
Clinical Futures – Progress Following Gateway Review	Reasonable
Cyber Security	Reasonable
GDPR	Reasonable
Clinical Futures – IT Work stream	Reasonable
Use of Digital Technology	Advisory
Medical Staffing	Limited
Organisational Development and Training	Reasonable
HSDU Project	Reasonable
Capital Systems	Reasonable
Water Safety	Reasonable
Grange University Hospital – Open Book Audit	Reasonable
Grange University Hospital – Project Audit	Substantial

3. PROGRESS AGAINST THE 2019/20 INTERNAL AUDIT PLAN

Number of audits in plan	41*
Number of audits reported as final	1
Number of audits reported in draft	6
Number of audits in progress	13

* Total excludes AGS and G&A Module and includes two audits carried forward from 2018/19.

INTERNAL AUDIT PROGRESS REPORT 2019/2020

4.1

- 3.1** Appendix A details progress in respect of each of the reviews in the 2019/20 Internal Audit Plan. One audit (Annual Quality Statement) has been reported as final to date.

4. SUMMARY OF FINDINGS

- 4.1** Limited assurance reports are considered by the Audit Committee in detail. A separate presentation is provided to communicate the main messages from the Reasonable and Substantial assurance reports issued since the last meeting in April 2019 to the Audit Committee.

5. CONTINGENCY

There is a contingency element in the 2019/20 Internal Audit Plan. These days will be utilised in discussion with the Health Board in response to emerging risks.

6. ENGAGEMENT

ADDITIONAL MEETINGS HELD AND COMMITTEES ATTENDED DURING THE REPORTING PERIOD

- 6.1** Board/Sub Committee/other events:

- Board;
- Quality & Patient Safety Committee;
- Information Governance Committee; and
- Finance & Performance Committee.

- 6.2** Meetings:

- Regular update meetings regarding the Clinical Futures Programme;
- Audit scoping and debrief meetings;
- Chief Executive quarterly;
- Board Secretary bi-weekly;
- Assistant Director of Finance (Corporate Finance) monthly;
- Audit Committee Chair quarterly;
- Chair bi-annually;
- Well-being of Future Generations Act Steering Group; and
- Wales Audit Office, Health Inspectorate Wales and Ombudsman quarterly.

7. RECOMMENDATION

- 7.1** The Audit Committee is invited to note the above.

Planned output	Outline timing	Status	Assurance
Corporate Governance, Risk and Regulatory Compliance			
Governance, Leadership and Accountability (Health and Care Standards)	Q4		
Annual Governance Statement	Q4		
Risk Management and Assurance	Q4		
Welsh Language Standards	Q2	Work in Progress	
Health and Care Standards	Q4		
Health and Safety Management and Fire Safety Follow-up	Q1	Work in Progress	
Strategic Planning, Performance Management and Reporting			
Clinical Futures – Staff Engagement	Q2	Work in Progress	
Clinical Futures II – Operational Commissioning Planning	Q3		
Clinical Futures III – Critical Path	Q4		
Service Change Plan 2	Q3		
Dashboard Reporting	Q3		
Financial Governance and Management			
Financial Planning and Budgetary Control	Q3		
Losses and Special Payments	Q4		
Business Case Scrutiny Arrangements	Q2	Work in Progress	

Planned output	Outline timing	Status	Assurance
Procurement	Q1	Work in Progress	
Charitable Funds	Q2	Work in Progress	
Patients Property and Monies	Q1	Draft Report	
Private and Overseas Patients Follow-up	2018/19	Draft Report	
Clinical Governance, Quality and Safety			
Annual Quality Statement	Q1	Final Report	N/a
Medical Equipment and Devices Follow-up	Q3		
Maternity Services	Q3		
Discharge Planning Follow-up	Q1	Work in Progress	
Putting Things Right	Q4		
Clinical Audit Follow-up	Q3		
Patient Experience	2018/19	Work in Progress	
Information Governance and Security			
111 Service	Q4		
Freedom of Information Requests	Q1	Draft Report	Substantial
IT Service Management Follow-up	Q3		
IT Business Continuity/Disaster Recovery	Q3		

Planned output	Outline timing	Status	Assurance
Operational Service and Functional Management			
Job Planning	Q1	Work in Progress	
Outpatients	Q2	Work in Progress	
Escalation Policy	Q2	Work in Progress	
Divisional Review – Scheduled Care	Q2	Work in Progress	
Theatres	Q4		
Workforce Management			
Staff Experience Framework	Q4		
Pay Incentives	Q1	Draft Report	Limited
PADR Follow-up	Q2	Work in Progress	
Healthcare Support Workers Delegation Framework	Q3		
Capital & Estates			
Carbon Reduction Commitment	Q1	Draft Report	N/a
Environmental Sustainability Report	Q1	Draft Report	N/a
Major Capital Projects	Q3		
Anti-Fraud Capital Systems	Q3		
Estates Assurance	Q2		
Grange University Hospital	Separate Plan		

INTERNAL AUDIT PROGRESS REPORT 2019/2020
KEY PERFORMANCE INDICATORS
30 June 2019

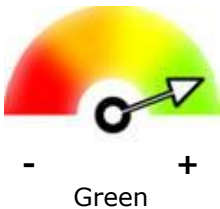
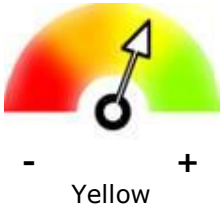
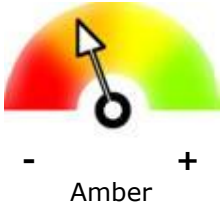
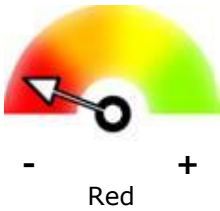
Appendix B

Indicator	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2019/20		April 2019	By 30 April	Not agreed	Draft plan	Final plan
Report turnaround: time from fieldwork completion to draft reporting [10 days]		3 of 3	80%	$v > 20\%$	$10\% < v < 20\%$	$v < 10\%$
Report turnaround: time taken for management response to draft report [15 days]		1 of 1	80%	$v > 20\%$	$10\% < v < 20\%$	$v < 10\%$
Report turnaround: time from management response to issue of final report [10 days]		1 of 1	80%	$v > 20\%$	$10\% < v < 20\%$	$v < 10\%$

INTERNAL AUDIT PROGRESS REPORT 2019/2020

Audit Assurance Ratings

4.1

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.
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.

INTERNAL AUDIT PROGRESS REPORT 2019/2020

4.1

Office details:

Audit and Assurance Services
Cwmbran House,
Mamhilad Park Estate,
Pontypool,
NP4 0XS

Contact details

James Quance (Head of Internal Audit) – 01495 300841

Audit Committee 18 July 2019

Reasonable and Substantial Assurance Internal Audit Reports

Risk Management

Reasonable Assurance



Assurance Summary					
1	2017/18 Follow-up			✓	
2	Risk management strategy, policy and procedures			✓	
3	Risk awareness	Not rated—covered in Landscape Review			
4	Risk mitigation, monitoring and reporting			✓	

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

+

- Action Plan
- Landscape Review

-

- Management oversight of risk
- Form and content of risk registers



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Health & Care Standards

Reasonable Assurance



Assurance Summary					
1	QPS Committee Assurance			✓	
2	Suitable Oversight through the Health and Care Standards Group			✓	
3	Training and Awareness				✓
4	Previous actions raised completed and additional actions identified			✓	

Priority	H	M	L	Total
Number of recommendations	0	3	0	3

+

- Awareness within the Health Board
- Progress from prior year

-

- Attendance at H&CS Group
- Driver Diagrams



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Well-being of Future Generations Act

Reasonable Assurance



Assurance Summary					
1	The Act features in strategic planning and performance activities.			✓	
2	The Act is taken into account in investment and service development.			✓	
3	A programme is in place to embed the five ways of working.				✓
4	Well-being objectives are monitored.		✓		
5	Arrangements are in place for reporting on outcomes.			✓	

Priority	H	M	L	Total
Number of recommendations	1	2	-	3

+

- Embedding five ways of working

-

- Programme Board effectiveness
- Outcomes/actions and monitoring



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Clinical Futures – Progress Following Gateway review

Reasonable Assurance



Assurance Summary					
1	Action plan			✓	
2	Action plan progress			✓	
3	Governance and reporting process		✓		
4	Clinical engagement			✓	
5	Finance system and financial sustainability			✓	
6	Non-financial and financial benefits			✓	

Priority	H	M	L	Total
Number of recommendations	-	2	-	2

+

- Good general progress

-

- Accountability and responsibilities



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OD & Training

Reasonable Assurance



Assurance Summary					
1	Policies and procedures, including an organisational development strategy, are in place to support the IMTP.			✓	
2	The Health Board's programme of organisational development initiatives is aligned to the IMTP.				✓
3	Organisational development initiatives are achieving desired outcomes.			✓	
4	The Health Board has a coherent strategic approach to training.			✓	
5	The process for identifying training needs and responding to them is operating effectively.			✓	
6	Training resources are being applied effectively to support the organisational development objectives.		✓		

+

- OD strategy

-

- Use of training resources
- Success factors

Priority	H	M	L	Total
Number of recommendations	-	3	1	4



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Annual Quality Statement (2019/20)

No Assurance Rating Given

- No issues have come to our attention that lead us to believe that the AQS has not been prepared in accordance with the Welsh Government Guidance, or that information in the AQS is not materially consistent with source documents.
- Whilst we obtained all supporting information required within our sample testing of the AQS, we had difficulty obtaining some of this information.

Specialist Services Unit – IT Audits



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Cyber Security

Reasonable Assurance



Assurance Summary					
1.	Governance			✓	
2.	External Review Awareness			✓	
3.	Implementing Actions			✓	

Priority	H	M	L	Total
Number of recommendations	0	3	0	3

+

- Framework
- Increased Resource
- Actions Progressing

-

- Reporting Process
- Active Security
- Staff Awareness



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GDPR

Reasonable Assurance



Assurance Summary					
1.	Central Actions			✓	
1.	Local Governance			✓	
1.	IARs			✓	

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

+

- Framework
- Training and Guidance
- Central IAR

-

- Records of Processing
- Procedure Documentation
- Breach Procedures



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Clinical Futures – IT Work stream

Reasonable Assurance



Assurance Summary					
1.	GUH Work Stream			✓	
2.	Informatics Work Stream			✓	
3.	Monitoring				✓
4.	Resources		✓		

Priority	H	M	L	Total
Number of recommendations	0	5	1	6

+

- Project Monitoring
- Technical Specification
- Plans

-

- Revenue Implications
- Redesign Process
- Implementation plans
- Mobile Telephone
- ICT Resource



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Use of Digital Technology

Advisory Review

Assessed Status Against Key Signifier Questions

- Is the Health Board re-imagining service delivery and business processes?
- Is the Health Board redefining the relationship with the service user?
- Is the Health Board leveraging the wider ecosystem in Health and Social Care?
- Do UHB staff have the right technology skill-set and mind-set?
- Does the Health Board have leaders who see the bigger picture?
- Does the Health Board have a good system for prioritising digital transformation initiatives?

+

- Positioning
- Service Redesign
- Cross Sector Working
- Vision
- Staff Positivity

-

- Funding
- ICT Resource
- Legacy Systems
- Staff Engagement
- Articulation of Vision



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Specialist Services Unit – Capital & Estates Audits



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HSDU Project

Reasonable Assurance



Assurance Summary					
1	Project Governance			✓	
2	Appointments and contract			✓	
3	Project Management			✓	
4	Workstreams			✓	

Priority	H	M	L	Total
Number of recommendations	-	6	-	6

+ Positive Themes

- Governance framework.
- Procurement strategy [noting change to SCP prior to OBC submission].
- Project management [for current stage of project i.e. progress to FBC stage]

- Observations/ Recommendations

- Formal acceptance of key roles [Project Owner and Project Director].
- Update of Project Team terms of reference.
- Contract documentation signed post commencement of work / commissions.
- Review of risk register required.
- KPIs to be developed.
- Stakeholder involvement with design.



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Capital Systems

Reasonable Assurance



Assurance Summary					
1	Follow up			✓	
2	Monitoring & Reporting		✓		
3	Risk Management			✓	
4	Change Management			✓	
5	Programme Management			✓	

Priority	H	M	L	Total
Number of recommendations	0	6	1	7

+ Positive Themes

- Regular Project Progress meetings.
- Appropriate use of external advisers to facilitate project and cost management.
- Project monitoring arrangements including review of construction programmes.
- Regular review of project risks.

- Observations/ Recommendations

- Varying reporting and accountability arrangements across projects.
- Visibility of Project Director oversight of project performance.
- Inadequate Project Execution Plans.
- Minimum documentation requirements not defined.
- Form and content of risk registers.
- Delegated authority within project approved sums not defined.
- Change control processes not fully documented.



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Water Safety

Reasonable Assurance



Assurance Summary					
1	Governance				✓
2	Monitoring and Reporting			✓	
3	Procedures				✓
4	Management		✓		
5	Risk Management		✓		

Priority	H	M	L	Total
Number of recommendations	2	2	0	4

+ Positive Themes

- Water Safety Policy & Water Safety Plans.
- Governance framework.
- Training requirements for all relevant staff with water safety responsibilities.

- Observations/ Recommendations

- Attendance at Water Safety Group.
- Lack of flushing records maintained on wards.
- Maintenance of log books to record completion of scheduled maintenance tasks.
- High priority recommendations outstanding from last Royal Gwent Hospital risk assessment.



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Open Book Audit



Reasonable Assurance

+ Positive Themes

- Appropriate contractual arrangements in place.
- Robust staff time recording [SCP and external advisers].
- Payments by SCP to supply chain made within contractual terms.
- Expenses appropriately charged to the project.
- All recommendations raised in the report were implemented post audit fieldwork

- Observations/ Recommendations

The following issues were noted, however the quantum of these issues is noted in relation to the project costs (£211m):

- Central wage administration incorrectly inc. in staff levies [c. £44,696 to end of project] - Recovered.
- Central training incorrectly included in staff levies [c. £111,496 to end of project] -Recovered.
- Volume rebates not declared.

Assurance Summary					
1	Control framework			✓	
2	Staff costs				✓
3	Fee - off-site overheads and profit margin		✓		
4	Volume rebates		✓		
5	Sub-contractors, Materials and Purchased Services				✓
6	Other direct costs				✓
7	Expenses				✓

Priority	H	M	L	Total
Number of recommendations	-	3	-	3



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Grange University Hospital Project Audit

Substantial Assurance



Assurance Summary					
1	Follow Up			✓	
2	Performance of UHB, Advisors, HB Staff and Supply Chain			✓	
3	Valuations / Fees			✓	
4	Payments				✓
5	Change Management				✓
6	Discharge of Supervisor Role				✓

Priority	H	M	L	Total
Number of recommendations	-	2	1	3

+ Positive Themes

- Performance reporting for all parties.
- Financial vetting of SCP.
- Adherence of Cost Adviser to process for review of SCP valuations.
- Payments authorised in accordance with Health Board and project defined delegated limits.
- Defined change management process and compliance with the same.
- Supervisor role discharged appropriately.

- Observations/ Recommendations

- Appointment to roles of Programme Director and Project Director.
- Project Board membership: lack of Estates / Construction representation.
- Non compliance with Cost Adviser methodology for valuation of materials off site.



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Medical Locum and Agency – Compliance with Welsh Health Circular 2017-042

Internal Audit Report

2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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2. Scope and Objectives	4
3. Associated Risks	5

Opinion and key findings

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Appendix A	Management Action Plan
Appendix B	Follow-up on prior year recommendations
Appendix C	Assurance opinion and action plan risk rating
Appendix D	Responsibility Statement

Review reference:	ABUHB-1819-33
Report status:	Final
Fieldwork commencement:	6 th December 2018
Fieldwork completion:	8 th February 2019
Draft report issued:	1. 8 th February 2019 2. 26 th February 2019
Draft report clearance meetings:	1. 12 th February 2019 2. 22 nd February 2019 3. 14 th May 2019
Management response received:	1. 26 th April 2019 2. 17 th May 2019
Final report issued:	21 st May 2019
Auditor/s:	James Quance, Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Emma Rees, Audit Manager
Executive sign off	Paul Buss, Medical Director
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 Kath Smith, Interim Associate Director of Operational Delivery
 Kathryn Bourne, Head of Specialist Medical & Dental Workforce
 Fidelma Davies, Head of Strategic Financial Planning
 Kate Davies, Workforce Performance Manager

Committee

Audit Committee
 Finance & Performance 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 Aneurin Bevan 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 medical locum and agency – compliance with Welsh Health Circular 2017-042 was completed in line with the 2018/19 Internal Audit Plan. The review sought to continue to review the effectiveness of the processes put in place by Aneurin Bevan University Health Board ('the Health Board') to reduce medical agency expenditure.

Welsh Health Circular 2017-042 'Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales' ('the Circular') was issued in October 2017, setting out a programme of action across NHS Wales aiming to drive down agency and locum deployment and encourage the return of people to the NHS labour market. This included setting caps for medical locum and agency hourly rates. At the point the Circular was introduced, the Health Board was spending £7.9m on medical agency staff and £13.8m on medical locum staff per year (based on 2017/18 figures, the medical locum figure includes £3.3m of WLI spend). Reduction of medical locum and agency spend, with a particular focus on lowering medical agency costs, is a key area of focus within the financial constraints experienced by NHS Wales.

In January 2018, as part of the 2017/18 Internal Audit Plan, we undertook an initial, high level review of compliance with the Circular. Whilst the report received a reasonable assurance rating based on the design and limited time to operate controls, one high priority finding was raised around compliance with the authorisation process for breaches of the caps for hourly rates. Additionally, two medium priority findings were raised concerning the maintenance of data to support Welsh Government reporting requirements.

2. Scope and Objectives

This internal audit, undertaken in January 2019, assessed the adequacy and effectiveness of internal controls in operation following a full year for controls to be embedded and for the recommendations of our previous audit to be implemented. Weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The specific objective of this audit was to assess ongoing implementation of, and compliance with, the Circular, namely that:

- medical locum and agency rates paid are at or below the cap rate identified within the Circular;
- records of agency and locum staff payments ensure accurate and timely reporting that meets the requirements of Welsh Government ('WG'); and

- appropriate action is taken to reduce medical locum and agency spend.

We also followed up on the implementation of our prior year recommendations.

Limitations of scope

The audit did not cover the work being undertaken within NHS Shared Services Partnership Procurement Services to bring agency rates within the cap on an All Wales basis. It also did not cover the process for procuring or contracting with agencies.

3. Associated Risks

The risks considered in the review were:

- non-compliance with Welsh Health Circular ('WHC') 2017-042; and
- failure to reduce medical agency and locum spend.

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 for medical locum and agency – compliance with WHC 2017-042 is **Limited Assurance**.

RATING	INDICATOR	DEFINITION
Limited Assurance		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 overall level of assurance that can be assigned to a review is dependent

on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

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

					
1	Medical locum and agency rates paid are at or below the cap rate identified within the Circular		✓		
2	Records of agency and locum staff payments ensure accurate and timely reporting that meets the requirements of Welsh Government		✓		
3	Appropriate action is taken to reduce medical locum and agency spend			✓	

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

Design of Systems/Controls

The findings from the review have highlighted four issues that are classified as weakness in the system control/design for medical locum and agency – compliance with WHC 2017-042.

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 medical locum and agency – compliance with WHC 2017-042.

6. Summary of Audit Findings

Analysis

Over the four financial years from 2012 to 2017, the Health Board had the second lowest spend on medical agency staff across the six largest health boards in Wales, Cardiff & Vale UHB having the lowest (figure 1). Achieving

a 35% reduction within 12 months, as required by the Circular, was therefore a considerably greater challenge for the Health Board when compared with other Health Boards with greater scope for reduction. Between 2012 and 2017, medical agency spend increased across NHS Wales as a whole.

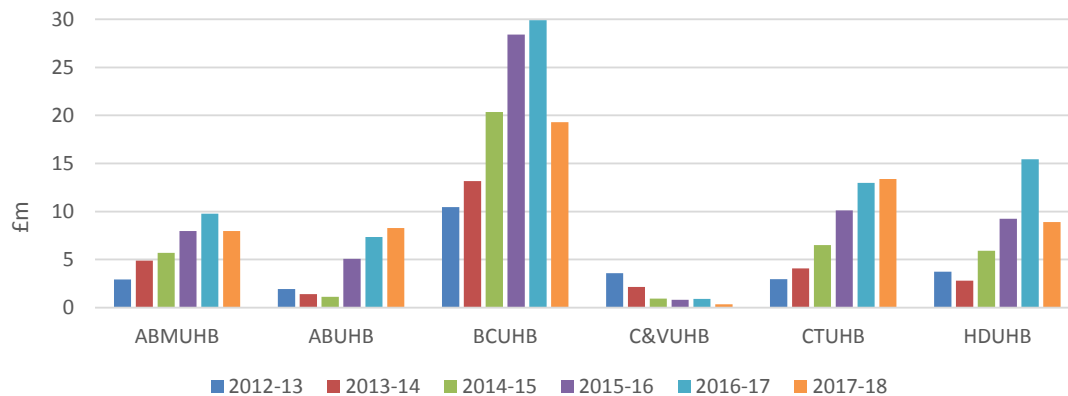


Figure 1: Medical agency expenditure by financial year for the six largest Welsh health bodies (source: January 2019 WAO report 'Expenditure on agency staff by NHS Wales')

2017/18 then saw a significant reduction in medical agency spend, totalling £17.3m throughout NHS Wales. However, Aneurin Bevan UHB's medical agency costs increased by £916,000 (12%) during this time, the largest increase across all Welsh health bodies in both absolute and relative terms (figure 2).

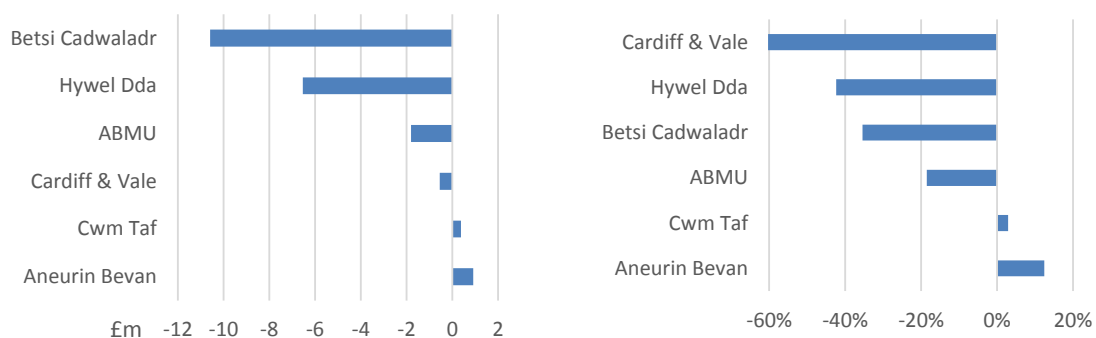


Figure 2: All Wales change in medical agency expenditure 2016-17 to 2017/18 for the six largest Welsh health bodies (source: January 2019 WAO report 'Expenditure on agency staff by NHS Wales')

Welsh Health Circular 2017-042 'Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales' was introduced in November 2017. Across all of NHS Wales, there has been an overall reduction in medical agency spend since the introduction of the Circular (figure 3). However, after an initial fall in the six months from October 2017

to March 2018, there has been a general upwards trend in All Wales agency expenditure.

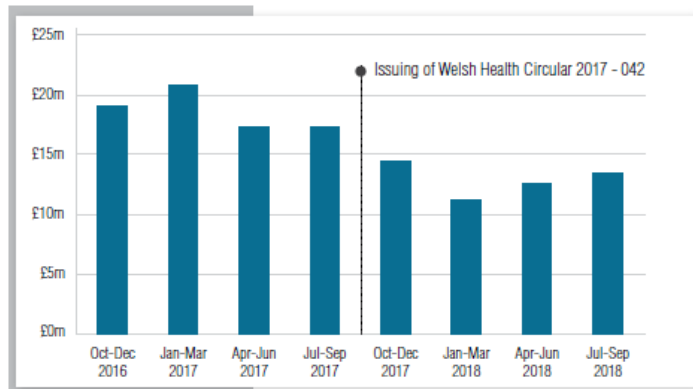


Figure 3: Medical agency spend in NHS Wales before and after implementation of the Circular

(source: January 2019 WAO report 'Expenditure on agency staff by NHS Wales')

The Health Board was consistent with this trend. In the first three months post introduction of the Circular, the Health Board saw a consistent decrease in monthly agency spend, from over £600,000 in October 2017 to under £400,000 in February 2018 (figure 4). The January and February 2018 monthly spend was below the WG target.

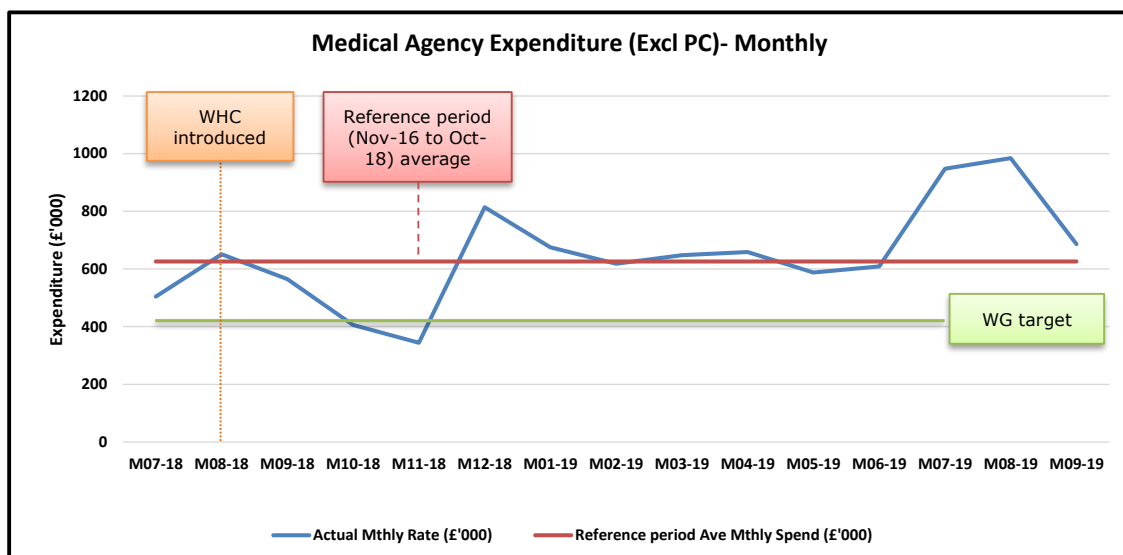


Figure 4: Aneurin Bevan UHB monthly medical agency expenditure (excluding Primary Care)
(source: Aneurin Bevan UHB Quarter 3 2018/19 Welsh Government submission)

March 2018 then saw a significant rise of £475,000 in the Health Board's medical agency costs, taking the monthly spend well above both the reference period average. Specific high spend areas included:

- Ophthalmology: cover for sickness in key posts resulting in high cost, short term cover;

- Orthopaedics: combination of sickness, vacancies and additional rota cover;
- Paediatrics and Obstetrics & Gynaecology: costs of sustaining existing rotas across sites and additional clinics to help deliver the RTT target;
- Unscheduled Care specialties: sickness and vacancy cover to sustain rotas across multiple sites, including the Royal Gwent Winter Ward, Emergency Departments and Care of the Elderly services.

The Health Board's monthly medical agency expenditure has remained at or above the monthly average for the reference period since March 2018. We understand this to be due to strategic decisions taken at Executive level to ensure service continuity whilst maintaining patient safety, particularly in the areas noted above. Furthermore, given that the Health Board started from one of the lowest medical agency spends in Wales, management gave more focus to the medical locum bank, with a view to improving systems and encouraging more doctors into the bank, thus reducing reliance on agency doctors in the longer term.

Within the Health Board, during the period April to December 2018, 10,068 shifts were filled by medical locum and agency doctors. Of these, the Circular cap was breached in 5,326 (52%) cases, 88% of which (4,669 shifts) were medical agency shifts.

The Health Board remains reliant on agency doctors, with 56% of shifts (5,646 shifts) being filled through agencies between April and December 2018. 86% of the agency shifts were covering vacancies.

During April and May 2018, divisional planning workshops were held, aimed at identifying the challenges faced by divisions with regard medical locum and agency staff and to put plans in place to address these challenges. Updates on these plans have been provided to the Executive Management Team ('EMT') and/or the Finance & Planning Committee ('FPC'). However, in spite of the efforts of the Health Board, the action taken has not yet been successful in reducing agency expenditure and, noting the vacancy position, it is difficult to see how this can be achieved in the short term whilst maintaining patient safety and necessary service continuity.

Findings

We recognise the position of the Health Board regarding the balance that must be struck between covering vacancies, maintaining patient safety and strategic decisions to focus on longer term solutions. However, within the scope of the audit we identified a number of issues regarding the processes that are operating within the Health Board for the request, approval and reporting of breaches of the cap, which impact on compliance with the Circular. These are set out below and contribute to the limited assurance opinion.

Three **high priority** issues were identified that require prompt management actions:

1. Procedures for booking medical locum and agency staff

Our fieldwork identified widespread non-compliance with the documented 'Controls process for authorisation, booking and escalation of locum and agency doctors in ABUHB' ('the Procedures'), resulting in non-compliance with the Circular. The issues identified include:

- Executive (i.e., Board) level approval is often not obtained for breaches of the cap (required by the Circular) – of the 4,626 breaches from April to November 2018, 176 (4%) had Executive approval requested but not received and 1,156 (25%) had no approver identified (see finding 2);
- the Medical Staffing Coordinators ('MSCs')¹ are not always seeking appropriate approvals at other stages of the process (see finding 2);
- payment of expenses (prohibited by the Circular) – we identified 30 instances of expenses being paid and have anecdotal evidence that accommodation is used as a negotiating tool to try and reduce agency rates; and
- honouring previous rates (frowned upon by the Circular) and paying doctors at a higher rate than in the previous 12 months (prohibited by the Circular) – we identified 218 shifts where honouring previous rates has resulted in breaches of the cap.

There was consultation on the Procedures when they were originally developed. It was accepted at the time that they were onerous, but complied with the Circular. No suggestions for simplifying them could be identified at that time, so they were accepted. However, the Procedures have subsequently proved so difficult and time consuming to follow leading to the risk of delays in filling shifts or locum/agency doctors being lost to other organisations.

With over twelve months' experience of the Procedures in operation, we have recommended that it is a good point to take stock of the level of non-compliance and to consider how the process could be made more efficient whilst remaining compliant with the Circular. This should involve discussion with Welsh Government regarding the requirement for each breach to be signed off at Executive level and whether there is scope in certain specific situations for Executive approval to be delegated in accordance with the Health Board's scheme of delegation.

¹ For the purposes of our report, 'Medical Staffing Coordinators' and 'MSCs' refer to staff with medical staffing coordinator roles, including those with wider responsibilities and differing job titles.

2. The right people making the right decisions

Due to the level of non-compliance with the documented Procedures noted in finding 1, there is a risk that decisions around the use of medical locum and agency staff are not being made on a timely basis at an appropriate level within the Health Board.

We have recommended that, in conjunction with finding 1, the Health Board should undertake a review of the current MSC model and documented Procedures, with a view to ensuring the right people are making the right decisions on a timely and effective basis.

3. Recording of medical locum and agency data

There are no controls over the spreadsheets used by the divisions to record medical locum and agency data ('the divisional spreadsheets'), meaning it is difficult to effectively analyse the data and not possible to provide assurance over the completeness and accuracy of the data.

We also identified a large number of instances where the divisional spreadsheet data had not been input completely by the MSCs, for example 1,733 instances where the WHC cap rate column showed 'FALSE' and 1,154 instances where the reason for a breach in the WHC capped rate has not been completed.

We recognise that the Health Board is implementing the Patchwork system as a pilot, amongst other things to aid with the controls over medical locum and agency data. However, until this is fully implemented, the Health Board is reliant upon the divisional spreadsheets for Welsh Government and internal reporting on medical locum and agency usage.

Therefore, in this interim period, we have recommended that the divisions put appropriate controls in place over the divisional spreadsheets they use to capture the data and that the Health Board reviews its data needs to see if any of the columns could be removed or the data collected more effectively.

Should the Health Board decide not to use Patchwork, either at all or in certain areas of the Health Board, management would need to implement another secure, robust electronic system to capture the medical locum and agency data.

We identified two **medium priority** issues which we consider require management's attention and provides scope for improvements to be made:

- Despite the efforts of the Health Board, reliance and spend on agency doctors has remained consistent with the previous year. We understand

this is largely due to strategic decisions taken at Executive level to ensure service continuity whilst maintaining patient safety. The spirit of the Circular is to continue to drive down medical agency spend. We have recommended that the Health Board identifies an achievable target, timescale and action plan for reduction in agency spend.

- Discussions with the MSCs highlighted a number of behaviours that limit the Health Board's ability to reduce its reliance / spend on medical locum and agency staff. We have recommended that these behaviours be addressed as part of the action plan recommended in finding 4.

We have raised one **low priority** finding around maximising the benefit of the Patchwork pilot by ensuring the feedback mechanism from the MSCs to the implementation team is operating effectively and 'audit reports' are run from Patchwork to ensure the system is being appropriately used.

Full details of our findings are reported in Appendix A.

Testing

Due to the number of issues and areas of non-compliance identified in our discussions with the MSCs, we did not carry out any testing on the controls in place over booking medical locum and agency staff.

Follow-up on prior year recommendations

Our prior year audit was an initial, high level review of compliance with the Circular. Whilst the report received a reasonable assurance rating based on the design and limited time to operate controls, one high priority finding was raised around compliance with the authorisation process for breaches of the caps for hourly rates. Additionally, two medium priority findings were raised concerning the maintenance of data to support Welsh Government reporting requirements.

The table below gives a brief summary of the progress on implementing our prior year recommendations. Full details are included in Appendix B.

Area		Classification 2017/18	Direction of travel
1	Authorisation process	High	 No progress has been made to either amend the documented procedures or improve compliance rates with the process. Non-compliance with the process has increased on prior year.

Area		Classification 2017/18	Direction of travel
2	Workforce spreadsheet	Medium	 There has been no improvement in the controls over the divisional spreadsheets and the spreadsheet is still not being fully and accurately populated by the MSCs. The level of incomplete data has increased on the prior year.
3	WHC reporting requirements	Medium	 The divisional spreadsheets are still not always completed fully or accurately. The level of incomplete data has increased on the prior year. Additional work is still required to extract the required data.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below:

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

Finding 1 Procedures for booking medical locum & agency staff (Design)	Risk
Our fieldwork identified widespread non-compliance with the documented procedures for booking medical locum and agency staff ('the Procedures'). Some of these non-compliances with procedure also result in non-compliance with the Circular. <i>Note: All figures quoted in this finding relate to the eight months from April to November 2018.</i> Breach of process leading to non-compliance with the Circular The Procedures require that Executive (i.e., Board) level approval is obtained for breaches of the cap on a case by case basis. However, this has not been happening. Out of a total of 4,626 breaches, 2,296 (50%) were approved by divisional management only, 176 (4%) had Executive approval requested but not received and 1,156 (25%) had no approver identified. In some cases, we understand that strategic decisions have been made at Executive level to ensure service continuity whilst maintaining patient safety, resulting in divisional managers then approving breaches on this basis. However, it is not clear if this strictly meets the requirements of the Circular. Additionally, it is not in line with the Health Board's Procedures and the audit trail to support such decisions is not robust. We also appreciate that some of the approvals by divisional management may be genuinely allowed due to the General Managers being on the out of hours 'Exec on Call' rota, but only a small proportion would be due to this. Payment of travel and accommodation expenses is prohibited under the Circular. However, our review of the Workforce spreadsheet identified 30 instances in April and July 2018 where expenses were paid. Additionally, one MSC admitted to using accommodation as a negotiating tool to reduce agency rates. The latter is not recorded in the Workforce spreadsheet. Further review of the Workforce spreadsheet identified that the Health Board is still honouring rates from before the introduction of the Circular, which is frowned upon by the Circular. Honouring previous rates resulted in 218 shifts that breached the cap, 168 of which were agency bookings. 106 of the agency shifts related to one consultant who has been used long term in Older Adult Mental Health. Whilst the data to identify instances where doctors have been paid at a higher rate than within the previous 12 months is yet to be available, we were able to identify four instances where doctors have	Failure to comply with the Circular. Failure to reduce medical locum and agency spend. Delays in filling shifts or locum/agency doctors being lost to other organisations in the negotiation process.

been paid more than previously (note: this figure is not exhaustive and there may be more instances of this occurring).

General breach of process

The MSCs do not always seek approval at each stage of the booking process. Approvals that are received (including for breaches of cap) are often stored in the MSCs' individual inboxes rather than on a shared drive, therefore are inaccessible in the absence of the MSCs.

The request form required by the Procedures is not completed at all. Therefore, it is difficult to evidence that every option had been exhausted before booking agency staff.

The MSCs do not give priority to Medacs when booking agency doctors, because they feel that Medacs are less reliable at providing doctors than some of the other agencies (the workforce spreadsheet shows that Medacs provided cover for 31% of the agency shifts from April to November 2018). Some MSCs have their own 'preferred providers' that they go to first.

Medical Staffing Coordinators

Our discussions with the MSCs highlighted that not all were fully aware of the requirements of the Circular / Procedures. For example, some MSCs believe that 'Executive level approval' means divisional management.

There was consultation on the Procedures when they were originally developed and it was accepted at the time that they were onerous, but complied with the Circular. No suggestions for simplifying them could be identified at that time, so they were accepted. However, the Procedures have subsequently proved so difficult and time consuming for the MSCs to follow.

Recommendation 1

1.1 With over twelve months' experience of the Procedures in operation, it is now a good time for the Health Board to examine the efficiency and effectiveness of the process, taking into account the findings of this audit. In particular:

Priority level

High

Action Plan

- i. the Health Board should hold discussions with Welsh Government, regarding the Circular requirement for each breach to be signed off at Executive level and whether there is scope in certain specific situations for Executive approval to be delegated, in accordance with the Health Board's Scheme of Delegation. This could cover situations such as where a service needs to be maintained at a certain level (for example, Paediatrics) and longer term plans are in place to address vacancy issues but ongoing locum/agency cover is required to maintain service continuity in the short to medium term.
 - ii. the review should be done with collaboration between Workforce and the divisions (General Managers and MSCs), overseen by the Executive Lead for the Circular (Medical Director) and should cover all aspects of the Procedures, not just those related to the Circular.
- 1.2 The documented Procedures should be updated accordingly and approved by the Finance and Performance Committee.
- 1.3 The updated Procedures should be submitted to Welsh Government, highlighting any pertinent changes to those originally submitted. The Health Board should seek clarification from Welsh Government that the updates meet the requirements of the Circular.
- 1.4 Regardless of the outcome of the Procedure review, each division should ensure that the agreed process put in place by the Executive is adhered to, particularly in the areas of non-compliance identified in our audit.
- 1.5 Previously communicated messages on the requirements of the Circular and the Procedures should be reinforced with the MSCs. The divisions should ensure new MSCs receive appropriate information at their induction. See findings 2 and 3 also.
- Internal Audit can provide advice on revising the Procedures through attendance at an MSC meeting where they will be discussed.

Management Response 1	Responsible Officer/ Deadline
1.1 The documented procedures for booking medical locum and agency staff will be reviewed with a view to making them more efficient. i. The Health Board will seek clarity from Welsh Government on whether minuted Executive Team decisions made to explicitly maintain provision of specific clinical services prior to planned reconfiguration constitutes an advanced delegated authority to breach capped rate in specific circumstances, in line with the Scheme of Delegation. ii. The review will be led by Workforce and will involve the MSCs and Divisional General Managers, covering all aspects of the process.	Medical Director / Deputy Medical Director / Head of Specialist Medical & Dental Workforce / Interim Associate Director of Operational Delivery June 2019 July 2019
1.2 Any revisions to the documented Procedures will be approved through the Finance and Performance Committee.	Assistant Medical Director October 2019
1.3 The requirement to submit the revised Procedures to Welsh Government will be discussed at the all Wales Medical workforce Efficiencies group. The process will also be shared across Wales, to validate the levels of governance expected in the Health Board. If required, the revised Procedures will be submitted to Welsh Government.	Assistant Medical Director/ Head of Specialist Medical & Dental Workforce October 2019
1.4 Divisional management will ensure that the agreed Procedures are adhered to.	Director of Operations / Executive Director of Primary, Community & Mental Health June 2019
1.5 MSC line managers will ensure that messages relating to the Procedures and Circular are reinforced and that new MSCs receive appropriate induction training.	Head of Specialist Medical & Dental Workforce / Interim Associate Director of Operational Delivery May 2019

Finding 2 The right people making the right decisions (Design)	Risk
Due to the level of non-compliance with the documented Procedures, there is a risk that decisions around the use of medical locum and agency staff are not being made on a timely basis at an appropriate level within the Health Board. The MSCs are band 4/5 staff. Whilst responsible for filling the shifts and negotiating the rates, they have no clinical or budgetary authority to make the related decisions required to do so. Therefore, they should obtain authority from divisional management at each decision point in the process. However, this is not being fully complied with due to the onerous nature of the process. <i>Note: we understand that the MSCs do not proceed with an agency doctor without approval of the CV from a clinical director or approval of the rate from divisional management.</i> The MSCs are also regularly in the position of having to negotiate rates with the agencies (and sometimes with internal locums too) at times of intense pressure. This appears to be amiss with the fact they have no budgetary or clinical authority with which to negotiate. Additionally, we reported in finding 1 that Executive level approval is often not obtained for breaches of the cap on a case by case basis.	Failure to comply with the Circular. Failure to reduce medical locum and agency spend. Failure to ensure the right people make the right decisions on a timely and effective basis.
Recommendation 2	Priority level
2.1 In conjunction with the recommendations from finding 1, the Health Board should undertake a review of the current MSC model and documented Procedures, with a view to ensuring the right people are making the right decisions on a timely and effective basis.	High
Management Response 2	Responsible Officer/Deadline
2.1 The documented Procedures will be reviewed as per the response to recommendation 1.	

Action Plan

With regard to the MSC model, the Interim Associate Director of Operational Delivery has confirmed that they feel the current model is working well and has reinforced the required process in writing. The Health Board will: i. seek understanding on the current decision making authority delegated to the MSCs within each division, particularly with regard to negotiating with the medical agencies; ii. consider the outcome of (i) with regard to the Scheme of Delegation and what is permissible; and iii. update the Procedures with any changes required as a result of (i) and (ii) above, to ensure MSCs do not operate outside of their area of responsibility or delegated authority. Any resulting changes to the documented Procedures will be incorporated to the review in recommendation 1.	Interim Associate Director of Operational Delivery Completed Head of Specialist Medical & Dental Workforce / Interim Associate Director of Operational Delivery / Head of Strategic Financial Planning July 2019

Finding 3 Recording of medical locum & agency data (Design)	Risk
Workforce are dependent on the spreadsheets used by the divisions to record medical locum and agency data ('the divisional spreadsheets'). The divisions hold responsibility for the divisional spreadsheets. The data contained within them is copied into the central Workforce spreadsheet and is used for reporting to Welsh Government. Controls over the divisional spreadsheets There are minimal controls over the divisional spreadsheets: • formulae can be edited and not all MSCs password protect the spreadsheets; • drop down boxes which should not allow unauthorised entries have been edited; • it is possible to accidentally change previously input data without realising; and • there are no audit style checks on the completeness or accuracy of the data. Therefore, it is difficult for Workforce to effectively analyse the data and it is not possible for us to provide assurance over the completeness and accuracy of the data held within the spreadsheets. Completeness of data We identified a number of instances in the April – November 2018 Workforce spreadsheet where data had not been input completely by the MSCs. For example, out of a total of 10,556 locum and agency shifts: • the WHC cap rate column shows 'FALSE' for 1,733 shifts (this column is used in formulae that automatically identify breaches of the capped rates); • of the 4,626 breaches of the WHC cap, the authoriser was not identified for 1,154 and the reason for the breach not given for 539; and • for 759 shifts, the doctor's GMC number was marked as 'missing', 'requested', 'TBC' or blank (129 agency, 626 locum and 4 GP). <i>Note: we were made aware by one MSC that she had identified instances where the agencies had not undertaken appropriate checks on GMC numbers and gave three examples where they had tried to supply doctors who either did not have a GMC number or who had issues with their GMC registration.</i>	Potential for inaccurate data within the spreadsheet, leading to inaccurate reporting to Welsh Government. The data recording and reporting process is inefficient due to the limitations of using spreadsheets.

We understand that Workforce has reiterated the requirement for data to be entered completely and accurately at the MSC meetings, but that the data continues to be incomplete.

Efficiency of the spreadsheet

The MSCs all commented that the divisional spreadsheets are arduous to complete. There are 36 columns to complete for each booking, although only 29 of them are used regularly and some have drop down boxes to ease input. Most of the columns are necessary to allow the analysis of the data for WG reporting requirements and to support the audit trail of the process followed or are a divisional requirement for in-division monitoring.

The Specialist Medical & Dental Workforce team needs to undertake additional work to extract the required data, due to the limitations of the spreadsheet.

Electronic system

We recognise that the Health Board is currently in a difficult place with regard to finding an appropriate method to record the medical locum and agency data. It was advised by NHS Wales Shared Services Procurement Services (via the all Wales Medical Workforce Efficiencies Group) not to implement anything long term due to the upcoming changes to the framework over medical agencies and the potential for an All Wales software solution. Following the recommendation in our previous audit report, the Health Board recognised the need to implement a temporary system. We understand that IT were approached to help create a secure electronic system, but their advice was that the most cost effective solution would be to procure a system. This led to the pilot of Patchwork. Patchwork is a locum bank system that aims to streamline the management, booking and authorisation of locum shifts. This system has been piloted in A&E since November 2018 and was being rolled out in Acute Medicine at Nevill Hall at the time of our audit (January 2018). However, until Patchwork is fully implemented, the Health Board is reliant upon the workforce spreadsheets for WG and internal reporting on medical agency usage.

Additionally, Patchwork is currently only in pilot phase. Should the Health Board decide not to use Patchwork, either at all or in certain areas of the Health Board, management would need to implement another secure, robust electronic system to capture the medical locum and agency data.

Action Plan

Recommendation 3	Priority level
3.1 In the interim period until Patchwork (or another appropriate electronic system) is implemented, the divisions should put appropriate controls in place over the divisional spreadsheets used by their MSCs, including: i. Password protection of all spreadsheets stored on shared drives; ii. Removal of inappropriate/unapproved options from the drop down boxes and password protection of the lists that support them; iii. Password protection of cell containing formulae; iv. Regular audit style checks on the data, for example, exception reporting to identify anomalies that could be input errors, identification of blank cells that should have been completed and review of rates used/hours worked to audit trail to ensure accuracy of input; Note: the passwords used for ii and iii should not be known but the MSCs to prevent unauthorised amendment. 3.2 The Health Board should consider if any of the columns can be removed from the spreadsheet, or if the spreadsheet could be used more efficiently to capture the required data. 3.3 Previously communicated messages on the importance of complete and accurate data entry should be reinforced with the MSCs. Additionally, the MSCs should be reminded of the importance of ensuring a GMC number is obtained for all agency doctors. 3.4 Should the Health Board decide not to use Patchwork either at all or in certain areas of the Health Board, management would need to implement another secure, robust electronic system to capture the medical locum and agency data.	High
Management Response 3	Responsible Officer/ Deadline
3.1 Divisional management ensure that appropriate controls are put in place over the divisional spreadsheets. In particular:	Executive Director of Primary, Community &

Action Plan

• BPAs will work with local managers and MSCs to explore the possibility of password protecting SharePoint data locally; • managers will ensure the MSCs complete the required data fields and accurately; • any inaccurate/incomplete data identified by the workforce team will be returned to the local manager and MSC for action; and • all data will continue to be reviewed for accuracy on receipt by Workforce. A process for escalating any incomplete/inaccurate data to local managers will be developed. 3.2 The columns required by Workforce and the Finance team will be reviewed to ensure that they are necessary to provide meaningful data, with the understanding that the information held on the divisional spreadsheets is owned by the division and used for a variety of purposes including, for example, to calculate the accruals required for the financial ledger. 3.3 This message has been consistent since the introduction of the Welsh Health Circular. It will be reinforced at MSC Meetings and at Divisional Management Team ('DMT') via Workforce Business Partners. Local managers responsible for MSC will ensure this is adhered to. 3.4 The Health Board acknowledges that an electronic system is required. An interim evaluation of the Patchwork system is underway. Following this review, any residual action to address the recommendation will be identified and addressed through the Medical Staffing Action Plan.	Mental Health / Director of Finance / Interim Associate Director of Operational Delivery / Head of Specialist Medical & Dental Workforce / Workforce Performance Manager June 2019 Workforce Performance Manager July 2019 Interim Associate Director of Operational Delivery / Head of Specialist Medical & Dental Workforce July 2019 and ongoing Deputy Medical Director / Head of Specialist Medical & Dental Workforce / Workforce Performance Manager July 2019

Finding 4 Action plans to reduce medical agency spend (Design)	Risk
The Health Board is reliant upon agency doctors to fill shifts, with an average of 56% of medical agency and locum shifts being filled by agency doctors (see analysis in section 6 for further detail). The vast majority of agency shifts are due to vacancies – for the nine months from April to December 2019, 86% of agency bookings and 88% of cap breaches were due to vacancies. We understand that the Health Board currently has 120 WTE vacancies, but is only covering 30 WTE of these. The divisions developed plans to address reliance on agency doctors through workshops undertaken during April and May 2018 and there are a number of initiatives across the Health Board and across NHS Wales to attract doctors into substantive posts. However, despite these initiatives and the efforts of the Health Board, reliance on agency doctors and, therefore, medical agency spend has remained consistent with the previous year, prior to the introduction of the Circular. We understand this to be due largely to strategic decisions taken at Executive level to ensure service continuity whilst maintaining patient safety, particularly in the areas noted above. Furthermore, given the fact that the Health Board started from one of the lowest medical agency spend rates in Wales, management gave more focus to medical locum spend, with a view to improving their systems and encouraging more doctors into their medical locum bank, thus reducing reliance on agency doctors in the longer term. We recognise that the deadline to achieve the reduction of 35% in medical agency spend has now past. However, it is in the spirit of the Circular to continue to drive down medical agency spend and usage. We feel the Health Board would benefit from more formalised action plans to bring together and monitor the activity and initiatives to reduce medical agency spend.	Failure to comply with the Circular. Failure to reduce medical locum and agency spend.
Recommendation 4	Priority level
4.1 The Health Board should identify an achievable target and timescale for reduction in agency spend and pull together an overarching plan to attain this. 4.2 Divisional plans to reduce agency spend will play a supporting role in the overarching plan. Given that the actions taken so far have not been successful in reducing agency spend, the Health Board	Medium

Action Plan

should revisit the divisional plans to ensure they are fit for purpose. The review of the divisional plans should seek to identify learning points: what has worked well and could be replicated elsewhere and what is not working well, therefore may not be worth pursuing. 4.3 Both the overarching and divisional plans should include SMART actions, with identified responsible individuals and timescales. 4.4 The plans should be subject to regular scrutiny, at both divisional and Board level. A RAG rating system could be used to track progress against the plan and would assist in holding responsible individuals/areas to account.	
Management Response 4	Responsible Officer / Deadline
4.1 The detailed medical staffing models will continue to be developed through the Clinical Futures programme to sustainably staff the future hospital configuration of clinical services. This will provide the overarching medical workforce model to deliver medical services. Within this a recruitment and retention plan will also be developed and the use of a vat exemption model will be explored.	Director of Operations / Deputy Medical Director / Director of Finance September 2019
4.2 Divisional medical locum and agency expenditure data will be provided to the Director of Operations for the divisional assurance meetings to provide scrutiny of divisional actions. Divisional plans will be reviewed with the Deputy Medical Director.	Deputy Medical Director September 2019
4.3 The overarching medical workforce model will allow business case development and service redesign to support the recruitment to implement optimal medical establishment to reduce agency and locum requirement.	Deputy Medical Director / Interim Associate Director of Operational Delivery September 2019
4.4 Success of implementation of recruitment or service redesign will be assessed at DMT scrutiny meetings and Finance and Performance Committee against ongoing locum/agency expenditure.	Deputy Medical Director / Interim Associate Director of Operational

Aneurin Bevan University Health Board

Medical Locum and Agency – Compliance with the Circular

Action Plan

	Delivery September 2019

Finding 5 Behaviours (Operation)	Risk
Our discussions with the MSCs and supporting review of the Workforce spreadsheet for April – November 2018 identified a number of behaviours that limit the organisation's ability to reduce its reliance and spend on medical locum and agency doctors. Internal behaviours – Health Board The Health Board does not always pay the locum doctors on a timely basis. This has led to a lack of willingness in some doctors to do locum work. We recognise Patchwork will assist with rectifying this problem once rolled out across the organisation. Where cover is needed for a long period, the divisions will book agency doctors for longer periods. Whilst we appreciate there are instances where continuity is necessary, this approach does limit the Health Board's ability to reduce the rates during the booked period. Within some specialties, business cases have been approved to enable doctors to be paid at a higher rate than in another specialty. This causes some friction between the doctors and encourages doctors from other specialties to challenge the MSCs on the rates being paid. Doctors Communication between the Consultants and MSCs can be poor. For example, an MSC can spend considerable time filling a shift, only to find that the Consultant had already organised cover without informing the MSC. Sometimes, this also led to the Consultant agreeing an inappropriate rate with the doctor providing cover. We were also informed that there have been instances where the MSCs were not informed of cover that was dealt with out of hours. One division reported that some locum doctors will 'barter' for better rates (i.e., above the Health Board rates and often above the cap) once an agency booking has been made. The doctors offer a rate above the Health Board or capped rate but lower than the agency. Locum and agency doctors often refuse to take substantive posts because they feel the salary is too low. The Health Board is very much aware of this, but we have included it here for completeness.	Failure to comply with the Circular. Failure to reduce medical locum and agency spend.

Action Plan

Agencies

Many of the MSCs reported difficulty in negotiating reduced rates with the agencies (see also finding 2). However, a few of the MSCs reported that they were able to negotiate the rates or commission down. We have included a table below of the varying rates paid by agencies for each grade:

Agency rates by grade	Min £/hr	Max £/hr
Associate Specialist	30.99	30.99
Consultant	60.00	127.56
F1	57.00	57.00
F2	53.62	64.35
Specialty Doctor	33.99	144.00
StH	34.13	94.95
StL	30.99	81.55

We recognise that there will be some variation in rates within a grade, for example due to different levels of experience or a premium for unsocial hours. However, there is a high possibility that agencies are charging different rates to different MSCs for the same grade. Additionally, the MSCs reported that, once an agency doctor has been used, it is very difficult

to try and renegotiate the rate down if that doctor is used again.

There have been some issues with agency doctors who expect shifts on a 40 hour week basis, but the HB only offers 37.5 hours per week, sometimes resulting in additional hours work having to be given.

One MSC highlighted that there was an issue with a small number of long-term agency doctors demanding employee rights, particularly with regard to bank holidays and sick pay, resulting in a pay-out from the Health Board.

Communication

We understand that the above issues had not been communicated to either the Workforce or Recruitment teams.

Recommendation 5

5.1 As part of the action plans recommended in finding 3, the Health Board should consider the behaviours identified above, identifying how best to address them in order to assist with reducing medical locum and agency spend / reliance.

Priority level**Medium**

Action Plan

5.2 The Health Board should undertake a detailed review to assess whether the agencies are charging different MSCs different rates for the same grades. This information could be used in future rate negotiations.	
Management Response 5	Responsible Officer/ Deadline
5.1 The behaviours identified will be examined further and a plan to resolve developed, where appropriate. Some of these issues/behaviours identified are more complex to resolve, for example, there are significant risks and complexities regarding the ad hoc locum leave which is not only pertinent to the Health Board and is being reviewed on an all Wales basis. However, guidance will be issued once the work is complete.	Deputy Medical Director / Interim Associate Director of Operational Delivery / Head of Specialist Medical & Dental Workforce September 2019
5.2 NHS Wales Shared Services Partnership Procurement Services will be undertaking a review of the rates charged by medical agencies, recognising that the rates can vary between specialties and that this is permissible within the Crown Corporate Services framework agreement.	Deputy Medical Director July 2019

Action Plan

Finding 6 Maximising the benefit of the Patchwork pilot (Operation)	Risk
Patchwork is a medical locum bank system that aims to streamline the management, booking, authorisation and payment of locum shifts. The Health Board is implementing this system in order to increase shift fill rates (particularly in A&E) and to help attract a wider pool of doctors to the locum bank. The pilot started within the A&E departments in November 2018 and was being rolled out across the rest of Unscheduled Care at the time of the audit (January 2019). The 2018/19 Q3 WG submission reported that some benefits of Patchwork are already being seen, including shifts being released quickly via the Patchwork app, improved accuracy in monitoring hours worked and paid, locum timesheets being processed in a timely manner and six shifts converted from agency to locum. Our discussions with the MSCs identified a small number of teething issues with Patchwork. These teething issues were not specific to the Circular, therefore have been communicated verbally to management. Further discussions with Workforce and the Patchwork implementation team highlighted that these issues had not been reported to them in order that they can be addressed. Alternative systems Our discussions with the MSCs also highlighted that alternative systems are being considered by some divisions in isolation. For example, Families & Therapies are considering a similar locum bank system called Messly and Scheduled Care have submitted a bid as part of the Clinical Futures programme to use an electronic rostering system (Medirota) capable of sending notification to doctors when shifts are available.	The Health Board may not gain full benefit from the Patchwork trial. If the divisions consider software solutions in isolation to each other, the differing software used in each division could make the management and recording process less efficient.
Recommendation 6	Priority level
6.1 The Health Board should address the teething issues identified by the MSCs. 6.2 Management should ensure that the feedback mechanism from the MSCs and doctors to the Patchwork implementation team on how the Patchwork pilot is working effectively. The MSCs	Low

Action Plan

should be reminded that all issues with Patchwork, no matter how small, should be reported to the implementation team on a timely basis. 6.3 The Patchwork implementation team should run regular 'audit reports' from Patchwork to ensure that the MSCs are using the system appropriately, particularly with regard to recording authorisation for agency doctors and for changes to locum doctor rates. 6.4 Management should make the divisions aware of the Patchwork pilot and of the need to ensure a coordinated approach to the consideration, pilot and procurement of any locum bank system.			
Management Response 6		Responsible Officer/ Deadline	
6.1	The "teething issues" identified by the audit have now been resolved.	Workforce Manager Completed	Performance
6.2	The MSCs are now using the feedback mechanism to the implementation team and changes are being made to Patchwork accordingly.	Workforce Manager Completed	Performance
6.3	The Patchwork implementation team now run monthly audit reports to ensure the system is being used appropriately.	Workforce Manager Completed	Performance
6.4	The Families and Therapies division have since been in touch to discuss the Patchwork pilot and the Scheduled Care division has been made aware of the pilot. An evaluation of the Patchwork pilot will be undertaken during June 2019 which will inform future discussions with divisions. The results of the evaluation will be fed back to the Medical Director, Director of Operations and divisional management in August 2019.	Interim Associate Director of Operational Delivery / Head of Specialist Medical & Dental Workforce / Workforce Manager	Performance July 2019

Follow up on prior year recommendations

Previous Finding 1 Authorisation Process (Operation)**Overview of original finding (Priority Rating: High)**

We identified that records of the authorisation process were difficult to retrieve and that the Request Form required by the Procedures was not always being used. Therefore, it was difficult for the Health Board to demonstrate the need to fill a shift, that authorisation had been obtained at each stage and that internal options have been considered and exhausted prior to approaching agencies.

Original Recommendation

The Health Board should examine some of the underlying reasons as to why the process is not followed and if required, make the necessary amendments. In the absence of sufficient rationale, each division should ensure that the agreed approval process that has been put in place by the Executive is adhered to.

As part of future reviews of the process, the Health Board should consider how technology can streamline the process, by providing an effective solution for authorising shifts swiftly.

Original Management Response

Workforce will continue to reinforce the agreed process through regular medical staffing co-ordinators meetings. The Deputy Medical Director will also ensure that this is discussed with General Managers via the monthly locum and agency meetings. *Dr Stephen Edwards / Kathryn Bourne – Immediate and Ongoing*

There are a number of electronic options available to the Health Board. The following three are currently being explored:

1. in-house system working with IT and Finance;
2. allocate 'locum on duty'; and
3. Locum on Tap.

Dr Stephen Edwards / Kathryn Bourne – September 2018 for option appraisal

Follow up on prior year recommendations

Current Findings**Current Status of Implementation:
Not Implemented**

The documented process for booking medical locum and agency staff remains unchanged. The current audit identified that the process is not being adhered to and there is an increase in the number of non-compliances from our previous audit.

The General Manager monthly medical locum and agency meetings were stepped down after the reporting process had bedded in. The Health Board realised that monthly meetings added little value to the process, because many of the issues were longer term, did not change significantly month on month and were picked up in the quarterly reporting process. We understand the Assistant Medical Director does check any requests for medium/longer term breaches of the cap he receives are supported by an action plan around the related post.

Whilst steps have been made to identify a potential electronic system to streamline the process (via Patchwork), no progress has been made to either amend the documented procedures or improve compliance rates with the process.

Therefore, this finding has not been implemented.

See finding 1 in Appendix A.

Follow up on prior year recommendations

Previous Finding 2 Workforce spreadsheet (Design)**Overview of original finding (Priority Rating: Medium)**

The method for capturing data for onwards reporting to the Welsh Government is completed via a standard spreadsheet developed by the Specialist Medical & Dental Workforce & Job Evaluation Services within Workforce and OD. This includes details of the key elements set out within the Circular and is the primary tool for each division to record their booked agency and locum shifts. We identified that there was a lack of control within the spreadsheet leading to a high risk of error within the data. Additionally, the spreadsheet was not always completed accurately or fully by the MSCs.

Original Recommendation

The spreadsheet should be refined and procedures made more robust by:

- preventing free text in drop down cells for capped rates and formulae cells;
- requiring the continuous engagement field to be populated;
- removing or requiring consistent use of the 'number of sessions' field; and
- ensuring that all cap breaches record who authorised the breach and the reason.

In addition, the spreadsheet should be protected, with limited editing rights and password control. Periodically, audit / exception tools should be used to ensure the integrity of the spreadsheet is still intact.

Original Management Response

As the implementation of WHC 2017/042 has progressed, improvements have been made to the data spreadsheet, these may not all have been in place at the time of the audit.

- **preventing free text in drop down cells for capped rates and formulae cells**

Workforce has developed the spreadsheet since the audit and all cells that can be drop down are. In respect of the reasons for breaches, the 5 top reasons for are currently being agreed with the divisions and will then be included as a drop down. *Dr Stephen Edwards / Kate Davies - April 2018*

The spreadsheet should be refined and procedures made more robust by:

- **requiring the continuous engagement field to be populated;**

Follow up on prior year recommendations

Where this is relevant i.e. to agency and long-term engagement this is being populated by the divisions. Short-term booking for agency and any locums would not require this field to be completed. *Kate Davies - Immediate and ongoing*

- **removing or requiring consistent use of the 'number of sessions' field;**

This has been removed from the spreadsheet. *Kate Davies – Completed*

- **ensuring that all cap breaches record who authorised the breach and the reason;**

If not complete, the spreadsheet is returned to the division for completion. *Kate Davies - Immediate and ongoing*

In addition, the spreadsheet should be protected, with limited editing rights and password control. Periodically, audit / exception tools should be used to ensure the integrity of the spreadsheet is still intact.

The master spreadsheet held within workforce is password protected with limited access and is only populated by specific workforce staff. If this is sent elsewhere it is password protected to comply with information governance.

The divisions are responsible for ensuring the information governance of the data provided to us.

Kate Davies – Completed

Current Findings

**Current Status of Implementation:
Not Implemented**

Whilst the Health Board has taken steps to identify an alternative and more secure system for recording medical locum and agency shifts (Patchwork), spreadsheets remain the primary tool for recording and reporting on all bookings. Whilst there have been improvements in the controls over the spreadsheet held by Workforce, our current audit identified that there has been no improvement in the controls over the spreadsheets used within the divisions, i.e., at the point of data entry. Additionally the spreadsheet is still not being fully or accurately populated by the MSCs. Therefore, the risk of inaccuracies or errors in the data remains high. A higher level of incomplete data was noted in the current year audit.

Further details, including our recommendation, have been included in finding 3 of Appendix A.

Follow up on prior year recommendations

Previous Finding 3 Welsh Health Circular reporting requirements (Operation)**Overview of original finding (Priority Rating: Medium)**

We identified that the Workforce spreadsheet could capture the necessary data to meet the reporting requirements, but this would require the spreadsheet to be completed accurately and fully, which was not happening. We also noted that additional work is required to extract the required data (this is undertaken by the Specialist Medical & Dental Workforce & Job Evaluation Services within Workforce & Organisational Development).

Original Recommendation

Action is required to ensure that the divisions populate the spreadsheet with the necessary data, to enable the highest paid and longest serving locum and agency workers to be reported upon in an efficient manner.

From November 2018, the spreadsheet will also need to include details of rates paid that are higher than the preceding 12 months.

Original Management Response

Workforce have provided clearer instruction to the Medical Staffing Co-ordinators (MSCs) on the date to use for the continuous engagement.

The criteria for the highest paid and longest serving has been further clarified. The data to do this is available.

Data will be available from November 2018 to permit reporting of any rates paid that are higher than in the preceding 12 months.

Dr Stephen Edwards / Kathryn Bourne - Completed

Current Findings

Current Status of Implementation:
Not Implemented

As noted in finding 3 of Appendix A and in previous finding 2 above, the workforce spreadsheet is still not always completed fully or accurately by the MSCs and the level of incomplete data has increased on the prior year. The Specialist Medical & Dental Workforce team also still needs to undertake additional work to extract the required data, due to the limitations of the spreadsheet.

Steps have been taken to introduce a more robust recording system called Patchwork. However, this system is predominantly focused on recording locum bookings and does not currently have the functionality to record all required audit trail information for agency bookings (note: it does record the agency data required for reporting to WG).

Therefore, we consider that this finding has not been implemented.

Further details, including our recommendation, have been included in finding 3 of Appendix A.

Follow up on prior year recommendations

Aneurin Bevan University Health Board

4.2

Audit Assurance Ratings



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



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



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



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

Prioritisation of Recommendations

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

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

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Aneurin Bevan University Health Board

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

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

4.2

Aneurin Bevan University Health Board

4.2



Office details:

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 GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee Thursday 18 th July 2019 Agenda Item: 5.1

Audit Committee

Update on Governance, Financial Control Procedures, Technical Accounting Issues, Single Tender Actions and Post Payment Verification

5.1

Executive Summary

This report gives the Audit Committee an update in relation to a number of standing items are which are reviewed in line with the committee's terms of reference and work plan:

- Governance Issues including standing orders, SFIs and financial control procedures
- Technical accounting issues
- Public Sector Payment Policy compliance
- Single Tender Actions
- Post Payment Verification
- Payments Exceeding £100K

The Audit Committee is requested to note this report.

The Board is asked to: (please tick as appropriate)

Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Glyn Jones, Director of Finance and Performance

Report Author: Estelle Evans, Head of Financial Services and Accounting

Report Received consideration and supported by :

Executive Team		Committee of the Board	
		[Committee Name]	

Date of the Report: 04th July 2019

Supplementary Papers Attached:

- Appendix 1 – Project Plan
- Appendix 2 – Single Tender Action
- Appendix 3 – PPV Mid-Year

Purpose of the Report

This report gives the Audit Committee an update in relation to a number of standing items which are reviewed in line with the committee's terms of reference and work plan:

- Governance Issues including standing orders, SFI's and financial control procedures
- Technical accounting issues
- Public Sector Payment Policy compliance
- Single Tender Actions
- Post Payment Verification
- Payments Exceeding £100K

Background and Context

This report includes a number of standing items that are to be reviewed in accordance with the Audit Committee's annual work plan which in turn has been developed from the terms of reference of the Committee. The report also includes a section relating to the Public Sector Payment Policy which the Committee has historically asked to be routinely reported.

Assessment and Conclusion

1. Review of Standing Orders, SFIs and Scheme of Delegation.

No update to report with regard to the Standing Orders or the Scheme of Delegation.

The SFIs are being reviewed on an All Wales basis by NHS Wales Shared Services Partnership.

2. Financial Control Procedures (FCPs)

A separate paper is on the agenda in relation to Financial Control Procedures that have been reviewed by the Executive Team.

3. Technical Accounting Issues

IFRS16 Leases - update on action to date

As notified in the January Audit Committee governance paper the deadline for the implementation of IFRS16 has been deferred until 1st April 2020. However, Welsh Government has asked all Health Bodies to submit the IFRS16 impact to depreciation and impairments within the August and November Non Cash Submission. This information is required by Welsh Government as part of the comprehensive spending review (CSR), however, the actual date for the CSR has yet to be finalised.

The Capital Sub-Group of the main Technical Accounting group have raised concerns to Welsh Government regarding the requirement to include the estimated impact of the implementation of IFRS16 in the August non-cash submission due to the following issues:

- All organisations will be reliant on valuations being provided from the District Valuer for either land/building splits on qualifying existing operational leases or peppercorn leases.
- We will need to contract with the District Valuer to provide this service on behalf of the Health Board as will all other Health Bodies in Wales which given the tight timescale may cause issues with regard to the District Valuer's capacity.

To assess the impact of implementing IFRS16 within the Health Board the following action has been taken to date.

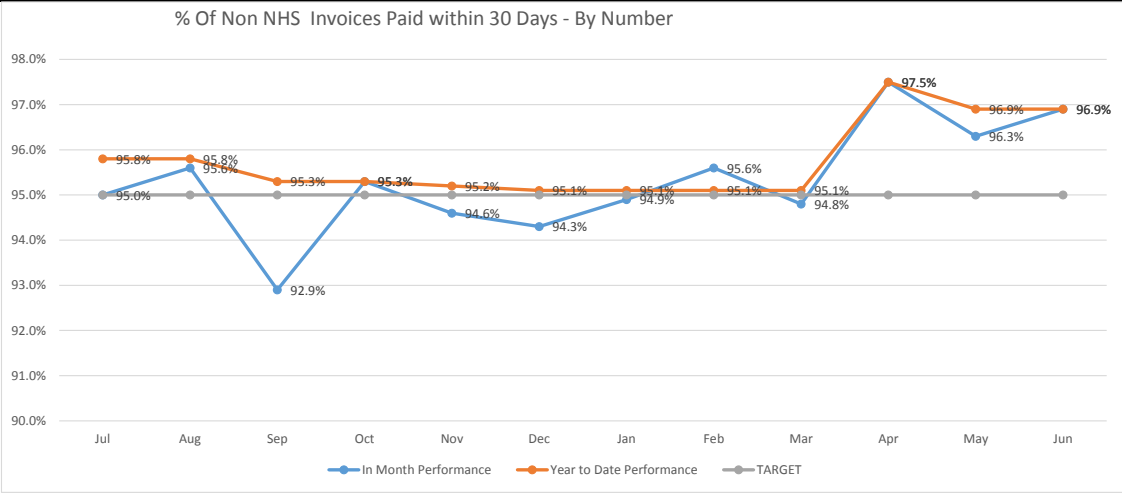
- A project plan identify all key dates and the associated information requirements has been produced which is attached in Appendix 1.
- The property lease register (EPIMS) has been obtained from NHS Wales Shared Services Partnership and distributed within the Health Board for ratification to ensure that all properties held by the Health Board are identified on the register.
- Copies of the lease contracts for each property identified have been requested and some received.
- Discussions have been held with procurement with regard to obtaining copies of reagent/consumable contracts that may contain a lease.
- Managed service contracts have been requested/received to enable a review to be carried out as to whether a lease is included in the contract
- Equipment Leases have been identified where they have been coded to the leases subjective.
- Further ledger downloads have been actioned for all of 2018-19 on subjectives, which may contain reagent/consumable/IT contracts with further review of any possible contracts on-going.
- Given the deadline of early August for the non-cash submission time limited support has been identified to assist with this task. The consultant has been providing IFRS16 assistance in another Welsh Health Board until recently.

It is important to note that the August figures would be an estimate for the following year's impacts and it is expected that these would be revised in November and also during 2020/21.

The most important impact for Welsh Government in relation to the CSR will be the potential impact between revenue and capital resource limits in terms of funding the changes going forward.

4. Public Sector Payment Policy

The following table shows the Public Sector Payment Policy performance over the last 12 months on a monthly and year to date basis to June 2019. The target of 95% has been achieved on a year to date basis.



5. Single Quotation and Tender Actions – April 2019 to June 2019

It is a requirement of Aneurin Bevan University Health Board Standing Financial Instructions that all requests for a Single Tender Action or a Single Quotation action are submitted to the Chief Executive for consideration and also reported to the Audit Committee.

The Audit Committee should note the detail of the attached table (Appendix 2) and monitor the number and value of business that is being submitted for a Single Tender or Single Quotation approval. The overarching guidelines on spending of public money are that it should be carried out in a fair, transparent and open manner, ensuring that competition is sought wherever possible. Therefore, the number of single action requests should be kept to a minimum.

There have been 15 requests submitted which have been approved during the period with an annual value of £501K.

Of these 15 approved requests, 10 were classified as either licensing or maintenance/ service type arrangements, the scope of which could cover the on-going servicing/support of medical equipment, ICT Hardware/Software or general licensing. There were 4 that were a purchase of new/replacement equipment and 1 was part goods part service.

6. Post Payment Verification

General Medical Services

The PPV team has recovered £1,182 from 3 completed visits to GMS contractors in the Aneurin Bevan UHB area due to errors identified in contractor’s enhanced service claims. The overall claim error rate for the locality was 5.06% from all claims sampled. One practice stands out as outliers for GMS services

Practice 5 – this was a routine visit with a sample size of 296 claims with an error rate of 35 claims (11.82%). This practice will be revisited within 12 months to look at 100% of claims for seven different enhanced services.

General Ophthalmic Services

The PPV team has recovered £125 from completed visits to GOS contractors in the Aneurin Bevan UHB area due to 5 errors identified in contractors' GOS claims. The overall claim error rate for the locality was 0.97% from all claims sampled.

General Pharmaceutical Services

The PPV team has recovered £196 from completed visits to 5 GPS contractors in the Aneurin Bevan UHB area due to errors identified in contractor's Medical Review Use claims. The overall claim error rate for the Health Board was 1.68% from all claims sampled. There is one outlier:

Practice 2 – this was a routine visit with a sample size of 80 claims with an error rate of 4 claims (5%).

Appendix 3 provides further detail in relation to the above.

7. Payments In Excess of £100K

The Committee requested that rather than a separate report, this item would be covered by exception.

The Health Board has made 129 payments in excess of £100,000 during the months of March, April and May 2019, totalling £190.341m. 74 of the payments were regular and specifically identified within the scheme of delegation. 55 other payments were identified as requiring additional approvals prior to payment. Contracts were in place for all 61 payments made to private sector suppliers. Therefore there were no exceptional issues to report.

Recommendation

The Audit Committee is asked to note this report.

Supporting Assessment and Additional Information

Risk Assessment (including links to Risk Register)	<i>SFIs, SOs, Financial controls and accounting systems and processes form the basis of many organisational controls without which the organisation would be exposed to significant financial and reputational risk.</i>
Financial Assessment	<i>No direct financial implications but the financial governance issues covered in this standard Audit Committee paper set a framework of key financial controls for the organisation.</i>
Quality, Safety and Patient Experience Assessment	<i>Not applicable</i>
Equality and Diversity Impact Assessment	<i>No adverse impact</i>

(including child impact assessment)	
Health and Care Standards	<i>No applicable</i>
Link to Integrated Medium Term Plan/Corporate Objectives	<i>SFIs, SOs, Financial controls and accounting systems and processes form the basis of many organisational controls which form part of the delivery of financial targets and good governance.</i>
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	<i>Not relevant</i>
Glossary of New Terms	<i>FCP – Financial Control Procedure SFIs- Standing Financial Instructions SOs- Standing Orders</i>
Public Interest	<i>Report to be published in public domain.</i>

Project plan to ensure that the HB comply with the implementation requirements of IFRS16 - Leases - Implementation date 01.04.2020
DEL & AME submissions to WG - estimated figures required for August 2019 and November 2019 submission

Appendix 1

TASK	WHO	Jun-18	Jul-18	Sep-18	Nov-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sept-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
General Tasks																					
Briefing Document prepared re IFRS16 implications	EE																				
Email to all RPAs re IFRS16 Exposure Draft data required by WG - to be completed re new leases etc.	EE/ All RPAs																				
RPAs to notify ESCA of any new/additional leases	All RPAs																				
Briefing Document prepared re IFRS16 implications re delayed implementation	EE																				
Presentation re implication of IFRS16 - FRM	EE																				
Finance Academy Workshop	EE/SG/PB/CB																				
Capital Technical Accounting Group - Areas of IFRS16 legislation - Common principles	KJ/EE/SG																				
Calculation of estimated IFRS16 implications for submission in the DEL & AME submission to WG	DC																				
Review of estimated IFRS16 calculations	EE/KJ/DC																				
DEL & AME submissions to WG	KJ																				
Comprehensive Spending Review - date TBC	KJ																				
Initial calculations of implications of IFRS16	EE/DC																				
Re-review of initial IFRS16 calculations	EE/KJ/DC																				
Revisit submitted IFRS calculations as part of the DEL and AME submission to WG	EE/KJ																				
Identify any changes to original calculations prior to go live date of 01.04.2020	EE/KJ																				
Property Leases																					
EPIMS property lease report requested	SG																				
EPIMS property lease report received	SG/SCS (NWSSP)																				
EPIMS property lease report reviewed for accuracy	SG																				
IFRS implementation working papers reviewed to identify copies of property leases on EPIMS report already obtained	SG																				
Copies of missing leases identified on the EPIMS report requested for review	SG																				
District Valuers reports requested - TBC																					
Equipment Leases																					
Equipment Lease Register requested from Procurement	SG																				
Ledger downloads actioned and reviewed for accuracy	SG																				
Reagent / Consumables / Managed Service Contracts																					
Discussions with Procurement re identification of reagent/consumable/managed practices	EE/PB																				
Ledger downloads actioned on other non-lease codes for M1-J2 2018/19	JP																				
Ledger downloads actioned on other non-lease codes for M1-J3 2019/20	SG																				
Non-lease codes to be reviewed to ascertain if they contain any reagent/consumable/managed service contracts	SG																				
Email to be sent to Procurement re identifying and ascertaining copies of reagent/consumable/managed service contracts for review	EE																				
Lease Cars																					
Lease Car spreadsheet obtained & reviewed	SG																				
Photocopiers																					
Photocopier spreadsheet obtained & reviewed	SG																				
PACs Contract																					
Copies of contracts requested	SG																				
GPIC Contract																					
Copies of contracts requested	SG																				
Contract received	SG																				

Appendix A - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date
27/02/2019	Single Quotation	318	Renewal of Datasym Menumark Licence and Renewal of Menumark and Menumate software and Hardware support for 16 ptills for period April 2019 – March 2020	£16,295.00	Datasym UK Ltd	Software	This is required while implementation of new catering information system risk being undertaken. New system will not be available in time for change in April.	SQA appropriate for short-term cover until new system is available	Approved	18/03/2019
07/03/2019	Single Quotation	324	Purchase of a Meiko Reception Table - Addition to existing Dishwasher	£9,572.00	Meiko	Goods	Service Improvement to the operation of the functioning Dishwasher.	Appropriate for service improvement	Approved	20/03/2019
20/03/2019	Single Quotation	327	Maintenance for Theatre Trolleys Stock	£9,376.90	Anetic Aid	Service	This will create cost avoidance add hock repair cost on labour and heavily discounted parts along with saving clinical down time of equipment. Anetic Aid need to service and maintain their own equipment.	SQA Appropriate for cost reasons for adhoc repairs	Approved	26/03/2019
21/03/2019	Single Quotation	328	Project Manager - Scheduled Care	£12,000.00	Institute of Clinical Science and Technology (ICST)	Service	To oversee and act as a project manager for a short period of time to deliver specific discreet pieces of project work. This will be to work with clinicians to develop and implement clinical pathways for Fractured NOF, Back pain, Management of spinal emergency admissions and ENT. To deliver clearly defined outcomes.	SQA is appropriate action	Approved	27/03/2019
26/02/2019	Single Tender	321	Purchase of 18 new tills to replace existing EPOS system	£30,676.64	Vista Technology Services	Goods	Purchase of 18 till to replace existing Renewal of Datasym Menumark and Menumate software and hardware support for period April 2019 - March 2020	Appropriate for service improvement	Approved	11/03/2019
05/03/2019	Single Tender	323	GUH Toucan Xing	£35,000.00	Torfaen County Council	Service / Goods	LoR provided costs which are outside the allocated budget £69K, Torfaen County has provided a quotation at a considerably lower rate £25k cheaper Quoting £35k, they have an approved supplier list which have been through an existing tender procedure.	STA Appropriate for cost saving reasons	Approved	07/05/2019
19/03/2019	Single Tender	326	Selenity ER Tracker	£49,590.00	Selenity	Goods	Selenity are able to provide a bespoke software system with the ability to interface with ESR, Selenity are the only supplier able to offer this product.	Only one supplier in market to offer this system	Approved	25/03/2019
19/03/2019	Single Tender	327	Circle of Security Training	£67,500.00	Circle of Security International	Service	The Circle of Security programme is unique in it's evidence base and it's theoretical fit with the wider CAMHS transformation work programme.	Supports other projects carried out for the Transformational plan and can lead to HB and LA cost savings.	Approved	25/03/2019
11/10/2018	Single Tender	294	Pathology Accreditation	£70,000.00	United Kingdom Accreditation Service	Service	Assessment of ABUHB Pathology services with compliance to ISO 15189 standard - Medical Laboratories Requirements for Quality and Competence. No current end date as circa £70,000 per annum and required for each pathology discipline.	STA appropriate as a service requirement	Approved	09/04/2019
17/01/2019	Single Tender	311	BMJ Advertising Subscription	£51,000.00	BMJ Publishing Group	Service	This is a medical recruitment advertising subscription package with the British Medical Journal (BMJ). ABUHB will be able to advertise medical posts at all levels both online BMJ website and in the paper copy of the weekly journal. Year 1 - £51,000, Year 2 - £55,200, Year 3 - £60,000 - Spend 2016 - £62,151.24, Spend 2017 - £61,959.88, Spend 2018 - £64,510.90	STA offers cash releasing savings compared to previous year spends	Approved	07/05/2019
18/04/2019	Single Tender	ABU-STA-40225	Student Transport	£65,000.00	Various	Service	St John's Wales Patient Transport Service, All wales ambulance service, Securcare Ltd, British Red Cross, PPG, FALCK - Existing proposal expired 31st March - this is a 3 month extension for first quarter of new financial	STA is an appropriate course of action for service continuity purposes	Approved	18/04/2019
29/05/2019	Single Tender	ABU-STA-42009	Integrated clinical app for the management of Asthma in Primary Care	£4,166.66	My M Health	Service	Pilot project to show engagement with applications for management of chronic conditions	STA appropriate to pilot new project	Approved	26/06/2019
10/04/2019	Single Tender	ABU-STA-41595	Pathology UKNEQAS Accreditation Supplies	£11,900.00	UKNEQAS	Goods	Only provider for a National Scheme, it is hosted by an NHS provider and is run on a not for profit basis	Only one supplier in market and is a not for profit basis	Approved	16/04/2019
13/05/2019	Single Tender	ABU-STA-41825	Outsourcing MRI Scans	£36,800.00	Rutherford Cancer Centre	Service	Provision of MR scanning capacity by Rutherford Cancer Centre to support and maintain WAG guidelines for the ABUHB MR service. Rutherford centre are in the process of joining the All Wales Outsourcing Framework. This STA is for a 4 month period to allow ABUHB to compliantly utilise Rutherford Cancer Centre in the interim period while their application for the Outsourcing Framework is evaluated.	Appropriate for service continuity until framework project completed	Approved	28/05/2019
15/05/2019	Single Tender	ABU-STA-41863	Support to develop Well-being of Future Generations Act 2015 Self-Assessment tool	£32,175.00	JBPS Advisory Solutions Limited	Service	The self-assessment process which forms part of the Well-being of Future Generations Act (WbFGA) embedding programme is a bespoke process developed specifically by the existing Consultant for ABUHB. No other Consultant has the insight and understanding about how the self-assessment process works, and to our knowledge there is no other Consultant that has the expertise on how the WbFGA is applied to a Health Board context.	This supports work already carried out	Approved	24/05/2019

Aneurin Bevan University Health Board
Medical PPV Progress Report: 1st April 2019 to 30th September 2019

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	5.06%
Wales claim error % Ave	
2019/20 recovery amount	£1,181.73

	Visit 1				Visit 2				Visit 3					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
Practice 1	19/09/2014	Extended	5.23%	£1,327.62	09/02/2018	Routine	3.81%	£618.36	08/04/2019	Revisit				
Practice 2	24/07/2013	Routine	2.30%	£313.53	29/09/2016	Routine	1.01%	£92.44	17/04/2019	Routine				
Practice 3	04/12/2015	Extended	3.07%	£1,257.77	17/02/2017	Revisit	18.37%	£4,206.82	08/04/2019	Routine	304	9	2.96%	£300.69
Practice 4	05/07/2013	Routine	8.10%	£397.74	07/12/2015	Revisit	19.80%	£1,875.04	29/04/2019	Routine				
Practice 5	29/08/2013	Routine	8.53%	£867.83	11/11/2015	Extended	8.96%	£3,527.07	16/05/2019	Routine	296	35	11.82%	£652.40
Practice 6	19/09/2013	Revisit	8.91%	£226.07	16/07/2015	Routine	1.50%	£131.35	28/05/2019	Routine				
Practice 7	20/03/2013	Routine	16.18%	£2,133.13	20/10/2015	Extended	5.12%	£3,045.45	22/05/2019	Routine				
Practice 8	07/07/2015	Routine	2.73%	£398.24	13/07/2016	Revisit			17/06/2019	Routine				
Practice 9	10/03/2015	Routine	2.43%	£114.29	27/04/2018	Routine	3.52%	£283.24	20/06/2019	Revisit				
Practice 10	08/04/2016	Revisit	17.44%	£1,622.84	15/08/2018	Routine			11/06/2019	Routine	388	6	1.55%	£228.64
Practice 11	15/01/2014	Routine	2.84%	£291.43	15/10/2015	Extended	2.70%	£436.43	18/06/2019	Routine				
Practice 12	08/10/2013	Routine	6.94%	£646.57	06/01/2016	Extended	5.30%	£1,366.08	22/07/2019	Routine				
Practice 13	15/02/2013	Routine	8.39%	£793.05	29/04/2015	Extended	1.68%	£156.56	03/07/2019	Routine				
Practice 14	27/01/2016	Extended			21/05/2018	Revisit	2.97%	£527.36	30/08/2019	Routine				
Practice 15	11/06/2013	Revisit	8.70%	£8,161.47	15/09/2016	Routine	0.96%	£114.45		Routine				
Practice 16	24/01/2013	Routine	2.14%	£179.62	25/07/2018	Routine	1.35%	£148.05		Routine				
Practice 17	12/06/2013	Extended	8.08%	£1,476.11	22/11/2015	Extended	1.73%	£269.49		Routine				
Practice 18	26/11/2014	Routine	3.30%	£216.78	13/02/2018	Routine	9.46%	£1,146.47		Revisit				

Health Board	Year	Alcohol Misuse	Anti-Coagulation Monitoring	Anti-Coagulation Slow Loading	Care Homes	Contraceptive	Denosumab	DOAC	Flu	Gonadorelins	HPV	Learning Disabilities	Lithium	Minor Surgery	Minor Surgery (Supp)	MMR	Near Patient Testing	Nursing Home	Pertussis	Substance Misuse	Totals
Aneurin Bevan	2019/2020																				
	2018/2019	0	48	1	17	80	10	8	83	31	21	2	4	171	1	4	174	0	30	0	685
	2017/2018	0	34	0	33	44	0	0	211	26	0	8	6	111	0	1	145	1	10	2	632

	Health Board		
	2017/2018	2018/2019	2019/2020
Number of practices visited	30	47	TBC
Amount of claims sampled	9,863	18,968	TBC
Claim errors identified	632	685	TBC
Average admin error rate	5.80%	7.29%	TBC
Average claim error rate	6.57%	3.47%	TBC
Recovery amount	£18,522.46	£20,530.46	TBC

	All Wales		
	2017/2018	2018/2019	2019/2020
	193	216	TBC
	106,956	88,044	TBC
	9,969	6,495	TBC
	9.77%	4.52%	TBC
	9.32%	7.38%	TBC
	£223,547.14	£194,539.64	TBC

Key report points:
2018/19 saw the team look at twice as many claims as recorded in 2017-18 with only an increase of 53 errors. I find this pleasing as it shows our training work has been taking effect and practices are reducing their errors in general. The drop to 3.47% average rate further supports this
The recovery amount increased by £2,008.00, my feeling is this is due to a higher number of recoveries in Minor Surgery in 2018/19 which is a higher paid service, it would be nice to see a drop in financial recoveries in the coming financial years.
We delivered training for GMS practice managers in November 2018 and will be attending practice managers forum in September 2019 to further train and support the process, with the aim being a further reduction of errors and recoveries.
The UHB compared to the All Wales averages shows that performance is promising and the national rates and recoveries are higher than that of the UHB, this can continue to improve with our support and training.

Aneurin Bevan University Health Board
Ophthalmic PPV Progress Report: 1st April 2019 to 30th September 2019

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	0.97%
Wales claim error % Ave	
2019/20 recovery amount	£125.40

	Visit 1				Visit 2				Visit 3					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
Practice 1	15/07/2016	Routine	8.00%	£320.75	02/05/2018	Revisit	10.67%	£1,476.70	24/04/2019	HB request	103	0	0.00%	£0.00
Practice 2	06/07/2015	Routine	18.00%	£716.80	19/08/2016	Revisit	21.33%	£2,740.00	23/04/2019	Routine	103	2	1.94%	£61.00
Practice 3	08/11/2016	Routine	7.00%	£349.30	04/12/2017	Revisit	12.33%	£1,901.40	30/04/2019	Routine	103	1	0.97%	£14.80
Practice 4	14/11/2016	Routine	4.00%	£150.75	18/01/2018	Revisit	0.00%	£0.00	18/04/2019	Routine	103	0	0.00%	£0.00
Practice 5	02/08/2016	Routine	3.00%	£57.30	N/A				13/05/2019	Routine				
Practice 6	Check code	N/A			N/A				10/05/2019	Routine				
Practice 7	New code	N/A			N/A				20/05/2019	Routine				
Practice 8	New code	N/A			N/A				09/05/2019	Routine	103	2	1.94%	£49.60
Practice 9	30/06/2016	Routine	5.00%	£148.40	10/08/2017	Revisit	6.67%	£800.00	21/06/2019	Routine				
Practice 10	New code	N/A			N/A					Routine				
Practice 11	18/10/2017	Routine	2.00%	£106.60	N/A				05/06/2019	Routine				
Practice 12	06/11/2014	Routine	0.00%	£0.00	31/05/2018	Routine	2.91%	£78.20	02/07/2019	Revisit				
Practice 13	05/05/2015	Routine	7.00%	£358.30	N/A					Routine				
Practice 14	17/01/2017	Routine	2.00%	£120.60	N/A				21/08/2019	Routine				
Practice 15	17/07/2017	Routine	8.00%	£296.50	13/08/2018	Revisit	4.00%	£541.20		Revisit				
Practice 16	11/05/2016	Routine	2.00%	£120.00	N/A				16/08/2019	Routine				
Practice 17	Check code	N/A			N/A					Routine				
Practice 18	New code	N/A			N/A					Routine				
Practice 19	05/09/2016	Routine	12.00%	£324.50	20/12/2017	Revisit	2.00%	£222.45		Routine				
Practice 20	24/03/2015	Routine	1.00%	£28.80	29/08/2018	Routine	9.71%	£365.70		Revisit				
Practice 21	New code	N/A			N/A					Routine				
Practice 22	14/06/2016	Revisit	25.00%	£533.30	18/09/2017	Routine				Routine				

Health Board	Year	GOS 3	GOS 4	EHEW		All Wales	Year	GOS 3	GOS 4	EHEW
Aneurin Bevan	2019/2020					All Wales	2019/2020			
	2018/2019	6	78	132			2018/2019	81	381	571
	2017/2018	24	19	176			2017/2018	193	167	991

	Health Board		
	2017/2018	2018/2019	2019/2020
Number of practices visited	30	28	TBC
Amount of claims sampled	4,551	3,982	TBC
Claim errors identified	230	260	TBC
Average admin error rate	12.35%	14.63%	TBC
Average claim error rate	5.05%	6.53%	TBC
Recovery amount	£11,055.85	£8,066.95	TBC

All Wales		
2017/2018	2018/2019	2019/2020
172	141	TBC
22,083	17,506	TBC
1,342	1,080	TBC
7.37%	4.30%	TBC
6.08%	6.17%	TBC
£54,640.34	37,808.65	TBC

Key report points:

Evidence above suggests more issues with the EHEW provision in the service and there seems to be a bigger recovery from EHEW claims than the others combined. This is something we are looking to support with the reduction of errors.

The UHB measures against the average claim errors rate comparatively but there is still room for improvement which we will look to support with our visits.

I have delivered a training session to practices that will help in the longer term and we offer training on one-to-one basis for anyone with issues or problems.

The financial recovery improved between the years but as above we are looking to help reduce these further.

Aneurin Bevan University Health Board
Pharmacy PPV Progress Report: 1st April 2019 to 30th September 2019

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	1.68%
Wales claim error % Ave	
2019/20 recovery amount	£196.00

Practice code	Visit 1				Visit 2				Visit 3					
	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
Practice 1	N/A	N/A							11/04/2019	Routine				
Practice 2	N/A	N/A							10/04/2019	Routine	80	4	5.00%	£112.00
Practice 3	16/03/2017	Routine	0.00%	£0.00					10/04/2019	Routine	97	0	0.00%	£0.00
Practice 4	12/01/2017	Routine	1.25%	£56.00					08/05/2019	Routine				
Practice 5	03/10/2016	Routine	1.00%	£28.00					08/05/2019	Routine	61	0	0.00%	£0.00
Practice 6	14/08/2017	Routine	0.00%	£0.00					13/05/2019	Routine	100	0	0.00%	£0.00
Practice 7	25/10/2016	Routine	0.00%	£0.00					13/05/2019	Routine	78	3	3.85%	£84.00
Practice 8	01/11/2016	Routine	0.00%	£0.00					10/06/2019	Routine				
Practice 9	21/09/2016	Routine	0.00%	£0.00					10/06/2019	Routine				
Practice 10	09/03/2017	Routine	5.13%	£112.00					04/06/2019	Routine				
Practice 11	29/03/2017	Routine	5.00%	£28.00					04/06/2019	Routine				
Practice 12	21/02/2017	Routine	1.45%	£56.00					16/07/2019	Routine				
Practice 13	09/02/2017	Routine	0.00%	£0.00					16/07/2019	Routine				
Practice 14	23/02/2017	Routine	6.00%	£168.00					11/07/2019	Routine				
Practice 15	21/02/2017	Routine	0.00%	£0.00					11/07/2019	Routine				
Practice 16	29/03/2017	Routine	5.00%	£28.00						Routine				
Practice 17	21/02/2017	Routine	8.00%	£224.00						Routine				
Practice 18	23/02/2017	Routine	2.50%	£14.59						Routine				
Practice 19	21/02/2017	Routine	10.00%	£56.00						Routine				
Practice 20	31/05/2017	Routine	17.24%	£560.00	30/10/2018	Revisit	19.31%	£784.00		HB Request				
Practice 21	N/A	N/A								Routine				
Practice 22	04/10/2016	Routine	1.19%	£28.00						Routine				

Health Board	Year	MUR	Flu
Aneurin Bevan	2019/2020		
	2018/2019	91	24
	2017/2018	110	10

All Wales	Year	MUR	Flu
All Wales	2019/2020		
	2018/2019	635	139
	2017/2018	483	38

	Health Board		
	2017/2018	2018/2019	2019/2020
Number of practices visited	44	44	TBC
Amount of claims sampled	3,506	3,413	TBC
Claim errors identified	120	115	TBC
Average admin error rate	19.31%	13.62%	TBC
Average claim error rate	3.42%	3.37%	TBC
Recovery amount	£3,235.38	£2,918.04	TBC

	All Wales		
	2017/2018	2018/2019	2019/2020
	298	230	TBC
	22,931	18,570	TBC
	520	870	TBC
	16.83%	16.16%	TBC
	2.27%	4.68%	TBC
	£14,079.99	£20,033.71	TBC

Key report points:

Administrative errors are still high, they have reduced, but need further improvements. They bear no financial penalty at this time but relate to details in a patient record and as a result should be correct.

The Health Board is below national average for claim error percentage which is promising and was reduced from the previous financial year, this shows development that we can continue to support.

Recoveries have dropped and don't contribute greatly to the amount of national recoveries which is rewarding.

 GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 18 th July 2019 Agenda Item: 5.2

Audit Committee

Financial Control Procedures (FCPs) For Approval by the Audit Committee 18/07/19

5.2

Executive Summary

The Standing Financial Instructions (SFIs) of the Health Board require that FCPs have to be approved by the Audit Committee. The FCPs that were due to be reviewed are listed below. They were presented to the Executive Team on the 17 June 2019 who requested minor amendments which have since been carried out. The overall changes are routine updates and improvements and there are no material amendments. The FCPs that have been reviewed and key changes are summarised below.

- Budgetary Control.
- Capital Assets and Charges.
- Charitable Funds.
- Losses and Special Payments.
- Stores and Stocks.

1. Budgetary Control Policy

- Updated reference to Workforce and Organisational Development policies.
- Slight changes in wording and paragraph order for clarity.

2. Capital Assets and Charges

- Updated to follow standard layout.
- Definitions expanded.
- Replacement of "Budget Holders" with "Asset Owners".
- Other updates to reflect changes to reflect accounting standards and guidelines.

3. Charitable Funds (previously reviewed by the Charitable Funds Committee).

- Use of working title of Aneurin Bevan Health Charity for receiving cheques.
- Updates for changes in job titles.
- Change in bank account to Government Banking Services.
- Some changes in wording for clarification.
- Updated appendices to reflect current legislation/practice and to provide worked examples.

4. Losses and Special Payments

- Updated delegated limit table to reflect the latest manual for accounts.
- Change in personnel dealing with losses and special payments.
- Updated job titles.
- Change in wording to include "bribery and corruption" when referring to counter fraud.
- Updated appendices to reflect current guidelines and practice.
- Updated following the Executive Team meeting, to clarify the treatment of costs relating to employment tribunal cases when settling out of court.

5. Stores and Stocks

- Inclusion of section on consignment stock to reflect accounting requirements.
- Slight changes in wording for clarity in some areas.
- Updated contact information in relation to the finance department.

As required by the SFIs, the Audit Committee is asked to approve the FCPs. The updated FCPs will then be published on the Intranet and relevant stakeholders informed of the revised FCPs.

The Audit Committee is asked to: (please tick as appropriate)

Approve the Report	✓
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Glyn Jones, Director of Finance and Performance

Report Author: Mark Ross, Assistant Director of Finance

Report Received consideration and supported by :

Executive Team	✓	Committee of the Board	None

Date of the Report: 03 July 2019

Supplementary Papers Attached:

Appendix 1 – Budgetary Control Policy and Financial Control Procedure

Appendix 2 – Capital Assets and Charges FCP

Appendix 3 – Charitable Funds FCP

Appendix 4 – Losses and Special Payments FCP

Appendix 5 – Stores and Stocks FCP

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	<i>Sound governance of the Health Board ensures good financial management and reduces financial risk.</i>
Financial Assessment	<i>No impact.</i>
Quality, Safety and Patient Experience Assessment	<i>No impact.</i>
Equality and Diversity Impact Assessment (including child impact assessment)	<i>No impact.</i>
Health and Care Standards	<i>No impact</i>
Link to Integrated Medium Term Plan/Corporate Objectives	<i>No impact.</i>
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	<i>No impact</i>
Glossary of New Terms	<i>FCP - Financial Control Procedure.</i>
Public Interest	<i>Report to be published in the public domain.</i>



Aneurin Bevan University Health Board

Budgetary Control Policy and Financial Control Procedure

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue x
Approved by: Audit Committee
Owner: Director of Finance

Issue date: dd/month/year
Review by date: dd/month/+ 3 years
Policy Number: ABHB/Finance/0241

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1. Introduction

Aneurin Bevan University Health Board has a statutory requirement to meet its financial duty as set out in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014. That is the Board has to provide its services within its allocated resources. One of the key mechanisms for ensuring that this objective is met is a sound system of budgetary control.

2. Policy Statement

The Health Board must meet its statutory financial duties and this policy therefore sets out the key mechanisms by which the Board can deliver its financial duty.

2.1 Integrated Medium Term Plan (IMTP)

The NHS Finance (Wales) Act 2014 requires Health Boards to prepare a plan which sets out its strategy for securing that it will comply with the financial duty. The Integrated Medium Term Plan is therefore a statutory requirement and must show how the Board will meet its statutory duty to provide services within the allocated resources measured on a 3 year rolling basis.

The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its financial duty as set out in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014.

The Integrated Medium Term Plan (IMTP) therefore provides the foundation for the financial year by expressing the service, workforce and financial plan for year 1 of the three year plan and forms the basis of the Budget for the year.

2.2 Revenue Resource Limit

The Revenue Resource Limit (RRL) is the allocation of financial resources from Welsh Government WG for the financial year. Aneurin Bevan University Health Board has a statutory responsibility to deliver services within its allocated Revenue Resource Limit and three year breakeven duty. Whilst the agreed IMTP may have planned financial deficits and surpluses in any one year as part of the three year rolling breakeven duty any planned surplus or deficits will be reflected by Welsh Government in the RRL.

This Policy and Financial Control Procedure sets out how budgetary control processes enable the organisation to meet the statutory duty of meeting its RRL and 3 year breakeven duty.

3. Aims

The aim of this document is to set out the responsibilities of the Board, Chief Executive, Director of Finance and budget holders across the organisation in relation to budgetary control in order that organisation can exercise sound financial management and meet its statutory financial duty to break even.

The overall aim of the Budgetary Control Policy and financial control procedure is to enable financial control whilst supporting the achievement of service objectives.

4. Objectives

The Budgetary Control Policy and Financial Control Procedure aims to provide a framework for financial control to enable the organisation to meet its statutory financial targets. The objectives are specifically to:

- Describe how the organisation's Budget is approved based in turn on the first year of the Integrated Medium Term Plan which is now a statutory requirement of the Health Board.
- How budgets are formally delegated through the organisation following approval by the Board.
- To set out budget holders responsibilities and accountability to deliver services within the allocated budget.
- To set out a defined process that is to be followed by budget holders if budget overspends arise.

5. Scope

The Board delegates responsibility for budgets to the Chief Executive who in turn delegates these through management structures. Whilst the document primarily applies to all managers and clinicians that are given financial responsibilities as part of their roles and job descriptions, all staff of the Health Board have a part to play in effective budgetary control.

6. Roles and Responsibilities

6.1 The Board

The Board is responsible for ensuring that it meets its financial duty as set out in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014.

The Board is responsible for approving the Integrated Medium Term Financial Plan and Budget for the organisation.

6.2 Chief Executive

The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its statutory financial duty.

The Chief Executive has responsibility for initiating a formal process of budget delegation following approval of the Budget by the Board.

6.3 Director of Finance

Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board.

The Director of Finance will devise and maintain systems of budgetary control.

The Director of Finance will ensure that appropriate training is available for budget holders

6.4 Director of Workforce and OD

Effective financial management is a key personal objective for budget holders, therefore the Director of Workforce and OD will set up appropriate systems to ensure competencies are met and recorded within job descriptions across the organisation.

6.5 Director of Planning

The Director of Planning will ensure that processes are in place to develop the draft IMTP for Board approval within prescribed Welsh Government deadlines.

6.6 Budget Holders

A budget holder is defined as a person to whom a budget is delegated. At the lowest level the budget holder is defined as the person responsible for managing resources at the lowest cost centre level and is able to approve expenditure goods and services and pay related costs against a cost centre budget within financial approval limits set by their line manager. The line manager is likely to be managing a number of budget areas delegated to others within their management area but is nevertheless also a budget holder with responsibility for a number of budgets delegated to others.

Accountability for budgetary control is exercised through line management relationships and this principle applies through all tiers of management where budgetary control is applicable.

Specific responsibilities of budget holders are:

- Budget holders are responsible for providing the services within their respective budget within the available financial resources delegated to them and is held accountable for managing within the budget.
- Budget holders are responsible for developing recovery plans if budget overspends arise.
- Budget holders are responsible for formally recording recovery plan meetings with their line manager.
- Budget holders must keep a record of agreements to transfer budgets to other budget holders (Virements).

7. Main Procedure

7.1 Budgets

A budget is a plan expressed in financial terms. In the context of the Local Health Board, the plan is for the delivery of specific services and should represent the financial expression of service and workforce plans for the financial year within available resources. The Board approve the Budget for the year.

This policy and financial control procedure for budgetary control represents a key corporate objective for the organisation. Budgetary control is delegated to managers and represents a key management objective. Therefore it represents a significant element of a manager's responsibility and budgetary performance must form a key part of each manager's Performance Appraisal Development Review (PADR).

7.2 Approval of the IMTP Prior to the New Financial Year

It is a statutory requirement to produce an IMTP that must be approved by the Board prior to the start of the financial year. The IMTP plan will express service and workforce plans for the organisation over a period of three years and include a Medium Term Financial Plan that is derived from those plans.

The Board will:

- Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation. Following Board approval the IMTP will be submitted to Welsh Government prior to the beginning of the financial year of implementation.
- Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all probity and value for money requirements; and
- Where the LHB plan is not in place or in balance, prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance.

7.3 Budget for the Year

The organisation's budget plan for the forthcoming year will be developed from the first year of the Board's Integrated Medium Term Plan (IMTP). The corporate processes that develop the IMTP will ensure that service and workforce plans are developed and agreed by the organisation before the beginning of the financial year and are at a sufficient level of detail that enable budgets to be developed for the year.

The Executive Director with the lead for Planning will ensure that processes are in place to produce:

- A draft IMTP (within Welsh Government timescales), which will have sufficient detail within year 1 of the plan to enable the development of budgets for the forthcoming year financial year.
- A final IMTP is produced (within Welsh Government timescales) prior to the forthcoming financial year.

Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

- Be in accordance with the aims and objectives set out in the Integrated Medium Term Plan and Medium Term Financial Plan, and focussed on delivery of safe quality patient centred quality services
- Accord with Commissioning, Activity, Service, Quality, Performance, Capital and Workforce plans;
- Be produced following discussion with appropriate budget holders;
- Be prepared within the limits of available funds;
- Take account of ring-fenced or specified funding allocations;
- Take account of the principles of sustainable development; and
- Identify potential risks.

The plan will make explicit assumptions about budget reserves and contingencies for the year.

7.4 Delegation and Accountability

The Health Board has a statutory duty to manage its services within the Revenue Resource Limit allocated from Welsh Government WG. The Board therefore delegates responsibility for delivering a balanced budget to the Chief Executive within the framework of its Standing Orders and Standing Financial Instructions.

The Chief Executive may delegate the management of a budget or part of a budget to permit the performance of a defined range of activities. This delegation is made through management structures and defined in job descriptions and annual objectives. The delegation will cover:-

- the amount of the budget;
- the purpose(s) of the budget
- the requirement to achieve a balanced budget
- achievement of planned levels of service

Except where otherwise approved by the Chief Executive, taking account of advice of the Finance Director, budgets shall be used only for the purpose for which they were provided.

Budgets are delegated with assumptions about the levels of service to be provided within the available resources described by the budget. Budget holders do not have authority to commit resources to beyond the resources delegated in the budget. Expenditure for which no provision has been made in an approved budget, or is not subject to funding under the delegated powers of virements, shall only be incurred after authorisation of the Chief Executive.

Non-recurring funding must not be used to finance recurring expenditure without the authority in writing of the Chief Executive or nominated deputy for the purposes of financial control.

Managers must deliver a balanced budget within each and every financial year.

The key principle of delegation is that accountability for budgetary control is exercised through the line management hierarchy. Budgets are therefore formally delegated through the management hierarchy. Budget holders must not overspend against their budget. The requirement to deliver within the allocated budget must therefore form part of all budget holder's annual objectives and be reviewed as part of the annual review process.

The principles of delegation mean that accountability for budget management is to the line manager. Review of performance against budget should therefore take place as part of the line management PADR process in the context of the wider performance review of quality, safety and other targets. The principles and responsibilities set out in this policy therefore relate to all managers with budgetary responsibility and their line managers.

Budgets are delegated to nominated budget holders and are set for each cost centre. Budget holders are authorised to commit expenditure against the cost centres for which they are responsible. There can only be one nominated budget holder for a cost centre and they are held accountable for managing within the budget set. Budget holders must adhere to approval limits set out in the Aneurin Bevan Health Board 'Scheme of Delegation' and the approval hierarchy must follow the line management hierarchy. These approval limits must not be exceeded but may be restricted by the organisation.

If budget holders are unable to approve expenditure for their respective budgets due to absence then the principle of upward delegation will apply.

7.5 Process of Delegation

Following agreement of the Board to the plans, the Chief Executive will issue a formal budget letter to each director who in turn will issue similar letters to their line managers. This process will be repeated through each tier of management, setting out the expectations and responsibilities in terms of budgetary control and financial management.

The letter content may vary from year to year but will cover:

- The budget allocation.
- Activity and target achievement assumptions on which the budget has been based where this is a material issue. An example would be activity levels and achievement of elective targets such as referral to treatment times (RTT).
- That the budget holder is accountable for the delivery of a balanced budget position each financial year and is also accountable for the recovery of any deficits within the same period.

- That budgetary performance must form part of all budget holders' annual objectives and to be reviewed as part of the annual performance review.
- The expectation that formal mechanisms are set up to ensure that budget management is effective across their management area and that budget holders are held to account for their budgetary performance through every level of line management.
- That all line managers review their direct reports in relation to their budget performance at least on a monthly basis.
- That appropriate mechanisms are set up to control expenditure particularly where there are high cost and variable use items.
- That budget holders comply with policies that aid budgetary control including:
 - All Workforce and organisational development policies relating to authorisation of payments to and for staff
 - Vacancy Approval Process
 - Recruitment Procedures
 - Financial Control Procedure – Ordering of Goods and Services
 - Financial Control Procedure – Procurement Policy

A formal budget letter must be issued from each line manager as soon as possible following the start of the financial year. An example of a delegation letter is attached in Appendix 1.

7.6 Changes to the Budget

There may be times during the financial year when it is necessary to make adjustments to the budget agreed by the Board, for example if additional funding is made available to the Board from the Welsh Government. In these circumstances the Director of Finance, on behalf of the Chief Executive will present the Board with a revised Budget for approval. Prior to Board approval any additional funding will be held as a reserve for the purpose that it was allocated until such time that the Board has approved the use of additional funding.

7.7 Budgetary Control and Reporting

The Director of Finance will devise and maintain systems of budgetary control. These will include:

- Financial reports to the Board showing performance against budget for the period and a forecast of the outturn for the full financial year.
- Issuing financial reports on a timely basis to budget holders covering the areas for which they are responsible.
- Following the end of a month a report will be produced for the executive team, divisional directors setting out the year to date budget performance.
- Providing support from appropriately qualified and experienced finance staff to support managers in their analysis and management of budget performance.

Budget holders will ensure:

- Accountability for budgetary control is exercised through line management relationships and this principle applies through all tiers of management where budgetary control is applicable.
- Budget performance is discussed by managers and their immediate reports at least on a monthly basis.
- That all significant financial issues are reported through the management hierarchy, to enable the director responsible to report the possible financial impact to executive team and board.

7.8 Performance Management

Aneurin Bevan Health Board has a statutory duty to deliver its services within its allocated budget. The Board via the Chief Executive and tiers of line management formally delegates this responsibility to individual budget holders across the organisation. Budget holders are held to account for budgetary performance through formal line management arrangements and are expected to manage within delegated resources on both a monthly and annual basis. This requirement links to the Health Board’s statutory requirement to manage within its Revenue Resource Limit.

Where budget variances arise the following actions must be undertaken by the budget holder and line manager in a formal process of escalation:

- If a budget is overspent in any one month the budget holder where practicable will recover the position by the next reported period.
- If a deficit will take longer than one month to correct and recover then the budget holder and line manager will :

Either

- agree recovery actions over a period not exceeding 3 months

Or

- agree virements from another area of budgetary responsibility

A record of actions agreed must be made. A suggested format for recording actions is shown in Appendix 2.

- If a deficit cannot be recovered within a period of 3 months or virements agreed with the budget holder, the line manager will be required to agree remedial actions with the Divisional Director.
- If remedial actions to recover the deficit or agree virements still cannot be agreed with Divisional Director then the line management team will agree remedial actions or virements with the responsible Executive Director.
- If remedial actions to recover the deficit or agree virements still cannot be agreed with the Executive Director will agree remedial actions or agree virements with the Chief Executive.
- If there is continued failure to agree a recovery plan or virements the Executive Director and Chief Executive will agree remedial actions with the Audit Committee and Board.
- A record of the meeting to discuss and agree recovery actions must made. A suggested proforma is attached in Appendix 2 to record agreed actions.

Budgetary control must form a key objective each year for all management staff with budget responsibilities.

Managers will be held to account for not meeting budgetary targets and subject to formal review as part of their wider performance management review with their line manager.

7.9 Virements

Where budget funding is transferred between budget holders, known as a virement, a form must be completed to formally record the agreement and transfer of funds. A form is attached in Appendix 3.

The virement or allocation of central budget reserves should be formally notified to the Board as appropriate through the financial year.

8. Training

The Finance Director will ensure that appropriate training is available and accepted by managers and clinicians, who are required to fulfil the requirements of the policy. This will include training provided by one-to-one contact with finance department staff, formal financial management training, briefings, and finance content within other management development programmes.

Support from other corporate departments will also be provided to support budget managers, where appropriate.

9. Review

This policy and financial control procedure must be reviewed, maintained and developed periodically, in line with the Health Board's policy. Responsibility for this lies with the Chief Executive and Finance Director.

10. Audit

This document is a key organisational policy and as such will be subject to annual internal audit reviews to ensure the system is working effectively and that the processes set out in the policy and financial control procedure are being complied with across the organisation.

APPENDIX 1 - Example of Budget Delegation Letter.

The content may change from year to year, in line with the Health Boards plans and priorities.

Our Ref: NW/RH/

Direct Line:

XXth March 20XX

Dr xxxx
Divisional Director – xxx
Aneurin Bevan University Health Board
Royal Gwent Hospital
Cardiff Road
Newport
NP20 2UB

Dear xxx,

RE: DELEGATION OF BUDGETS FOR THE 20XX-XX FINANCIAL YEAR

As you will be aware, the Health Board has a statutory obligation to perform its functions within available financial resources. In line with the Board’s Standing Financial Instructions (SFI) and Budgetary Control Policy, I am formally writing to you to confirm the revenue budget delegated to you for the 20XX-XX financial year – this is set out in Table 1. Achieving your budget responsibilities is one of your key performance objectives and will be reviewed as part of your Performance Appraisal and Development Review (PADR).

Table 1: Delegated Annual Revenue Budget 20XX-XX financial year

Budget Area	Annual Revenue Budget £’000
Xxxx	xxxx

The annual budget shown above includes provision for:

- Agenda for Change and Medical pay awards
- Funding to support additional (£xxxk)
- Funding to support NICE demand and service growth (£xxxk)

The additional funding delegated is subject to review and evaluation of schemes. This is in order to provide assurance that the investment is achieving the necessary organisational performance targets.

This letter provides formal authorisation for you to incur expenditure during the financial year, up to the annual budget, to perform the functions necessary to deliver the Health Board's priorities and objectives. It also clarifies your accountability to deliver services within the budget and not to overspend.

You should manage your budgets in line with the Health Board's Budgetary Control Policy which is available on the intranet and sets out, in detail, budget holder's responsibilities and actions that should take place, if budget overspends arise. This letter should be read in conjunction with the Health Board's Standing Orders (SO), Standing Financial Instructions (SFI), financial policies and procedures – specifically, the Financial Control Procedure on Budgetary Control and the scheme of delegation.

Budgetary Management

The formal delegation of the budget should be cascaded through all tiers of line management responsible for budget management, with budgetary performance reviews undertaken and appropriate actions taken. It is important that all budget holders have read and understood the SFIs and financial control procedures and are competent to manage a budget. Therefore all budget holders are required to confirm this as part of accepting their budget responsibilities.

Additional Allocations

The budget delegated to you is in line with the financial plan agreed by the Board on the XXrd January 20XX. Further allocations will be made in year as required to reflect additional allocations from Welsh Government, allocation of the agreed provisions within the financial plan and any investment priorities or choices made by the Executive Team and Board in 20XX/XX.

In approving a balanced financial plan for 20XX/XX, the Board recognised that further detailed plans need to be finalised. Funding has been held in reserve pending the completion of these plans and may be allocated subject to satisfactory approval of these plans. This will need to include delivery of key performance targets and appropriate savings. These should be completed and forwarded to myself by the **XXth April 20XX**.

Aneurin Bevan University Health Board
 Title: Budgetary Control Policy & Financial Control Procedure
 Owner: Director of Finance

ABHB/Finance/0241

IMTP

The Health Board has submitted its outline IMTP to Welsh Government which whilst demonstrating a balanced financial position carries a high level of financial risk. It is therefore important that every budget holder delivers within their delegated budgets. The expectation is that the department will develop plans to deliver a break-even financial position within this funding envelope.

Financial Advice and Information

Your Business Partner Team are available to offer guidance and training for you and your team as required to facilitate understanding and managing your budget and the FBI (Finance Business Intelligence) reporting tool.

As part of supporting budget holders to competently manage their budgets, the Health Board requires all budget holders to successfully complete appropriate budget training. Further training opportunities will also be made available in year as part of the finance departments training programme for non-finance managers.

Please confirm your acceptance of the delegated budget by signing and returning Appendix 1 to me by **XXth April 20XX**.

Yours sincerely,

XXX

Executive Director of Operations, Corporate Services

CC XXX, Assistant Finance Director - Financial Planning & Performance
 XXX, Assistant Finance Director - Hospital Services
 BPA xxx

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date:dd/month/+ 3 years

Aneurin Bevan University Health Board
 Title: Budgetary Control Policy & Financial Control Procedure
 Owner: Director of Finance

ABHB/Finance/0241

References:

- Standing Orders – Reservation and Delegation of Powers for Aneurin Bevan Local Health Board,
http://howis.wales.nhs.uk/sitesplus/documents/866/ABHB_Corporate_0389%20LHB%20Model%20Standing%20Orders%20Reservation%20and%20Delegation%20of%20Powers_Issue%203.pdf
- Standing Financial Instructions for Aneurin Bevan Local Health Board
http://howis.wales.nhs.uk/sitesplus/documents/866/ABHB_Corporate_0390%20LHB%20Model%20Standing%20Financial%20Instructions_Issue%203.pdf, and
- Budgetary Control Policy and Procedure for Aneurin Bevan Local Health Board
http://howis.wales.nhs.uk/sitesplus/documents/866/ABHB_Finance_0241%20FCP%20Budgetary%20Control_Issue%202.pdf
- Scheme of Delegation for Aneurin Bevan Local Health Board
<http://howis.wales.nhs.uk/sitesplus/866/document/251633>

5.2

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date:dd/month/+ 3 years

(Delegation letter Appendix 1)

Acceptance of delegated budget for the 20XX-XX financial year

To: Divisional Director –

I am signing to confirm acceptance of the budget delegated to me, for the purposes outlined, in your letter dated XXth March 20XX. I can also confirm that I have read and understood the Health Board’s Standing Orders (SOs), Standing Financial Instructions (SFIs) and financial control procedures and policies and that I have undertaken the necessary training to competently manage a budget.

NAME:	SIGNATURE:
POST TITLE:	
DATE:	

APPENDIX 2 - Template for Line Manager/Budget Holder Recovery Meeting

ABUHB BUDGETARY CONTROL POLICY

Record of Line Manager/Budget Holder Meeting to Agree Budget Overspend Recovery Actions

1. Attendees

List of Staff Attending Recovery Meeting	Position
Date of Meeting:	

2. Agreed Actions to Recover Budget Overspend

List Actions	Effective Date

3. Agreement

Delegated Budget Holder	Date
Line Manager Signature	Date

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/+ 3 years

Aneurin Bevan University Health Board
 Title: Budgetary Control Policy & Financial Control Procedure
 Owner: Director of Finance

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APPENDIX 3 – Virement Form

ABUHB BUDGETARY CONTROL POLICY

VIREMENT FORM

1. Reason for the Virement (Budget Transfer)

Description of Service or Rationale for Transfer	WTE	£
Budget Transfer Timescale i.e. Non recurrent, Recurrent or Time limited		

2. Transfer Agreement

Budget Holder Transferring Funds	Budget Holder Receiving Funds
Name:	Name:
Position:	Position:
Budget Cost Centre and Subjective code:	Budget Cost Centre and Subjective code:
Signed:	Signed:
Date:	Date:

3. For Finance Use

Oracle Account Code			£ Dr		£ Cr	
CC	Subj	Analysis				
Actioned By:						
Name:						
Signed:						
Date:				Ledger Mth/Yr		

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/+ 3 years



Aneurin Bevan University Health Board

Financial Control Procedure

Capital Assets and Charges

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue X
Approved by: Audit Committee
Owner: Director of Finance

Issue date: dd/month/year
Review by date: dd/month/+3 years
Policy No: ABUHB/Finance/0242

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1 Introduction

This procedure is to ensure that there are robust controls in place to set out the responsibilities of officers in relationship to the identification, accounting and security of capital assets.

2 Policy Statement

The procedure sets out the requirements to ensure adequate controls over fixed assets. This procedure is compliant with the Aneurin Bevan University Health Board (ABUHB) Standing Financial Instructions and should be read in conjunction with the Manual for Accounts and the Capital Procedures and Guidance notes Financial Control Procedure.

3 Aims

The purpose of this document is to set out clearly the responsibilities of staff within ABUHB with regard to fixed assets.

4 Objectives

The objective of this procedure is to set out a control framework to ensure that fixed assets are properly used, secured and accounted for correctly.

5 Scope

5.1 This procedure details the principle for purchasing, recording, transferring, disposing and general financial management of capital assets for ABUHB.

5.2 This procedure should be read in conjunction with the ABUHB Standing Financial Instructions, Capital Procedure and Guidance Notes and other financial procedures, e.g. Ordering Goods and Services, Accounts Payable etc. and the guidance in the capital chapter of the Manual for Accounts.

6 Roles and Responsibilities

6.1 The Finance Director

Is responsible for:

- Maintaining an Asset Register to record the value of both purchased and donated assets.
- Calculating depreciation charges for each asset in use.

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6.2 The Divisional Director of Facilities

Is responsible for:

- Managing ABUHB Land, Buildings and Engineering services including fittings.

6.3 Asset Owners

Asset Owners are managers who have responsibility for managing assets and are responsible for:

- Managing Capital Equipment used in their departments.
- The security of their assets and notifying the Head of Capital Finance of any changes to assets.

For new purchases, Asset Owners will need to be identified on the New Asset form (Appendix 1).

7 Main Body (General)

7.1 General

7.1.1 ABUHB operates the REAL Asset Management system (RAM) to record details of its Capital expenditure on fixed assets in the asset register.

7.1.2 Property, Plant and Equipment expenditure is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the UHB;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

7.1.3 Expenditure that does not meet this definition is known as revenue expenditure and is charged to budget holder's annual revenue budgets.

7.1.4 A full audit trail must be available to trace all Capital Expenditure incurred.

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7.2 Purchase of Capital assets

7.2.1 Capital expenditure can be funded as follows:

- Discretionary Capital
- All Wales Capital Programme
- Internally generated funds e.g. Disposal of existing Assets
- Charitable donations
- Other /Welsh Government grants

The 'Capital Procedures and Guidance Notes' Policy deals specifically with the approval processes for Capital Expenditure with the 'Capital Scheme of Delegation' setting out the delegation of Capital Expenditure approval.

7.2.2 Asset Owners will be required to complete a New Asset form (Appendix 1) for all new equipment and return to the Head of Capital Finance.

7.2.3 Upon receipt of the New Asset form from the relevant Asset Owner, the Head of Capital Finance will:

- Validate the asset.
- Assign a unique asset register number
- Update the asset record on the asset register with the equipment details provided.

7.3 Capitalisation of Assets held off site

7.3.1 Timing issues can arise regarding the capitalisation of assets at financial year end for which delivery has not yet been made. The Manual for Accounts sets out guidance to establish whether ownership, title and control are deemed to have passed to the Health Board to inform when expenditure can be capitalised.

7.3.2 In circumstances where assets are capitalised by the Health Board, but delivery of the asset has not taken place, budget holders in conjunction with procurement should ensure risks are assessed and managed regarding:

- Damage to Assets whilst held by Supplier;
- Deterioration & obsolescence of Assets whilst held by Supplier;
- Supplier insolvency.

7.3.3 If an asset is capitalised it should not be depreciated until brought into use, but it should be reviewed for impairment if held by the supplier for a significant amount of time.

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7.4 Valuation of Assets

7.4.1 The following applies to the valuation of assets held by Aneurin Bevan University Health Board:

- All assets acquired will be added to the register at cost - cost includes all direct costs to bring the asset into operation.
- Land and Building assets will be subjected to a formal valuation exercise every five years (or as directed by Welsh Government) by the District Valuer Services or other body determined by the Welsh Government.
- Land and Non-specialised in use properties will be held at market value for existing use.
- Specialised buildings will be held at depreciated replacement cost value as determined by the District Valuer Services.
- Assets under Construction will be held at cost and will be valued by the District Valuer Services on becoming operational.

7.4.2 Indexation will be applied to all assets as follows:

- Land and building assets in line with indices provided by the District Valuer Services.
- Indices for equipment will be provided from data compiled by NHS Wales Shared Services Partnership (formerly Welsh Health Estates).
- Indexation is applied from 1st April in each year.
- Assets under Construction, Assets Held for Sale and IT assets will not be subjected to indexation.

7.4.3 The Health Board through the Head of Capital Finance will annually consider whether all assets are still being held at their carrying amount or whether they have been subjected to an impairment. Impairment indicators can include:

Welsh Government Category –DEL. (Departmental Expenditure Limit)

- Loss or damage resulting from normal business operations.
- Abandonment of assets in the course of construction.
- The unnecessary over-specification of assets.

Welsh Government Category – AME. (Annually Managed Expenditure)

- Any loss as a result of a catastrophe.
- Unforeseen obsolescence.
- Change in use of an asset where specialised assets are no longer required for their original purpose.
- Revaluation on the movement of an asset from Asset under Construction into use following the first professional valuation.
- Revaluation in relation to an asset becoming surplus with plans to dispose.

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On assessing whether an impairment has occurred the Head of Capital Finance will liaise with the relevant Asset Owner or Facilities department where land, buildings and dwellings are concerned.

7.5 Disposal of Assets

7.5.1 Items can be available for disposal because they are:

- Not capable of performing the required operational tasks or being upgraded to do so.
- No longer required, due to changed procedures, functions or usage patterns.
- No longer complying with occupational health and safety standards.
- Beyond repair but able to be sold for scrap.

7.5.2 The Asset Owner responsible for disposing of the equipment must be aware that:

- They are accountable for all decisions they take in the disposal process
- Proper accounting and audit procedures should be observed and all decisions documented.

7.5.3 Assets identified for disposal may be dispensed with using the procedures below. Acceptable methods of disposal are:

- Transfer of the asset to another part of ABUHB.
- Private Sale.
- Assets donated to a charitable organisation subject to the provisions set out below.
- Destroyed or recycled.

7.5.4 Choice of the most appropriate disposal option will normally be influenced by the age and functionality of the equipment for disposal and by market value.

7.5.5 In all cases assets disposed of must be reported on an 'Asset Disposal' form (Appendix 2) to ensure they are removed from the central Fixed Asset Register. A more detailed description of each disposal option is set out below.

7.5.6 Private Sale - for Property or Land Disposals the Divisional Director of Facilities must be notified of surplus assets that could be available for disposal. All Land and Property disposals of any limit must receive the written approval of Welsh Government to confirm consent to dispose.

For equipment disposals, managers should contact the local procurement department who can arrange for the surplus items to be sold at auction if appropriate.

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Issue date: dd/month/year
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7.5.7 Donations – ABUHB may authorise the donation of the equipment to another organisation. Such donations should be to organisations and not to individuals. The preferred recipient of such donations by the Health Board should be health or well-being related. All donations must be approved by the Manager.

7.5.8 Destroyed or Recycled Equipment - Items with no market value and no use to any other organisation or person may be destroyed in an appropriate and safe manner. An Asset Disposal form must be completed and authorised by the Asset Owner and forwarded to the Head of Capital Finance for removal from the Fixed Asset Register.

7.5.9 Donation or sale of active Equipment - Ensure the Client is aware that the recipient of the equipment should be advised in writing that ABUHB will not be liable for any Health and Safety issues surrounding the use of the equipment – sample wording is set out below:

“It is the recipient’s responsibility to ensure that the equipment is suitable and safe for its intended use, installed correctly, and that it can be used without risk to health or safety. It is the recipient’s responsibility to obtain any instructions for and advice on the installation and use of the equipment and to carry out or to have competent persons carry out all necessary checks appropriate to the equipment. Aneurin Bevan University Health Board will not be liable for any loss, damage, or injury arising out of the installation or use of the equipment, however caused”.

Recipients should also be aware that maintenance is not included on the equipment.

7.5.10 All equipment recipients must be aware of the following: Aneurin Bevan University Health Board offers no warranty on the condition of the equipment it sells or donates. Sales or documentation should provide as full a description of the items as possible, specify that goods are sold ‘ex works’ or ‘as is, where is’, and invite prospective buyers/beneficiaries to inspect the goods before the sale/donation.

7.5.11 Summary of steps to be taken by Asset Owner on disposal:

- Identify assets for disposal.
- Validate serial numbers / identity of the asset with the Head of Capital Finance.
- Complete Asset Disposal sheet (Appendix 2) and forward to the Head of Capital Finance.
- Determine the market value of the asset.
- Select the best disposal option. If the item has a significant value then sale should be the preferred option.
- Remove items from maintenance arrangements.
- Obtain estimate of disposal costs (if required).

Status:
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- Ensure clarity around no ongoing guarantee of quality is given where an asset is sold or donated.
- Ensure procedures are followed to remove any data from equipment prior to disposal.
- Oversee any sale including the collection of any income. Ensure that a receipt is given on sale / disposal / donation.

7.5.12 Upon receipt of the authorised Disposal Form from the relevant Asset Owner the Head of Capital Finance will:

- Validate the asset.
- Remove the item from the Asset Register.

7.5.13 Asset Owners must notify the Head of Capital Finance of any asset transfers by submitting a Transferred Assets form (see Appendix 3).

7.6 Donated Assets

7.6.1 Asset Owners must notify the Head of Capital Finance of all assets donated to the ABUHB that meet the capital definition in paragraph 7.4.2 of this procedure by submitting a New Asset form (Appendix 1).

7.6.2 Disposals and transfers of donated assets follow the same process as set out in 7.7.4 for owned assets.

7.7 Capital Expenditure Reporting

7.7.1 The Head of Capital Finance will be responsible for:

- Recording the capital expenditure incurred.
- Comparing actual capital expenditure against approved expenditure limits.
- Reporting the details to the Monthly Capital Group meeting.
- Submitting Capital Monitoring Returns and Project Progress Reports to Welsh Government as required.

7.8 Asset Register

7.8.1 The asset register must contain the minimum data set for all capital expenditure as defined in the capital chapter in the Manual for Accounts.

7.8.2 The asset register must be capable of calculating the annual depreciation for each asset. These charges must be calculated in accordance with the guidance in the capital chapter in the Manual for Accounts.

7.8.3 The Head of Capital Finance will be responsible for:

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- Verifying expenditure deemed capital expenditure meets the capital definition.
- Entering the capital expenditure into the asset register.
- Reconciling capital expenditure entered in the asset register to that recorded in the ABUHB general ledger.
- Calculating, monthly, actual depreciation and posting the information into the general ledger.

7.8.4 The Head of Capital Finance will also be responsible for maintaining the asset register to record:

- Changes in valuation notified by the District Valuer Services.
- Changes in valuation arising from indexation.
- Details of assets transferred from one owner to another.
- Details of assets that are disposed/obsolete/condemned.
- Impairment of fixed assets.
- Accelerated depreciation.

The Head of Capital Finance must ensure that the relevant details are entered into the general ledger and ensure that such details reconcile to the asset register.

7.8.5 Asset lives used in calculating depreciation will be:

- Buildings – as notified by the District Valuer Services or other ABUHB nominated surveyor.
- Equipment – as per standard lives.

7.9 Owners Responsibilities

7.9.1 Owners are responsible for the security of their assets.

7.9.2 Owners must notify the Head of Capital Finance of any relevant asset information.

7.9.3 Owners must notify the Head of Capital Finance as soon as they are aware of the following:

- Details of new purchased or donated Assets following delivery to site (See Appendix 1).
- Details of assets that are disposed, obsolete or condemned (See Appendix 2).
- Details of transferred assets (See Appendix 3)
- Details of assets being replaced or planned to be replaced.
- Details of damage to assets.
- Details of any major parts of the asset that are replaced.

Status:
Approved by:

Issue date: dd/month/year
Review by date: dd/month/+3 years

7.10 Divisional Director of Facilities Responsibilities

7.10.1 The Divisional Director of Facilities has additional responsibilities over and above his owner's responsibilities.

7.10.2 The Divisional Director of Facilities is also responsible for:

- Liaison with the District Valuer Services when periodic revaluations are undertaken.
- Arranging for the District Valuer Services to revalue surplus buildings that are to be sold.
- Arranging for the District Valuer Services to revalue new buildings brought into use.
- Allocating building and engineering works capital expenditure to the appropriate asset block and asset category.
- Notifying the Head of Capital Finance of any changes affecting the revaluation of the estate.

7.11 Verification of Assets

7.11.1 The Head of Capital Finance will be responsible for writing to Asset Owners to request them to verify that their assets are still in their custody and being used.

7.11.2 The Head of Capital Finance will:

- Produce a list of each Owner's assets as recorded in the asset register.
- Send the list to each Owner.
- Request the Owner to verify that the asset is still in use.
- Request Owners to return their asset verifications by the given date.

7.11.3 Asset Owners will:

- Verify whether the asset is still in their custody and still in use.
- Notify the Head of Capital Finance, and provide a suitable explanation, of those assets that are no longer in use.
- Sign off the list and return it to the Head of Capital Finance by the due date.

7.11.4 The Head of Capital Finance will:

- Update the asset register to reflect the verification of asset returns.
- Investigate any discrepancies between the asset register and the verification of asset returns.
- Calculate the impact on depreciation charges.
- Post the revised depreciation to the general ledger.

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- Report Non Compliance with the annual verification process to Divisional Managers/ Executive Team.

7.12 Depreciation and Impairment Estimates

- 7.12.1 The Head of Capital Finance will be responsible for completing the Welsh Government's annual depreciation and impairment estimates in accordance with the guidelines provided.
- 7.12.2 The estimates will include the latest information on ABUHB's planned discretionary capital expenditure, expenditure on All Wales Capital Programme Schemes and planned disposals.
- 7.12.3 The Head of Capital Finance will be responsible for ensuring that the estimates are reviewed by the Assistant Director of Finance and signed off by the Finance Director.

8 Implementation

This document should be implemented with immediate effect.

9 Further Information

Enquiries regarding this policy should be directed to the Head of Capital Finance.

10 Audit

The Internal audit programme shall, from time to time, review the compliance with this position. In addition External Audit may review compliance with this procedure as part of their financial accounts audit work.

11 Review

Every three years, unless there is a requirement to review it sooner.

Aneurin Bevan University Health Board
Capital Assets and Charges
Owner: Director of Finance

ABUHB/Finance/0242

Appendix 1**Aneurin Bevan University Health Board****NEW ASSET****1. Asset Details**

Capital Asset No.	
Asset Description	
Model	
Serial No.	
EBME Reference No.	
Supplier Name	
Manufacturer	
Asset Value	
Date Received	

2. Site, Department & Owners Details

Site	
Ward/Room Location	
Department	
Owners Name	
Owners Designation	
Signed	
Contact Telephone No.	
Date	

3. Return to:

Head of Capital Finance, Finance Department, Ground Floor, Portacabins, Llanfrehfa Grange,
Llanfrehfa, Cwmbran.

Status:
Approved by:

Issue date: dd/month/year
Review by date: dd/month/+3 years

Aneurin Bevan University Health Board
Capital Assets and Charges
Owner: Director of Finance

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Appendix 2**Aneurin Bevan University Health Board****DISPOSED/OBSOLETE/CONDEMNED ASSETS****1. Asset Details**

Asset No.	
Asset Description	
EBME Reference No.	
Model/Serial No.	
Reason For Disposal	
Method of Disposal	
Date Disposed	
Sale Proceeds	

2. Site, Department & Owners Details

Site	
Department	
Owners Name	
Owners Designation	
Contact Telephone No.	
Signed	
Date	

3. Return to:

Head of Capital Finance, Finance Department, Ground Floor, Portacabins, Llanfrehfa Grange, Llanfrehfa, Cwmbran.

Status:
Approved by:

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Capital Assets and Charges
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Appendix 3**Aneurin Bevan University Health Board**

TRANSFERRED ASSETS

2. Asset Details

Asset No.	
Asset Description	
EBME Reference No.	
Model/Serial No.	
Reasons For Transfer	
Date Transferred	

4. Site, Department & Owners Details

	Original	New
Site		
Department		
Owners Name		
Owners Designation		
Signed		
Date		

5. Return to:

Head of Capital Finance, Finance Department, Ground Floor, Portacabins, Llanfrechfa Grange, Llanfrechfa, Cwmbran.

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Aneurin Bevan University Health Board

5.2

CHARITABLE FUNDS

Financial Control Procedure

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue x
Approved by: Audit Committee
Owner: Director of Finance

Issue date: dd/month/year
Review by date: dd/month/ +3 years
Policy No: ABUHB/Finance/0244

Aneurin Bevan University Health Board
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 Owner: Director of Finance

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1 Introduction

Charitable Funds is the term given to money that is donated to the Aneurin Bevan University Health Board and which is administered through a registered charity number 1098728. The Health Board is the Corporate Trustee of the charity (charitable funds) and has appointed the Charitable Funds Committee to oversee the management of its funds.

2 Policy Statement

Aneurin Bevan University Health Board is committed to ensuring that it has sound financial controls in place to ensure that there is good control and probity over the use of charitable funds. It is also committed to ensuring that it is compliant with charity regulations set out by the Charity Commission.

3 Aims

The document will set out procedures that are to be adopted by delegated Charitable Fund Account Managers in the day to day management of charitable funds and in setting out the corporate responsibilities of the Health Board.

4 Scope

The document is relevant to staff within the Corporate Finance Department and specifically the Charitable Funds Office. It is also relevant to staff that have been identified as Charitable Fund Account Managers and have been delegated a specific charitable fund account to manage on behalf of the trustee.

5 Roles and Responsibilities

5.1 Corporate

5.1.1. The Director of Finance is responsible for ensuring that proper financial controls and segregation of duties exist for charitable funds. The Assistant Director of Finance (Financial Systems & Services) assumes managerial responsibility for Charitable Funds, with the day to day management delegated to the Charitable Funds Manager.

5.1.2. Individuals must not set up a charity using the name of the Health Board or any of the Health Boards' hospitals without prior permission from the Health Board.

5.1.3. Individuals must not set up their own bank account to receive monies intended for the Aneurin Bevan Health Board Charitable Fund and Other Related Charities

5.1.4. All correspondence relating to charitable funds must be passed to the Charitable Funds Manager immediately. Disciplinary action will be taken where monies are misappropriated or mislaid because staff have not receipted monies promptly or not notified the Charitable Funds Manager of pertinent information.

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5.2 Charitable Fund Account Managers

This policy applies to all staff that have been identified as Charitable Fund Account Managers to manage those accounts.

6 General Information

- 6.1 Charitable Funds are variously described as Trust Funds, Endowment Funds, Gift Funds or Non Exchequer Funds. Property can only be held for charitable purposes if it is for public benefit and exclusively charitable.
- 6.2 The legal objects of the Aneurin Bevan University Health Board charity are as follows:

The trustees shall hold the trust funds upon trust to apply income, and at their discretion, so far as permissible, capital, for any charitable purpose or purposes relating to the National Health Service in the area of Gwent.
- 6.3 All expenditure and activities of the charity and individual accounts within charitable funds must be within the scope of the objects shown above.
- 6.4 Aneurin Bevan University Health Board Charitable Fund and Other Related Charities are registered with the Charity Commission for England & Wales. The registered charity number is 1098728.
- 6.5 Charitable Funds are used for items of expenditure relating to the Health Service which are not normally paid from revenue funds either because it would be inappropriate to do so or because revenue funds are insufficient. The funds are intended to provide those additional amenities that will improve the conditions under which patients are cared for and treated or staff work. Examples of items typically purchased from charitable funds are shown in Appendix 1.
- 6.6 Charitable funds may not be used to supplement remuneration directly or indirectly.
- 6.7 Income generated through the normal course of NHS staff activities should not be accounted through charitable funds but be part of the normal revenue income of the Health Board.

7 Financial Controls

- 7.1 The Director of Finance is responsible for maintaining all financial records to enable the production of reports and annual accounts that comply with accounting standards and Charity Commission regulation.

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- 7.2 All transactions must be coded correctly in the General Ledger and all supporting documentation must be retained for audit purposes.
- 7.3 Overdrawn funds are not permitted and therefore expenditure against a specific fund can only be allowed when sufficient funds exist.
- 7.4 In the unlikely event that an overdrawn fund balance occurs the account manager must ensure that the account is returned to credit within a reasonable period. Overdrawn funds must be reported to the Charitable Funds Committee.
- 7.5 Control accounts must be reconciled on a monthly basis by the Charitable Funds Manager and approved by the Assistant Head of Financial Accounting.
- 7.6 All inter-organisation balances between the charitable funds and the Health Board's revenue funds must be reviewed and cleared monthly.
- 7.7 The banking services for charitable funds must be in a separate bank account to those used for revenue funds.
- 7.8 All costs directly involved in the administration of the Charitable Funds must be identified in reports and annual accounts to reduce any subsidy from the Health Board.
- 7.9 Procedures, duties and controls must be reviewed for current relevance, practicability and efficiency as an ongoing basis.
- 7.10 Transaction listings and reconciliations must be reviewed for completion, reasonableness and evidence of posting.

8 Charitable Fund Account Managers

8.1 Signatories

All delegated charitable fund accounts must have two nominated signatories. The first signatory is the Charitable Fund Account Manager who takes primary responsibility for the management of the account and must be aware of and be compliant with this financial control procedure. The second signatory must be a person of equivalent or more senior position to the Charitable Fund Account Manager.

8.2 Delegation of Charitable Accounts

Charitable funds are formally delegated to account managers on an annual basis by letter from the Director of Finance on behalf of the Charitable Funds Committee. The letter which will be issued in March of each financial year is shown in Appendix 2 and will cover the following areas:

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- The basis that the account is being delegated.
- The terms of reference of the account.
- Authorised signatories of the account.
- The requirement to read and be familiar with the Charitable Funds Financial Control Procedure and Management Guide.
- The requirement to provide an annual return in relation to the activities and expenditure of the account.
- The withdrawal of the right to be a Charitable Fund Account Manager if compliance with requirements is not followed.

8.3 Reporting the Use of Delegated Funds

Charitable Funds Account Managers are required to submit an annual report to the Charitable Funds Committee setting out how the account has been used in the previous financial year. The reporting requirements vary depending on the fund balance on the account and is summarised as follows:

<i>AVERAGE VALUE OF FUND</i>	<i>REQUIREMENT</i>
Less than £25K	A simple proforma return setting out what the fund was used for and the main purchases and income activity made in the year. A proforma is attached in Appendix 3.
Greater Than £25K	A more detailed report setting out the activities and spending over the following headings: In the last Year Main activities Income sources Expenditure – detailing the items purchased and how they have improved the services provided by the ward/dept. Plans for the Forthcoming Year Main activities Income sources Expenditure Plans for Future Years Main activities Income sources Expenditure A proforma is attached in Appendix 4.

Reports must be submitted to the Charitable Funds Manager by 30th June following the end of the preceding financial year.

For significant funds with balances greater than £25K it is important that spending plans are in line with the strategic direction of the Board and additional level of scrutiny is required at a departmental or service level to ensure that funds are used appropriately.

8.4 New Charitable Fund Accounts

New charitable fund accounts must be approved by the Charitable Funds Committee by using the form shown in appendix 5. The purpose of the fund must be identified together with two signatories.

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9 Income

9.1 Acknowledgement

The process for acknowledging donations and legacies is shown in the diagram in Appendix 6.

9.2 Legacies

9.2.1 The Charitable Funds Manager will:-

- Send a letter of thanks to the Executors, if appropriate.
- Process and act on correspondence to ensure that the bequest is received promptly.
- Record the legacy details in the legacy register.
- Set up a separate restricted fund for each legacy received.
- Advise the Director of Finance of any issues arising from a legacy.
- Inform the Health Board's Property Group of any land and property bequeathed to the Health Board and act on their advice.

9.2.2 All legacies must be reported to the Charitable Funds Manager and used in accordance with the terms of the will and within a reasonable timescale.

9.3 Donations

9.3.1 All monetary donations, including funds raised by the staff such as raffle monies, must be receipted into Charitable Funds. Staff must not keep cash donations at a local level.

9.3.2 Charitable Fund Account managers must ensure that when a donation is received any condition or direction, which is attached, is noted and complied with. It may be necessary to decline the gift if the attached conditions are unduly onerous or if the Health Board is incapable of meeting the conditions. Account managers must report potential donations that could generate additional running costs to their Directorate Manager. The Directorate Manager must determine how these costs are to be met before accepting the donation.

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- 9.3.3 The Charitable Funds Manager must ensure that the Charitable Funds do not contain funds received for Clinical Trials. These funds are not deemed to be Charitable as it is the sponsoring company that benefits from the trial. Funds for research are permissible providing the research is published in the public domain.
- 9.3.4 The Charitable Funds Manager must ensure posters and leaflets are distributed across the Health Board informing people how they can make a monetary donation to the charity. Both the poster and leaflet must emphasise that donors must obtain a receipt for their donation. The procedure for making a monetary donation, with a sample poster, is shown in Appendix 7.
- 9.3.5 Documentation should include an option for the donor to make a 'Gift Aid' declaration allowing the Health Board to reclaim tax.
- 9.3.6 Cheques should be made payable to Aneurin Bevan Health Charity.
- 9.3.7 The account manager or their nominated individual or the Charitable Funds Manager must send a letter of acknowledgement to the donor. Some examples of wording to be included within thank you letters can be found in Appendix 8.
- 9.3.8 Small personal gifts such as chocolates and flowers given by grateful patients, relatives or friends need not be accounted for in the formal sense.
- 9.3.9 Gift cards and vouchers can be accepted as long as they are recorded as a donation and used for the benefit of the ward/department.

9.4 Fundraising

- 9.4.1 Most health service bodies raise funds on a regular basis through fetes, coffee mornings, lotteries and appeals etc. For small society lotteries, the charity must be registered with the licensing authority in the area where the principle office of the charity is located. Aggregated proceeds from all lotteries that take place across the Health Board must not be in excess of £250,000 in any one year.
- 9.4.2 Raffles may take place in Aneurin Bevan University Health Board, providing the following points are complied with:
- Raffles must be registered with the Charitable Funds Team using the 'Raffle Request Form' in Appendix 9.
 - The Charitable Funds Team will issue pre-printed raffle tickets together with a Raffle Return Form
 - Every ticket in the raffle must cost the same and the ticket fee must be paid before entry into the draw is allowed
 - Tickets must not be sold to, or by, those under the age of 16
 - Proceeds must not exceed £5,000 for a single draw

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- All proceeds of the raffle must be credited to the Charitable Funds account using the ward/department receipt book
- No single prize may be worth more than £1,000
- Alcohol donated as raffle prizes may be accepted at the discretion of the Ward/Department Manager
- Prizes may be purchased from charitable funds if sufficient funds are available but alcohol must not be purchased. Prizes should cost significantly less than the anticipated income from the raffle
- Raffle tickets must be drawn randomly and the winners must be notified by telephone or in writing by the designated staff member
- The Raffle Return Form must be completed and returned to the Charitable Funds Team together with any unused tickets within a month of the actual draw
- The winning tickets must be attached to the Raffle Return Form
- The rules governing the use of raffles will be printed on the back of the raffle return form for ease of reference
- The Charitable Funds Team will maintain a register of raffles in order to complete the required lottery return to the licensing authority in Torfaen County Borough Council.
- Aggregated proceeds from all raffles that take place across the Health Board must not be in excess of £250,000 in any one year.

9.4.3 Guidelines on sponsorship are detailed in Appendix 10.

9.5 Gift Aid

9.5.1 Donations and Fundraising (Sponsorship) Income can be Gift Aided.

9.5.2 The Gift Aid scheme allows the Charity to collect an additional amount over and above the donation in lieu of income tax.

9.5.3 Donors have to sign a declaration, prior to making their donation or undertaking their fundraising activity, that

- they wish the Charity to reclaim the tax relief
- they are currently UK taxpayers the amount of tax they pay exceeds the amount of tax reclaimable

9.5.4 The Charitable Fund Manager can provide gift aid declarations and advice on the scheme.

10. Investments

10.1 The investment policy is attached in Appendix 11.

10.2 The Charitable Funds Committee is responsible for appointing an investment management company or companies to manage the Charitable Fund's investments. The Investment Management Company must be informed of the Investment Policy of the charity and the trustees may rely on the professional advice of the Investment Management Company in formulating the policy. The policy should be reviewed annually to ensure it still fits with

the overall aims of the charity.10.3 The Charitable Funds Committee or a nominated representative should instruct the Investment Management Company to:-

- Provide details of all transactions undertaken on behalf of charity.
- Hold stock and share certificates for safekeeping.
- Provide details of dividends and interest received.
- Provide valuations on request.
- Attend the Charitable Funds Committee at least annually in order to formally present the investment performance of the period.

10.4 The Assistant Director of Finance (Financial Systems & Services) is responsible for:-

- Maintaining an Investment Register to record details of all investments held.
- Calculating realised gains or losses (profit/loss) on sale of investments.
- Calculating unrealised gains or losses on investments.
- Informing the Charitable Funds Committee at each meeting of the investment valuation.
- Ensuring all interest and dividends received are apportioned to the individual funds on the basis of the average monthly fund balance.
- Ensuring the investments held is reflected in the charity’s annual accounts.
- Ensuring working balances are kept in a Government Banking Service bank account

11. Expenditure

11.1 The detailed procedure for purchasing goods and services from Charitable Funds is detailed in Appendix 12– Purchases from Charitable Funds.

11.2 All purchases are subject to the following approval hierarchy:

Purchases Up To	Approvers
£5,000	Two individual account managers
Additional approvals for £5,001 - £15,000 £15,001 - £25,000 >£25,000	Divisional General Manager Executive Director Charitable Funds Committee

11.3 In addition to the approval hierarchy set out in the previous table for more significant funds, because of their relatively high value, an additional level of scrutiny is required at a departmental or service level to ensure that funds are used for the strategic benefit of the service or department and where a wider engagement would be desirable. Therefore evidence of planning engagement and specific plans for the account is required to support purchases where fund balances exceed £25K.

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- 11.4 An authorised signatory list is maintained by the Charitable Funds Manager. The approval hierarchy is also contained in the Oracle iProcurement module.
- 11.5 The Charitable Funds Manager will be responsible for ensuring that certification of expenditure by Authorised Signatories is within the limits set out in this procedure.
- 11.6 Expenditure can be incurred provided it falls within the remit of the fund from which it is being paid and satisfies the following criteria:
- 11.6.1 It is not for the benefit of an individual (e.g. retirement gifts) unless it is a payment to an individual that benefits a wider group – an example being a training course for the benefit of the department or service.
 - 11.6.2 Charitable funds cannot be used as funding support for staff without the approval of the Charitable Funds Committee.
 - 11.6.3 No alcohol to be purchased. There may be some exceptions in relation to patient care but this must be in line with the Alcohol and Substance Misuse Policy of the Health Board.
 - 11.6.4 Where meals are provided (for example as part of a conference for speakers) alcohol and tobacco cannot be claimed.
 - 11.6.5 A distinction should be made between work and work networking opportunities as opposed to purely social activities; the latter being inappropriate.
 - 11.6.6 The need to be proportionate and reasonable in expenditure.
 - 11.6.7 Consumable items should be paid from NHS funds not charitable funds.
 - 11.6.8 All minor works requests not available on Oracle should be submitted via the Charitable Funds Office where availability of funds and authorised signatory will be confirmed before the Works department initiates any works.
 - 11.6.9 Where expenses and reimbursements are to be reclaimed via charitable funds, claims must be made within 3 months of the date the expenditure was incurred in line with the wider Health Board policy.
 - 11.6.10 Loyalty cards may only be used to purchase goods if the card is registered to the department and not the individual.
 - 11.6.11 Examples of items typically purchased from charitable funds are shown in Appendix 1.

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12. Value Added Tax - VAT

- 12.1 Certain items purchased from charitable funds may be exempt from VAT where the goods are: -
- Purchased wholly from charitable funds.
 - Purchased by an eligible body wholly from funds provided by a charity or voluntary contributions.
- 12.2 The following items are exempt from VAT if used for the purposes stated
- Medical, scientific, computer, video, sterilising, laboratory or refrigeration equipment used in medical research, training, diagnosis or treatment
 - Parts and accessories for use with the above items
 - Qualifying aids for people with disabilities
 - Computer software solely for use in medical research, diagnosis or treatment and its repair and maintenance
- 12.3 Zero rating only applies when the item being purchased is used solely for the declared purpose e.g. a computer may qualify where used entirely for medical research. However zero rating does not apply if the computer were used partly for research and partly for general administrative work.
- 12.4 Charitable Fund Account Managers should refer to the VAT Guidelines - HM Custom & Excise - Notice 701/6 (4.11) Appendix 13 to determine the eligibility of particular purchases for VAT exemption.
- 12.5 The Procurement Department will complete a VAT exemption certificate, when placing the order, for those goods that are zero rated. A proforma VAT exemption certificate is shown in Appendix 14.
- 12.6 The Charitable Funds Manager will be responsible for clarifying VAT issues.

13. Accounting

- 13.1 The Assistant Director of Finance (Financial Systems & Services) is responsible for configuring the Oracle Financials System to be able to satisfy financial reporting regulation for Charities.
- 13.2 Accounts must be produced annually and be subject to external audit opinion and be filed with the Charities Commission before 31 January following the accounting year end.
- 13.3 The accounts must be submitted to the Charitable Funds Committee for approval.

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14. Administration Charges

- 14.1 All costs of administering the funds must be charged to the Charitable Funds accounts. Exchequer funds must not be used to subsidise charges.
- 14.2 Each Charitable Fund is charged with a fee that covers the cost of administering the funds on a day to day basis. The fee includes charges from the investment companies, finance and general administrative costs and auditors fees.
- 14.3 Administration charges are charged to each Fund annually. The total charges incurred by the Charity are apportioned to each fund on the basis of the average monthly fund balance. During the year an estimated charge may be applied to each fund, to ensure that individual fund accounts do not exceed available funds.

15. Corporate Reporting

- 15.1 On an annual basis the Assistant Director of Finance (Financial Systems & Services) will ensure that year end accounts and reports are prepared, in line with current accounting regulation for Charities and that the Charitable Funds Committee approve the audited accounts.
- 15.2 The Assistant Director of Finance (Financial Systems & Services) will provide a financial report to the each Charitable Funds Committee meeting giving details of the current financial position.
- 15.3 The Charitable Funds Manager will ensure that reports, showing opening and closing balances together with transactions, on each fund are available to view by fund managers through the Oracle Reporting Suite – Financial Business Intelligence (FBI).

16. Training

- 16.1 In addition to this Financial Control Procedure a Management User Guide has been developed which is issued to all Charitable Fund Account Managers. The guide gives practical advice to help managers know their responsibilities and to assist them in common activities such as receiving donations and purchasing goods or services from funds.
- 16.2 Further advice and training is available if necessary and can be arranged through the Charitable Funds Office.

17. Audit

- 17.1 Internal Audit and Wales Audit Office (WAO) will audit Charitable Fund Account Managers, General Offices and the Finance department periodically to determine the effectiveness of this procedure.
- 17.2 Auditors will present a report of their findings and recommendations to the Audit Committee and Charitable Funds Committee.

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18. Review

18.1 This procedure will be reviewed every three years unless a requirement arises earlier.

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Appendix 1**Aneurin Bevan University Health Board****5.2**

CHARITABLE FUNDS
Examples of Items Typically Purchased from Funds

The Health Board (the trustees) are keen that funds are used as soon as practicable following donation. The list below has been developed as an aid to managers and Charitable Fund Account Managers about the type of items that charitable funds can be used for.

If you wish to discuss any specific issues in more detail please contact:

Charitable Funds Team
 Tel No: 01495 765431 (internal calls to ext 55431)
 Fax No: 01495 765405
 E-mail: Charitable.Funds.ABB@wales.nhs.uk

Patients Expenditure	Notes
Medical equipment	• Donations are often received with a wish that equipment is purchased • Individuals fundraise in order to purchase a particular piece of equipment • Providing additional equipment would benefit both patients and staff. For example on a cardiology ward where patients are required to be weighed daily, there is a hoist provided at each end of the ward but an additional hoist would improve conditions. • Medical equipment when purchased through the charitable funds is VAT exempt • Maintenance costs and consumables need to be considered as these are usually met by revenue budgets
Seasonal activities/Occasions	• Gifts for patients resident in hospital over Christmas • Easter eggs, Halloween items

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	- Decorations for wards and departments at Christmas, Diamond Jubilee etc - Ward/Department buffets – open to all, patients , staff and visitors
Therapies	- Dance classes for older adult patients - Musical equipment - Gardening for Mental Health patients - Trips for diabetic and renal patients to show how they can manage their condition in normal day to day activities - Craft items
Environment	- Replacement of bay curtains that are adequate but worn - Cot bedding and mobiles - Pictures and murals - Plants at hospital entrances - Christmas trees and lights at hospital entrances - Garden furniture and benches - Refurbishment of areas to provide bereavement rooms - Redecoration to encompass new ideas of highlighting certain features by using different colours for patients to identify them more easily such as toilet doors, toilet seats
Other equipment	- Game consoles and games – as well as keeping children occupied it also improves patient co-ordination in stroke patients - Televisions - Music centres - Storage containers to tidy up areas - Dignity pegs – to clip bay curtains together - Bariatric equipment such as toilet seats, commodes, anaesthetic cushions and chairs as the Health Board provides standard items but unfortunately the physical size of patients treated is increasing and this exceeds the working load limit. - Bereavement memory boxes - Sympathy cards - Toys for children play areas

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Staff Expenditure	Donations are often given with a wish that they are spent on the staff
Training courses and conferences (including accommodation and travel expenses)	Knowledge gained by an individual on a training course can be passed on to other staff and will indirectly benefit patients
International conferences/courses	Revenue budgets do not usually support international events due to the cost but knowledge gained from this wider platform can improve practise here
Staff Awards (not cash)	- Prizes for poster presentations at Nurse Conference - Staff Recognition Award – in the form of a trophy - Team building events
Training equipment	- Provide the necessary equipment to enable in-house training - In-house training can be much cheaper than sending staff away on courses as there are no travel costs and staff are on hand in case of emergencies
Other equipment	- Kettles, Microwaves, Fridges. Additional items as what is provided is not always within staff proximity - Laptops – so staff can access information while away from their area of work - Computers with higher specifications than Health Board standard required to run certain types of software - Storage items – to tidy areas - Smart phones – provided in areas such as district nursing so that staff can access information and also in cardiology where GPs can access on call Consultants - Educational books
Other	
Environment	- Refurbishment of areas to provide additional storage - Improvements to work station areas
Research	- Provided it has gone through the Research and Development Committee - Provided it is for public benefit
Service Promotion	Items for stands at Big Cheese Event in Caerphilly and the Eisteddfod

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Appendix 2

Dear Charitable Fund Account Manager

Delegation of Charitable Funds

Fund No: Fund Name:

This letter formally delegates responsibility for the management of the above account to you as a Charitable Funds Account Manager for the financial year commencing 1 April 20XX.

All charitable funds within Aneurin Bevan University Health Board are managed within the umbrella of a registered charity no 1098728. Good governance is essential and therefore as the Charitable Funds Account Manager there are a number of responsibilities that you have and must be aware of and comply with as follows:

Authorised Signatories

All accounts must have two signatories identified to support all requests for expenditure from the account; the second signatory to the account must be at least of equivalent seniority in the organisation. Expenditure over certain thresholds will also require additional authorisation in accordance with the following table:

Purchases Up To	Approvers
£5,000	Two account signatories
Additional approvals for £5,001-£15,000	Divisional General Manager
£15,001-£25,000	Executive Director
>£25,000	Charitable Funds Committee

Use of the Charitable Account

A "USER GUIDE" for Charitable Fund Account Managers has been developed which provides essential information about how to manage an account from receiving donations and income to how to go about making purchases from the account. Please ensure you are familiar with this document which is attached.

The detailed procedures for managing charitable funds are contained in the Charitable Funds Financial Control Procedure with which you should also be familiar. This can be accessed from the Health Board's intranet.

Annual Reporting

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

The Charitable Funds Committee has introduced a requirement for account managers to provide an annual report on how the fund has been used in the last financial year and what the main sources of income were. Most funds are small in value and so only a brief pro-forma return will be required.

For larger funds that exceed £25K in value a slightly more detailed return is required describing the activities of the previous year and also to set out plans for the forthcoming and future years.

The Charitable Funds Committee reserves the right, as trustee of the charity, to delegate the use of the account to another manager if the requirements set out in this letter are not observed.

I would be grateful if you would sign this letter as acceptance of these terms and return it to the Charitable Funds Team by e-mail by no later than 30th April.

Charitable.Funds.ABB@wales.nhs.uk

If you have any queries I would be grateful if you would contact the Charitable Funds Manager on 01495 765414.

Yours sincerely

Director of Finance

Signature 1

Signature 2

Name:

Name:

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
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Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

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Appendix 3

**Charitable Fund Account Manager – Annual Report 20XX/20XX
 For the Charitable Funds Committee
 For funds less than £25K**

Account No:	
Account Name:	
Provisional Fund Balance as at 31.03.20XX	£

Financial Summary	
Income	
Expenditure	

Describe your main source of income for the year:

Please describe how the fund was used in the year, including the items purchased and how they were used to improve the service providing examples of benefits to patients and staff. If appropriate please provide photographs.

Please could you provide quotes from patients and staff about the difference purchases from charitable funds have made to them.

This information is used in the Charitable Funds Annual Report and to provide information to the Charitable Funds Committee.

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
Title: Charitable Funds Financial Control Procedure
Owner: Director of Finance

ABUHB/Finance/0244

Signed:	
	Charitable Funds Account Manager
Date:	

Signed:	
	2nd Signatory
Date:	

If you require assistance in completing this form, please contact the Charitable Funds Manager on 01495 765414

Appendix 4

**Charitable Fund Account Manager – Annual Report 20XX/20XX
For the Charitable Funds Committee
For funds more than £25K**

Account No:	
Account Name:	
Provisional Fund Balance as at 31.03.XX	

Financial Summary	
Income	
Expenditure	

Describe your main source of income for the year:

Please describe how the fund was used in the year, including the items purchased and how they were used to improve the service providing examples of benefits to patients and staff. If appropriate please provide photographs.

Please describe detailed plans with estimated costs for the fund in the next twelve months and also over the medium term of three years, describing the benefits these purchases will make to both staff and patients.

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

Please could you provide quotes from patients and staff about the difference purchases from charitable funds have made to them.

5.2

This information is used in the Charitable Funds Annual Report and to provide information to the Charitable Funds Committee.

Signed:	
	Charitable Funds Account Manager
Date:	

Signed:	
	2nd Signatory
Date:	

If you require assistance in completing this form, please contact the Charitable Funds Manager on 01495 765414

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

Appendix 5

Request Form to open New Charitable Fund Account Signatories

All delegated charitable fund accounts must have two nominated signatories. The first signatory is the Charitable Fund Account Manager who takes primary responsibility for the management of the account and must be aware of and be compliant with this financial control procedure. The second signatory must be a person of equivalent or more senior position to the Charitable Fund Account Manager.

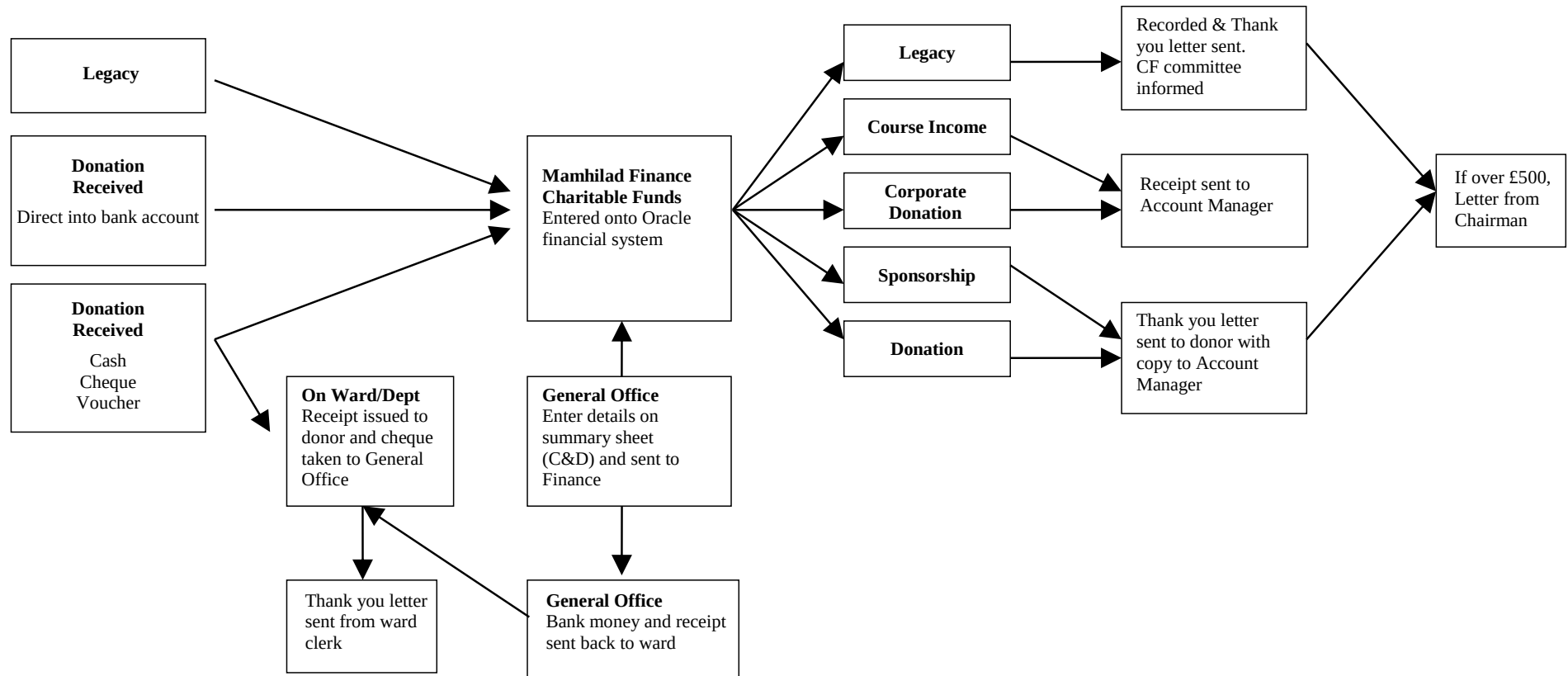
5.2

Proposed Name of Account:	
Hospital:	
Department/Ward:	
Purpose of Account:	
1 st Account Signatory:	
Name:	
Designation:	
Signed:	
Date:	
2 nd Account Signatory:	
Name	
Designation	
Signed	
Date	
Please note the second signatory must be of equal or higher grade	
For Finance Use	
Fund Name:	
Fund No:	
Date Set Up:	

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

APPENDIX 6 - PROCESS for ACKNOWLEDGING DONATIONS

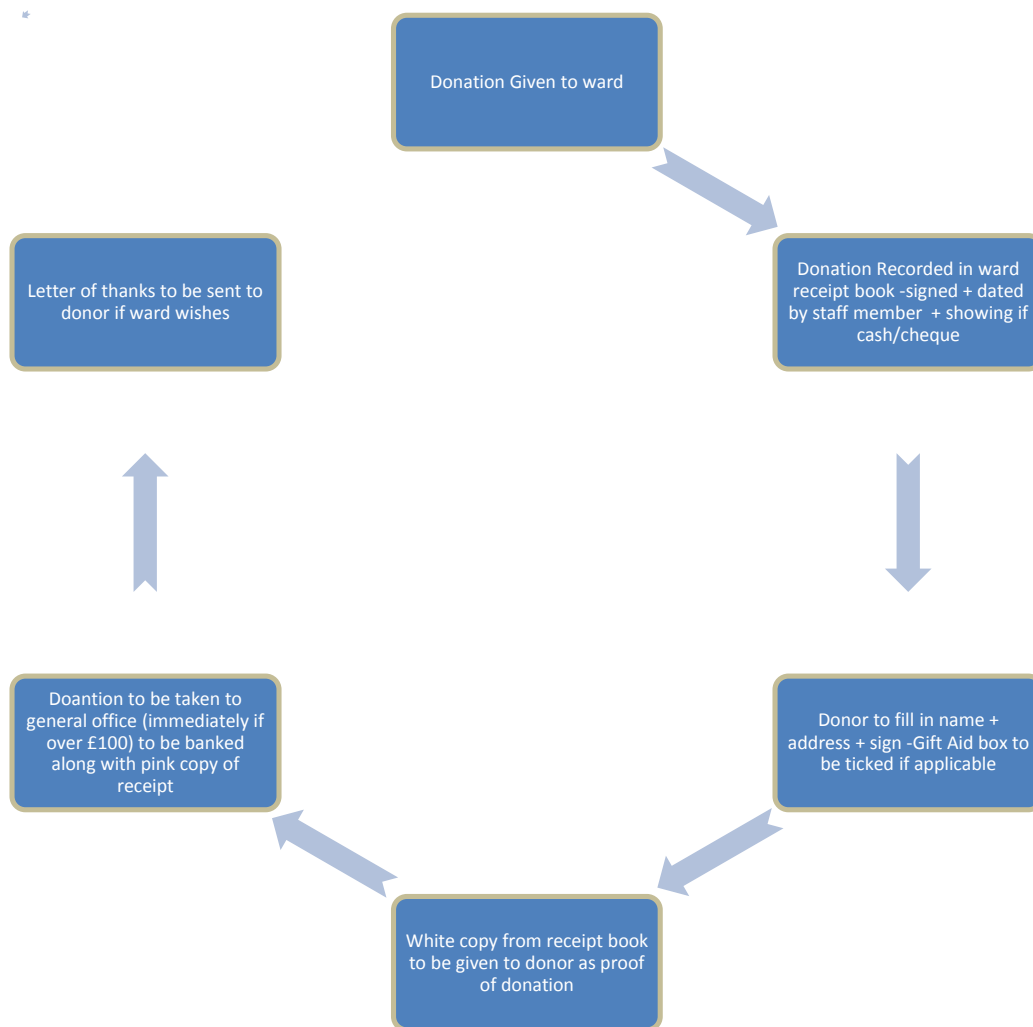


Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

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Appendix 6a

Ward Donation Procedure



5.2

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Appendix 7

Donations Procedure

1 Introduction

This procedure for monetary donations is based on the guidelines and recommendations of the Charity Commission and Wales Audit Office.

All donations must be receipted and paid into the Charitable Funds Account.

2 Poster & Leaflets

A poster and leaflet informing people of how to make monetary donations must be displayed in each ward/department. The poster is not designed to ask people for money but to inform potential donors of the procedure. Both the poster and leaflet emphasise that donors must obtain a receipt for their donation.

The poster is included within this appendix. The Charitable Funds Manager will supply copies of the donation leaflet on request.

3 Ward/Department Level

Authorised Officers, who have been nominated by the Authorised Signatory of each fund, are the only members of staff permitted to accept donations.

Each fund will have its own receipt book.

A receipt must be issued for each donation received. The receipt will be pre-numbered and in three parts (see Appendix 11):

- Top copy (white) to the donor
- Second copy (pink) to be sent either
 - a) to the Charitable Funds Manager, Finance Dept, C Block, Mamhilad House with the donation (**please do not send cash in the post**) or
 - b) taken to the General Office with the donation
- Bottom copy (yellow) to be retained in receipt book

The Authorised Officer must sign the receipt. The receipt should clearly indicate which ward or department the donation is for and whether the donation is cash/cheque or other.

Spoilt receipts (the top two copies) should be sent to the Charitable Funds Manager with the bottom copy being retained at ward level.

Account managers may request the Charitable Funds Manager to send a letter of thanks when a receipt is deemed to be insufficient.

Cash and cheques must be kept in a locked safe or cash box in the ward/department until it is convenient to take the donation to the General Office or send to the Charitable Funds Manager. The use of a cash box is only suitable for amounts up to £100. Cash Donations exceeding £100 must be taken to the General Office immediately.

Unauthorised persons should not accept donations but should direct the donor to one of the following: -

- An authorised person
- An information leaflet for making monetary donations
- The General Office.

Account managers should ensure that all staff within their area are aware of the donation process.

The Charitable Manager shall be responsible for: -

- Controlling and issuing pre-printed receipts to wards and departments.
- Monitoring receipts
- Ensuring continuity of receipt numbers
- Recording the income in the accounts.

4 General Office

Donations may be made at any General Office in accordance with the Charitable Funds Financial Procedure.

All receipts received from wards/departments by General Offices must be forwarded to the Charitable Funds Manager with their Cash Receipt and Bank Deposit sheets.

Aneurin Bevan University Health Board
Title: Charitable Funds Financial Control Procedure
Owner: Director of Finance

ABUHB/Finance/0244

5 Post

All postal donations should be sent to: -

The Charitable Funds Manager
Aneurin Bevan University Health Board
PO Box 10
Pontypool
NP4 0XG

6 Banking

All donations should be banked within one week of receipt.

5.2

Status: Issue x
Approved by: Audit Committee

Issue date: dd/month/year
Review by date: dd/month/ +3 years

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Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
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APPENDIX 7

5.2



Charitable Donations

Members of the public sometimes wish to make a donation for the benefit of our patients and staff. All such donations are gratefully accepted into the registered charity of the organisation. If you wish to make a donation please follow the steps below. Thank you.

Give donation to Staff-in-Charge

Hand in donation at General Office



OR



pick up a leaflet for further information



Cheques should be made payable to: -
Aneurin Bevan Health Charity

ALWAYS ASK FOR A RECEIPT

Donations are used for the general benefit of patients and staff of Aneurin Bevan University Health Board.

For more details please contact the Charitable Funds Department - Tel No: 01495 765414
 Aneurin Bevan University Health Board Charitable Fund and Other Related Charities
 Registered Charity No. 1098728

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

Receipt No: CF D00001

APPENDIX 7

Aneurin Bevan University Health Board Charitable Fund
Registered Charity No: 1098728
RECEIPT FOR INDIVIDUAL CHARITABLE DONATION

I, Name of Donor		
Of, Address of Donor		
	Post Code:	
Give to Aneurin Bevan Health Charity		
The sum of	£ (Cheque/Cash/other) Please make cheque payable to Aneurin Bevan Health Charity	For the general purposes of the charity, to be used for patient and staff welfare.
Without imposing any trust it is my wish that my donation should be used for:	Ward/Dept: Hospital: Other - please specify:	
GIFT AID DECLARATION  We are able to recover the tax on your donation which allows us to claim a further 25p for every £1 donated. In order that we can qualify for tax relief you must supply us with your full name, home address and post code and tick the box below. The amount of Income Tax and /or Capital Gains Tax you pay for each tax year must be at least equal to the amount of tax that the charity will reclaim on your gifts for that tax year. Please Tick if you would like Aneurin Bevan Health Charity to treat this donation as a Gift Aid donation. ☐		
Donor's Signature:		
Date:		
Receiving Staff's Signature:		
Staff Name: (please print)		
For Finance Use		
Oracle Receipt No:		
Fund No:		
Gift Aid Ref:		

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Appendix 8

Example of thank you letters

The information in bold will need to be changed as required. Please note this is just a guide and covers the basic elements of a thank you letter.

General Donation

Dear **Name**

Thank you for your donation of **amount** to **ward/department**.

We are grateful to receive donations which help to provide additional benefits for the care and treatment of patients, purchase medical equipment, improve the hospital environment and support the continuing education for staff.

On behalf of Aneurin Bevan Health Charity and in particular the staff on the **ward/department** I would like to thank you for this kind gift.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

In Loss

Dear **Name**

We are very sorry to hear of your sad loss. It is kind of you to think of us at this time.

On behalf of Aneurin Bevan Health Charity and in particular the staff on **name** ward I would like to thank you for donations totalling **amount** in memory of **name**. This money will be placed in the charitable fund for the **ward/ department** at the **Hospital** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff on the **ward/department**.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

In Lieu of Flowers

Dear **Name**

Thank you for your donation received in lieu of flowers at the funeral of **Name**. It is so kind of you to think of us at this sad time.

On behalf of Aneurin Bevan Health Charity and in particular the staff on **ward/department** I would like to thank you for donations totalling **amount**. This money will be placed in the charitable fund for the **ward/department** at the **Hospital** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

Care Received

Dear **Name**

Thank you for your donation of **amount** in respect of the care you received while a patient at our hospital.

On behalf of Aneurin Bevan Health Charity and in particular the staff on the **ward/department** I would like to thank you for this kind gift. The money will be placed in the charitable fund for the **ward/department** at the **Hospital** and will be used at the discretion of the Nurses and Doctors to provide additional benefits for the care and treatment of patients and also for the benefit of staff on the **ward/department**.

Please do not hesitate to contact me if at some time in the future you would like to know how this money is spent.

Yours sincerely

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

APPENDIX 9**Aneurin Bevan University Health Board Charitable Fund****Charitable Fund Procedures****Raffle Request Form**

Charitable Fund No.	
Name of Requester:	
Participating Dept:	
Hospital:	

Price per Ticket:	
No of tickets required	

Tickets will be issued in booklets of 4

The maximum number of tickets issued on initial request is 200

Further tickets can be made available for the same raffle if needed.

Date of Draw:	

Please note the closing date will automatically be set to the day before the actual draw

Prize Details	
1st Prize	
2 nd Prize	
3 rd Prize	
4 th Prize	
5 th Prize	

If there are more than 5 prizes, the 5th prize will read "Runner-up prizes"

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

APPENDIX 10

GUIDELINES RE SPONSORSHIP

Aneurin Bevan University Health Board is grateful to individuals who wish to raise money for its hospitals and clinics through sponsorship. All monies raised in this way are placed within the charitable funds of the Aneurin Bevan University Health Board. Charitable funds are intended to provide those additional amenities that will improve the condition under which patients are cared for and treated or the conditions under which staff work.

The following guidelines are provided to help you the organiser and us to ensure that monies raised for the Health Board via sponsorship does actually come to us.

By giving us as much information as possible we may adapt the sponsor form to suit your needs. We need to ensure that people contributing know who is participating in the sponsorship, what type of event is being sponsored, where and when the sponsorship is taking place and most importantly what and where the money is being raised for.

- 1) Sponsorship Forms can be obtained from the Charitable Funds Manager.
- 2) If you wish to donate on-line please visit the website www.justgiving.com and type in Aneurin Bevan and follow the instructions
- 3) All cheques are to be made payable to Aneurin Bevan Health Charity.
- 4) All forms and total sponsorship are to be returned to the Charitable Funds Manager.
- 5) On receiving the sponsorship the Charitable Funds Manager will issue a receipt or certificate showing the total raised.
- 6) Certificates may also be obtained for presentation on the day to thank individuals for participating.
- 7) Arrangements can be made for formal cheque presentation to the relevant department within the Health Board.

If you have any queries or if you require further information, please contact the Charitable Funds Team: -

Charitable Funds Team
 Aneurin Bevan University Health Board
 P O Box 10, Pontypool NP4 0XG **Tel No: 01495 765431**
Charitable.Funds.ABB@wales.nhs.uk

Appendix 11

Charitable Funds – Investment and Reserves Policy

1. Purpose

Aneurin Bevan University Health Board, as a Corporate Trustee, needs to ensure it can demonstrate effective management of current charitable funds, whether invested or held as liquid assets to meet forecast expenditure. It also needs to ensure donations are spent on a timely basis whilst maintaining a level of reserves that will ensure the ongoing viability of the charity.

The purpose of this document is to detail the current investment and reserves policy for Aneurin Bevan University Health Board Charitable Funds.

2. Investment Overview

The power of investment given to trustees is detailed in Section 3 of the Trustees Act 2000. This act imposes a duty on those acting as Charity trustees, when exercising their powers of investment, to consider the need for diversification, in order to reduce the risk of loss should an investment fail.

In addition as Corporate Trustee, Aneurin Bevan University Health Board, in line with the ethos of promoting Patient care, will attempt to ensure that all investments are ethically and environmentally sound and are not opposed to the purpose of the charity.

3. Investment Policy

The overall aim in investment of funds is to maximise total return whilst balancing risks and requirement for income. It has been agreed that:

- a) The Health Board's Charitable Funds can be invested in a number of different forms of investments, in line with the Trustees Investment Act 1961.
- b) The Charitable Fund Committee, on behalf of Aneurin Bevan University Health Board, has the delegated authority to appoint investment advisors. The investment management company will operate within the limits set down in the Health Board's Charitable Funds Investment Policy.

- c) The managed investment portfolio should equate to no more than 75% of the total funds, with the remaining sum being more readily available
- d) Any working capital balance will be retained in a Government Banking Service account which will be distinct from Aneurin Bevan University Health Board's 'revenue' account, to enable daily cash requirements to be met. At all times, it must be ensured that sufficient liquid resources are maintained to meet routine payment requirements.
- e) Investments are to be made within the limits of the Health Board's Ethical Policy, which exclude those companies whose main business is related to the production or sale of tobacco or alcohol and those companies involved in the arms trade.

4. Reserves Policy

The Charitable Funds Committee has considered the Charity's reserve policy, in light of both Charity Commission guidance on reserves and the current level of funds held.

The Committee has adopted a strategy of applying charitable funds within a reasonable time of receipt. Ideally spend should be within one to two years of the cash receipt unless the donation is made to an area or appeal which is saving towards a specific item over the medium to longer term. All planned expenditure must be to the benefit of NHS care, patient and staff welfare.

Having examined the circumstances facing the charity, namely its future income and expenditure patterns and value of fixed asset investments held, the target level of reserves is the equivalent of the value of the non-liquid assets of the charity. Maintaining reserves at this level will mitigate the risk of significant fluctuations in the levels of donations and provide financial stability for the charity.

5. Review

The Health Board's Charitable Funds Investment and Reserve policy will be reviewed annually by the Charitable Funds Committee.

Appendix 12

PURCHASES FROM CHARITABLE FUNDS

I. Purchases For Goods and Services

Purchases for goods and services, including reimbursements, should be made via the ABUHB Oracle Financial system and be supported by an official order. An order can be issued to a supplier from the procurement department on receipt of an approved requisition. When goods are received they need to be receipted to allow invoices to be paid. The process of requisition, order, receipt and payment is shown below and included as a flow chart in appendix 12a

A. Requisition

Requisitions are raised via Oracle SSP (Self Service Procurement) and requisitioners must:

- Provide as many details as possible of the goods or services to be ordered and any quotations received must be attached.
- Clearly indicate "CHARITABLE FUNDS".
- Include financial code (fund number).
- Be authorised in accordance with the approval hierarchy set out in section 8 above.
- Ensure that all requisitions are submitted via the Charitable Funds Manager

Before processing the requisition The Charitable Funds Manager will:

- Check that sufficient funds exist against the specific fund being used.
- Check the appropriateness of expenditure from Charitable Funds.
- Check eligibility for VAT exemption.
- Check authorisation as per approval hierarchy.

B. Order

Once the requisition has been approved the Procurement Department will issue an official order together with a VAT exemption certificate where necessary and the supplier will deliver goods or services in due course.

An electronic copy of the order will be available on the Oracle system.

C. Receipt of Goods/Services

When goods have been received, the account manager should immediately acknowledge delivery of goods to enable subsequent invoices to be paid. The delivery must be 'receipted' in the Receipting module of the Oracle SSP system detailing the date of receipt, number of units received etc.

D. Payment

When an invoice is issued from the supplier the Charitable Funds Section will match the invoice to the receipted Oracle order to enable payment to be processed.

E. Payment to account manager

Charitable Fund Account managers must obtain authorisation from a second authorised signatory when requesting reimbursement of purchases they have made on behalf of the charitable fund.

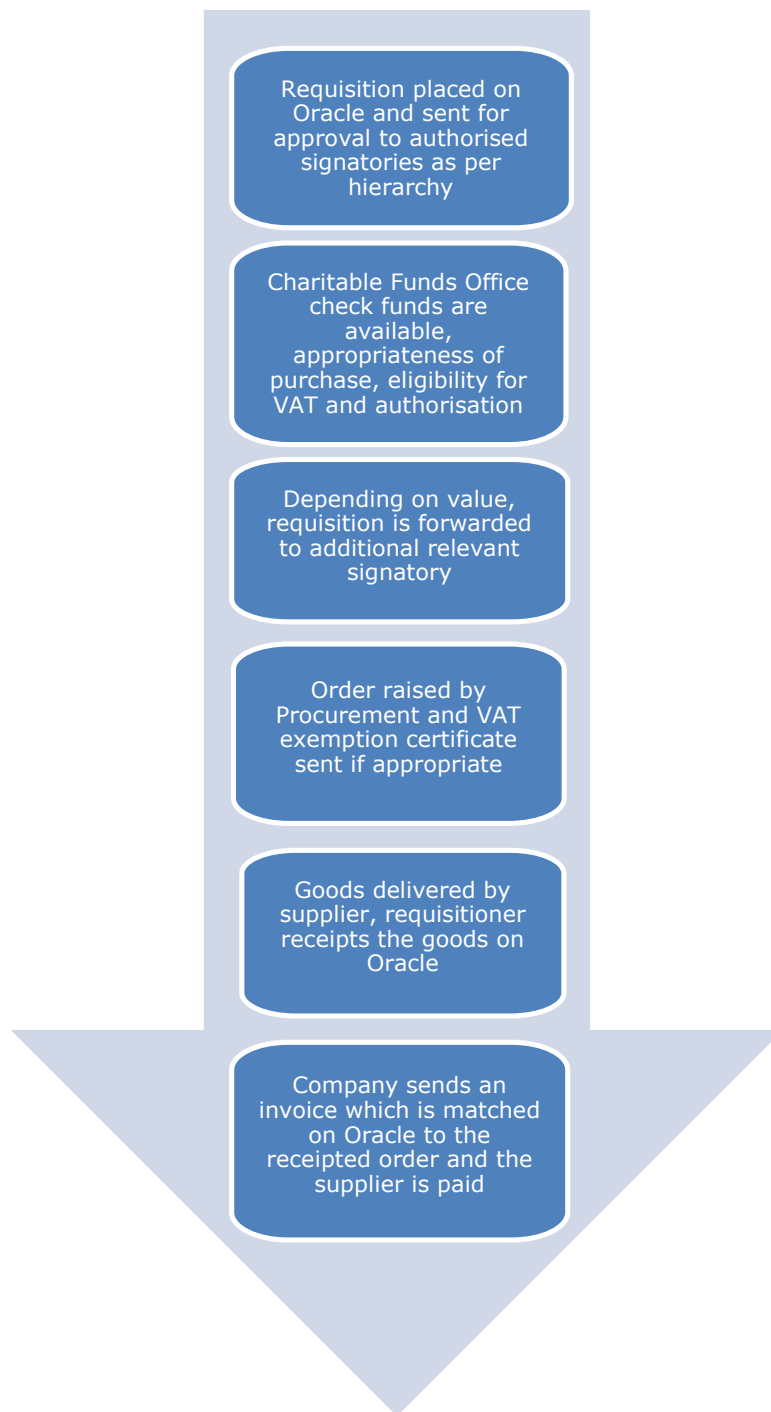
F. Requests to Pay Employees

Where an additional payment is required to be made to an individual employee for undertaking tasks relating to the objects of the charitable fund then a **Staff Payments Claim Form** must be completed. An example is shown in **Appendix 12b**.

Please note that ABUHB has a responsibility to ensure all income due to employees complies with taxation regulations and this responsibility extends to charitable funds, including staff prizes given as cash.

Appendix 12a

Charitable Funds Ordering Process



5.2

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

APPENDIX 12b

**ANEURIN BEVAN UNIVERSITY HEALTH BOARD
 CHARITABLE FUNDS
 STAFF PAYMENTS - CLAIM FORM**
 (For staff that are employed by Aneurin Bevan ULHB)

PAYMENTS TO STAFF THROUGH PAYROLL**To be completed by claimant**

Name:

Address:

Payroll No: **Grade:**

Dates Worked	Sessions Worked	Payment Claimed

Signed:

Date:

To be completed by Authorised Signatory / Fund Holder

Payment to be made:

Fund to be charged:

Authorised by:

Date:

Please send claim to Payroll Services, Floor 4, Companies House,
 Cardiff or email Payroll.Services2@wales.nhs.uk

Please send a copy of this form to Charitable Funds, Finance Department,
 C Block, Mamhilad or email to Charitable.Funds.ABB@wales.nhs.uk

To be completed by Paymaster Services

Actioned by: **Month / Week**

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

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Appendix 13**Charitable Purchases – VAT Guidance****HM Customs and Excise Notice 701/6 (4.11)****Charity funded equipment for medical, veterinary etc uses**

Not eligible for relief	Goods	Eligible for relief as:
X	Air Conditioners	
	Air control systems, specialist (capable of precisely controlling pressure, temperature and humidity)	Laboratory equipment Laboratory equipment
X	Air filters, general	
	Air filtration systems, specialist (built to meet specific circumstances)	Laboratory equipment
X	Air showers	
X	Alarms, security or smoke	
X	Alarm bracelets	
X	Alcohol spray	
	Anaesthetic apparatus	Medical equipment
	Animal cages, specialist (for example, free from chemicals and not available for consumer use)	Laboratory equipment
	Aprons, lead lined for x-ray protection	Medical equipment
X	Aprons, other	
	Artificial Limbs	Goods for use of disabled person
	Autoclaves	Sterilising equipment
X	Bactericides	
	Bandages	Medical equipment
	Barometers	Scientific equipment
	Bedding, specialist (for example, free from chemicals) for animal cages	Laboratory equipment
	Bedpans	Medical equipment
	Bedpan washers, with sterilising steam cycle	Sterilising equipment
X	Bedpan washers, other	
	Beds, highly specialised e.g. net suspension or medical water beds	Medical equipment

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

	Beds, hospital – with tilting action or variable height features	Goods for use of disabled person
X	Biocidal sprays	
X	Blankets	
	Bunsen burners	Laboratory equipment
	Bottle washers, animal cage specific	Laboratory equipment
	Cages, animal, specialist (for example, free from chemicals and not available for consumer use)	Laboratory equipment
X	Cameras, still	
	Cameras, video	Video equipment
X	Cameras, digital (with video capability)	
	Cameras, thermal imaging	Scientific Equipment
X	Cartridges, printer	
X	Catering equipment	
	Catheters	Medical equipment
X	CD players or recorders	
	Centrifuges	Scientific or laboratory equipment
	Clamps – medical	Medical equipment
X	Cleaning equipment	
X	Closed circuit television systems	
	Commode chairs	Goods for use of disabled person
	Computer disks and tapes	Accessory to computer equipment
	Computer keyboards	Computer equipment
	Computer mouse	Accessory to computer equipment
	Computer printers	Accessory to computer equipment
	Computer screens	
	Computer screen filters	Accessory to computer equipment
	Computer servers	Computer equipment

5.2

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

X	Computer stationery	
	Computer tablet, including iPads	Computer equipment, provided there is evidence the item is to be used mainly for medical or veterinary research, and so on.
X	Cotton wool	
X	Curtains	
X	Data	
	Deep freezers	Refrigeration equipment
	Dental chairs	Medical equipment
	Dental drills	Medical equipment
	Dental mirrors	Medical equipment
	Dental spittoons	Medical equipment
X	Disinfectants	
	Drip poles	Medical equipment
X	Drugs trolleys	
	DVD players, recorders or blank DVDs	Video equipment
	Endoscopes	Medical equipment
	Electro-cardiographs	Medical equipment
X	Ethernet	
	Eye test charts	Medical equipment
	Examination couches, adjustable	Medical equipment
	First aid kits – supplied as pre-packaged units	Medical equipment
	Forceps	Medical equipment
X	Fuel	
	Fume cupboards	Laboratory equipment
X	Gloves, nitrile	
	Gloves, surgical	Medical equipment
X	Gloves, other	
X	Gymnasium equipment	
X	Hearing aids	
	Heart pacemakers	Medical equipment or goods for use disabled person
	Hoists and patient lifting devices	Goods for use disabled person
	Howie-style lab coats (reusable)	Laboratory equipment

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

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X	Howie-style lab coats (disposable)	
	Hypodermic needles	Medical equipment
	Ice making machines	Refrigeration equipment
	Identification bracelets for patients	Medical equipment
	iPads	Computer equipment
X	iPhones	
	Kidney bowls	Medical equipment
	Lab coats, including Howie-style reusable lab coats	Laboratory equipment
X	Laboratory animals	
	Laboratory benches	Laboratory equipment
	Laboratory glassware	Laboratory equipment
X	Lockers	
	Mattresses, specially designed for the relief/prevention of pressure sores	Medical equipment
	Medicine measures, graduated	Medical equipment
	Microscopes	Scientific or laboratory equipment
X	Mobile phones	
X	Nurse call systems	
X	Occupation therapy materials	
	Operating lights	Medical equipment
X	Overbed tables	
X	Overhead projecting units	
	Pacemakers	Medical equipment or goods for use disabled person
X	Pagers	
	Patient trolleys and stretchers	Medical equipment
	Physiotherapy equipment, specialised – other than gymnasium equipment	Medical equipment
	Pillows orthopaedic, specially designed and used for neck or spinal injuries	Medical equipment

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

X	Pillows, other	
	Pipettes	Laboratory Equipment
X	Power supplies, including UPS	
X	Printer cartridges	
X	Projectors (including ceiling mounted options)	
	Rack washers, animal cage specific	Medical equipment
	Radiography equipment	Medical equipment
	Renal dialysis units	Medical equipment or goods for use of disabled person
	Resuscitation equipment	Medical equipment
	Resuscitation dummies	Resuscitation training model
X	Routers	
	Scalpels	Medical equipment
X	Screens	
	Sharps bins	Medical equipment
X	Smartphones	
X	Sound systems	
	Specialist animal cages (for example, free from chemicals and not available for consumer use)	
	Specialist bedding (for example, free from chemicals) for animal cages	Laboratory equipment
	Sphygmomanometers	Medical equipment
	Splints	Medical equipment
X	Stationery	
X	Sterilising Solutions	
X	Sterilising wipes	
	Stethoscopes	Medical equipment
	Surgical gloves	Medical equipment
	Surgical gowns	Medical equipment
	Surgical masks	Medical equipment
	Suture needles	Medical equipment
	Swabs	Medical equipment
	Syringes	Medical equipment
	Tablet, computer (including iPads)	Computer equipment, provided there is evidence the item is to be used mainly for

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

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		medical or veterinary research, and so on.
X	Tape recorders	
X	Telephones	
X	Television Sets	
	Test tubes	Laboratory equipment
	Thermal imaging cameras	Scientific equipment
	Thermometers, clinical	Medical equipment
	Thermometers, other	Scientific equipment
	Tongue depressors	Medical equipment
X	Towels	
X	Uniforms	
	USB memory sticks	Computer equipment
	Video cameras	Video equipment
	Video tapes	Video equipment
	Video players	Video equipment
	Video monitor	Video equipment
X	Wall screens or monitors	
X	Waste disposal bags, boxes, jars & snacks	
X	Waste disposal machinery	
	Weighing machines	Scientific equipment
	Wheelchairs	Goods for use of disabled person
X	WiFi systems	
X	Wipes, clean room	
X	Wipes, sterilising	
	Wound dressings	Medical equipment
	X-ray films/plates	Medical equipment
	X-ray machines-medical	Medical equipment
	X-ray machines-other	Scientific equipment
	X-ray viewers	Medical equipment

5.2

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years

Aneurin Bevan University Health Board
 Title: Charitable Funds Financial Control Procedure
 Owner: Director of Finance

ABUHB/Finance/0244

Appendix 14**Aneurin Bevan University Health Board****Certificate for purchases/imports using donated funds**

Purchase/import by an eligible NHS body of medical, scientific equipment, etc

1	I	
2	of	Aneurin Bevan University Health Board PO Box 10 Pontypool NP4 0XG
3	Which is	A National Health Service Health Board
4	Declare that the above named is purchasing/importing	Relevant Goods (Medical Equipment)
5	Which I believe are	Medical Equipment, Scientific Equipment, Computer Equipment, Video Equipment, Sterilising Equipment, Laboratory Equipment, Refrigeration Equipment or parts of accessories of the equipment named above.
6	From	

and paid for this supply with funds provided entirely by charitable or voluntary contributions.

I also declare that the goods will be used in either medical research, treatment, diagnosis or training
 and I claim relief from value added tax under item 5, Group 15 of Schedule 8 to the Value Added Tax Act 1994.

SIGNATURE	
DATE	

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: dd/month/ +3 years



Aneurin Bevan University Health Board

Financial Control Procedure Losses and Special Payments

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue x
Approved by: Audit Committee
Owner: Finance Director

Issue date: dd/month/year
Review by date: + 3 year
Policy Number: ABUHB/Finance/0240

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1. Introduction

This procedure sets out the delegation limits for losses and special payments detailing how payments are approved, accounted for and reported within the organisation.

2. Policy Statement

Losses and special payments are items that Welsh Government (WG) would not have contemplated when it agreed funds for the Health service or passed legislation. By their very nature they are items that ideally should not arise. They are, therefore, subject to a special Financial Control Procedure compared with the generality of payments.

3. Aims

To ensure that all Health Board employees are aware of the reporting requirements in relation to Medical Negligence and Personal injury incidents and all other minor losses incurred within ABUHB.

4. Objectives

This document sets out the process to be adhered to within the Health Board when reporting a loss to the organisation to ensure that:

- That staff have a clear understanding of their responsibilities with regards to the security of ABUHB assets.
- Set out how losses and special payments are recorded when identified.
- Set out the how payments are approved that constitute a loss (e.g. clinical injury compensation payments).
- How losses are reported in the Health Board.
- The accounting arrangements.

5. Scope

5.1 All ABUHB employees have a general responsibility for the security of Health Board property and for minimising the risk of loss. Divisional directors have additional responsibilities for the security of patient's property and monies where it has been deposited for safe custody in accordance with the Patient's Property Financial Control Procedure.

5.2 All employees have a responsibility to report a loss to their manager. Managers have a responsibility to notify the Health Board in writing of all losses using the documentation outlined in this procedure.

5.3 Much of this Financial Control Procedure is drawn from guidance issued in the Welsh Government IFRS NHS Wales Manual for Accounts. This procedure covers all losses which are described in this policy over the following categories:

- Medical Negligence
- Personal Injury
- Ombudsman Claims
- Minor losses
 - Category 1 - Loss of Cash
 - Category 2 - Fruitless payments
 - Category 3 - Bad debts and claims abandoned
 - Category 4- Damage to buildings
 - Stock discrepancies and losses
 - Fraud
 - Special Payments

5.4 This policy should be read in conjunction with the IFRS Wales Manual for Accounts – Chapter 6 – Losses and Special payments, Aneurin Bevan Health Board (ABUHB) Standing Orders and Standing Financial Instructions.

6. Roles and Responsibilities

6.1 The Director of Finance is responsible for:

- Ensuring the appropriate systems are in place to record losses and special payments.
- Ensuring appropriate systems are in place to enable losses and special payments to be accounted for properly and reported to the Board and Welsh Government.
- Ensuring the ABUHB has a nominated and trained Local Counter Fraud Specialist and that cases of fraud, misappropriation or other financial irregularities are investigated. The Counter Fraud Bribery and Corruption Policy sets out detailed procedures for dealing with fraud.

6.2 The Medical Director is responsible for the processing of claims for medical negligence, personal injury, loss of patient belongings and other patient related losses.

6.3 All ABUHB staff are responsible for:

- Proper security of ABUHB property and for the avoidance of loss.
- Notifying their line manager of all losses and potential losses.
- Notifying the ABUHB Local Counter Fraud Specialist if a fraud bribery or corruption is discovered or suspected.

6.4 General Managers and Directors:

- Must ensure that processes are in place to ensure the security of patient's property where it has been handed in to the ABUHB staff for safe keeping in line with the Patient's Property Financial Control Procedure.

6.5 All Managers

- Are responsible for reporting all losses, using the appropriate documentation outlined in this procedure.

7. Delegated Limits

7.1 Losses and special payments above the limits delegated to the ABUHB shown in Appendix 1 must be submitted to the Welsh Government for approval prior to any special payment or write off being made. The responsibility for submitting details of the loss to the WG is shown in Appendix 1 depending on the category of loss.

7.2 The delegation limits for Losses and special payments in ABUHB are shown in the following table and in the HB Scheme of delegation.

	Clinical Negligence/Personal Injury		Redress	
	Settlements	Legal Fees	Settlements	Legal Fees
>£1,000,000	Welsh Government and Board	Welsh Government and Board	N/A	N/A
>£100,000<£1,000,000	Board	Board	N/A	N/A
>£25,000<£100,000	CEO	CEO	CEO	N/A
>£10,000<£25,000	Head of Legal Services	Head of Legal Services	Head of Legal Services	Head of Legal Services
<£10,000	Head of Legal Services	Claims Manager	Head of Legal Services	Claims Manager

Ombudsman Claims

Per normal Scheme of Delegation approval limits.

Approvals of Losses & Special payments			
Category	<£10	Up to delegated limit (see appendix 1)	Over Delegated limit
Category 1 – Loss of Cash	n/a	Claims & Litigation sub group	Welsh Government
Category 2 – Fruitless Payments	n/a	As per scheme of delegation	Welsh Government
Category 3 – Bad debts and claims abandoned	AFD	Audit Committee	Welsh Government
Category 4 – Damage to buildings	n/a	As per scheme of delegation	Welsh Government
Category 5 – Compensation payments made under legal obligation	n/a	As per table in section 7.2 above in line with scheme of delegation	Welsh Government
Category 6 – Extra contractual payments to contractors	n/a	As per scheme of delegation	Welsh Government
Category 7 – Ex gratia payments	n/a	Head of Legal Services	Welsh Government
Category 8 – Extra statutory, extra regulatory payments	n/a	n/a*	Welsh Government

* The Health Board has no delegated limit.

All losses irrespective of value are reported to the audit committee.

8. Reporting Incidents of Loss and Potential Loss

- 8.1** Any member of staff identifying a potential loss shall report the incident details to their Head of Department who will immediately take action to recover the loss if possible. The circumstances in which the loss arose should be investigated and where necessary tighter controls put in place.
- 8.2** In the case of losses arising from clinical negligence or personal injury the ***Policy for the Management of Clinical Negligence and Personal Injury Litigation*** should be referred to.
- 8.3** The Head of Department must complete the relevant losses form from the Appendices to this policy and forward it to the address set out on the form. The police must be contacted as appropriate.

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- 8.4** All details relating to the “write-off” will then be forwarded to the Assistant Director of Finance - Financial Systems and Services (or their representative) who shall enter the details in the ABUHB Losses and Special Payments Register (LaSPaR).
- 8.5** In the case of fraud or suspected fraud, the Head of Counter Fraud will seek authorisation to prosecute from the Director of Finance and Procurement once the enquiry has been completed. The Counter Fraud, Bribery and Corruption Policy should be referred to for all suspected cases of fraud.
- 8.6** It is the responsibility of individual employees to safeguard public funds and resources and to report fraud or suspicion of fraud directly to the Local Counter Fraud Specialist. Counter Fraud Specialist Services are based in Block C, Floor 2 Mamhilad House,
- 8.7** Cases of overpayment of salaries and wages are subject to the Recovery of Overpayment to Employees Policy.

9. Approval of Payments

Appendix 2 shows the approval processes in diagram form for all losses. This section describes the process for each category of loss in detail.

9.1 Clinical Negligence & Personal Injury

The process for approving payments in cases of clinical negligence and personal injury is described in *the **Policy for Management of Clinical Negligence and Personal Injury Litigation***. All payments are subject to the delegated limits set out in 5 above.

Where concerns are pursued and the possibility of a qualifying liability is identified, confirmation of such is through the Redress Panel. Where these cases are expected to settle for less than £25K they are subject to the WG ‘Putting Things Right’ framework. These cases are considered through the Redress Panel but are still subject to the delegated limits set out in 5 above. Where cases are received as a medical negligence or personal injury claims they are investigated as a claim regardless of the value in line with the Policy for the Management of Clinical Negligence and Personal Injury Litigation.

The budget and costs for clinical negligence and personal injury costs are held by the Medical Director. Redress payments for settlements and medical expert fees are reimbursed by the WG as and when incurred by the Health Board.

9.2 Ombudsman Cases

Where the Ombudsman makes a recommendation to make a compensation payment the payment is approved by and charged to the appropriate divisional or locality budget.

9.3 Other Losses

Other losses may include Theft, fraud, arson, and sabotage, neglect of duty or gross carelessness.

9.4 Category 1 – Losses of Cash

(a) Overpayments of salaries, wages, fees or allowances.

Other causes including un-vouched or incompletely vouched payments, overpayments other than those in (b) above, physical losses of cash and cash equivalents such as stamps caused by fire, accident or similar causes.

Staff identifying any loss should immediately report this to their senior manager.

In all of the above cases a “loss of cash” form, attached in Appendix 3, must be completed by the manager of the department that incurred the loss. The form must then be submitted to the relevant department as identified on the bottom of the form for processing.

9.5 Category 2 – Fruitless payments, including abandoned capital schemes and constructive losses.

These are defined as payments that a potential recipient is legally entitled to even though the ABUHB will receive nothing in return. Examples are:

- (a) Forfeiture under contracts as a result of error or negligence by the ABUHB,
- (b) Payment for travel or hotel accommodation wrongly booked, or for goods or services incorrectly ordered or accepted.
- (c) The cost of rectifying design faults due to lack of diligence or defective professional practices.
- (d) Payment for bank charges incurred by ABUHB employees as a result of late payment of wages where it has been proven that the Health Board is at fault (Appendix 4)

In all cases there must have been an element of blame by a member of ABUHB staff.

Many degrees of error might be involved. The criterion is not whether the error is considered serious enough to warrant disciplinary action but simply whether the ABUHB was at fault in incurring, or not avoiding, the liability to make the payment.

As fruitless payments will be legally due to the recipient they are not regarded as special payments. However, as due benefit will not have been received in return, they should be regarded as losses.

In relation to capital schemes, the delegated limit from WG to the LHB is £250,000.

A written report must be completed for all incidents and sent to the Director of Finance so that appropriate action can be taken.

9.6 Category 3: Bad Debts and claims abandoned

Bad debts and claims abandoned should be entered in the losses register when it has been determined that the loss is irrecoverable.

Bad debts can only be written off when all reasonable action has been taken to recover the debt.

Debts must be approved for write off by the Audit Committee.

Any such loss written off will be charged to the originating budget.

9.7 Category 4 - Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:

- (a) Culpable causes e.g. theft, fraud, arson or sabotage, neglect of duty or gross carelessness
- (b) Losses by fire (other than arson)
- (c) Losses by weather damage or accident
- (d) Losses due to deterioration in use or deterioration in store due to defects in administration such as over-provisioning or obsolescence.

In all of the above cases a "report of loss" form, attached in Appendix 5, must be completed by the manager of the department that incurred the loss. The form must then be submitted to the Assistant Director of Finance – Financial Systems and Services.

9.8 Stock discrepancies and losses

If stock becomes obsolete the responsible Department must notify the Assistant Director of Finance – Financial Systems and Services in writing so that arrangements can be made for it to be written off.

A stock take of all items will be taken at year-end in accordance with the Stocks and Stores procedure. All losses arising and their value should be clearly identified on the stock taking sheets which are completed on an annual basis. Any loss due to obsolete stock incurred during the year should be formally notified to the Assistant Director of Finance – Financial Systems and Services, in writing so that the appropriate action can be taken. All obsolete stock losses are recorded on the Losses and Special Payments Register

10. Fraud, Bribery and Corruption

All suspected cases of Fraud, Bribery and Corruption within the Health Board must be reported immediately and in accordance with the Counter Fraud, Bribery and Corruption Policy.

11. Special Payments

Claims for compensation fall into one of the following three classifications:

11.1 Category 5 Compensation payments made under legal obligation:

- These are identified as those where a clear liability exists as a result of a court order or a legally binding arbitration award. Payments into court and out of court settlements are not payments made under legal obligation*.
- Claims must be submitted to the Director of Finance for a decision. The advice of the Chief Executive will be sought as appropriate.
- No acceptance of liability must be given when a claim is received, only an acknowledgement that the claim is receiving attention.

* Legal obligation include employment tribunal rulings. Any settlement on legal advice outside of the tribunal must be treated as ex-gratia payments within the relevant delegated limit.

11.2 Category 6 - Extra contractual payments to contractors.

These are payments which, although not due legally under an original contract, appear to be obligations which a court might uphold. Any such payment must be justified on value for money grounds.

11.3 Category 7 Ex Gratia Payments

Ex Gratia payments are payments, which the ABUHB is not obliged to make or for which there is no statutory cover, or legal liability. There are five separate types of Ex Gratia payment:

- i. Maladministration,
- ii. Loss of personal effects,
- iii. Clinical negligence and personal injury,
- iv. Settlements on termination of employment,
- v. Other cases.

Appendix 6 details the policy and procedure for all cases of claims for Ex Gratia Payments.

In all of the above cases an "ex gratia" form, attached in Appendix 7, must be completed by the manager of the department that incurred the loss. The form must then be submitted to the relevant department for processing as identified on the bottom of the form. Where the likely loss is in excess of £50K the form in Appendix 8 must be completed and submitted to the relevant department to be submitted to Welsh Government for further approval to write off the loss within the Health Board.

11.4 Category 8 - Extra statutory payments.

These are payments which the Secretary of State is not empowered by statute to make. Any proposal to make such a payment must be agreed jointly by the Director of Finance and WG.

12. Accounting for Losses and Special Payments

The accounting of losses and special payments is set out in the WG IFRS NHS Wales Manual for Accounts. The Director of Finance is responsible for ensuring details of losses and special payments are entered into the Losses and Special Payments Register (LaSPaR). Day to Day responsibility for accounting for losses and special payments is delegated to the Assistant Director of Finance - Financial Systems and Services.

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: +3 dd/month/year

13. Reporting of Losses & Special Payments in The Organisation

All losses are reported to each Audit Committee meeting by the Assistant Director of Finance – Financial Systems and Services. The report will include a section setting out the organisational framework of how all losses are reviewed in the organisation. It will also include any specific cases, trends or incidents which other Committees within the organisational framework have been notified of or have highlighted to be of concern. The purpose of the report to the Audit Committee is to provide details of financial impact of losses and also to provide the Committee with assurance that processes are in place to review and learn from all incidents.

14. Further Information

Enquiries regarding this procedure should be directed to either the Director of Finance or the Assistant Director of Finance - Financial Systems and Services

15. Equality

An equality impact assessment been carried out

16. Audit

The procedure will be subject to internal audit review from time to time.

17. Review

This procedure will be reviewed every three years unless a requirement arises earlier.

APPENDIX 1

Delegated Limits for “Write Off”

It is the responsibility of the Director of Finance to seek Welsh Government approval for claims that exceed the thresholds identified below with the exception of all clinical negligence and personal injury claims where the responsibility lies with the Medical Director

<u>CATEGORY OF LOSS/SPECIAL PAYMENT</u>	<u>DELEGATED LIMITS</u>
	£
A Losses (except in respect of primary care provider services)	
1. Loss of cash due to:	
a. theft, fraud, etc.	50,000
b. overpayment of salaries, wages, fees and allowances	50,000
c. other causes, including un-vouched or incompletely vouched payments, overpayments other than those included under 1(b); physical losses of cash and cash equivalents e.g., stamps due to fire (other than arson), accident and similar causes	50,000
2. Fruitless payments (including abandoned capital schemes)	250,000
3. Bad debts and claims abandoned:	
a. private patients (Sections 65 and 66 NHS Act 1977)	50,000
b. overseas visitors (Section 121 NHS Act 1977)	50,000
c. cases other than a-b	50,000
4. Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:	
a. culpable causes eg. theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000
b. other causes	50,000

DELEGATED LIMITS

£

B Special payments (except in respect of primary care provider services)

5.	Compensation payments made under legal obligation	FULL *
6.	Extra contractual payments to contractors	50,000
7.	Ex-gratia payments	
a.	to patients and staff for loss of personal effects	50,000
b.	for clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	1,000,000 including Claimant's costs *
c.	for personal injury claims involving negligence where legal advice obtained and relevant guidance has been applied	1,000,000 including Claimant's costs *
d.	other clinical negligence cases and personal injury claims	50,000 *
e.	other, except cases for maladministration where there was <u>no</u> financial loss by claimant	50,000
f.	maladministration where there was <u>no</u> financial loss by claimant	NIL
g.	patient referrals outside the UK and EEA guidelines	NIL

*** For all clinical negligence and personal injury cases (including court cases) the use of periodical payments should be considered for any settlement (exclusive of legal costs) involving costs to the NHS of £250,000 or more, or for lower awards when this represents good value for money. Proposed out of Court periodical payment awards require approval from the WG H&SSG FD.**

8.	Extra statutory and extra regulatory payments	NIL

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Issue date: dd/month/year
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C Losses and special payments in respect of provision of primary care provider services

Losses		Limit
		£
9.	a. Losses due to overpayments to practitioners of fees, allowances or salary	
	i. involving fraud	1,000
	ii. other	1,000
	b. Un-vouched or incompletely vouched payments	1,000
10.	Claims abandoned	1,000

D Special Payments

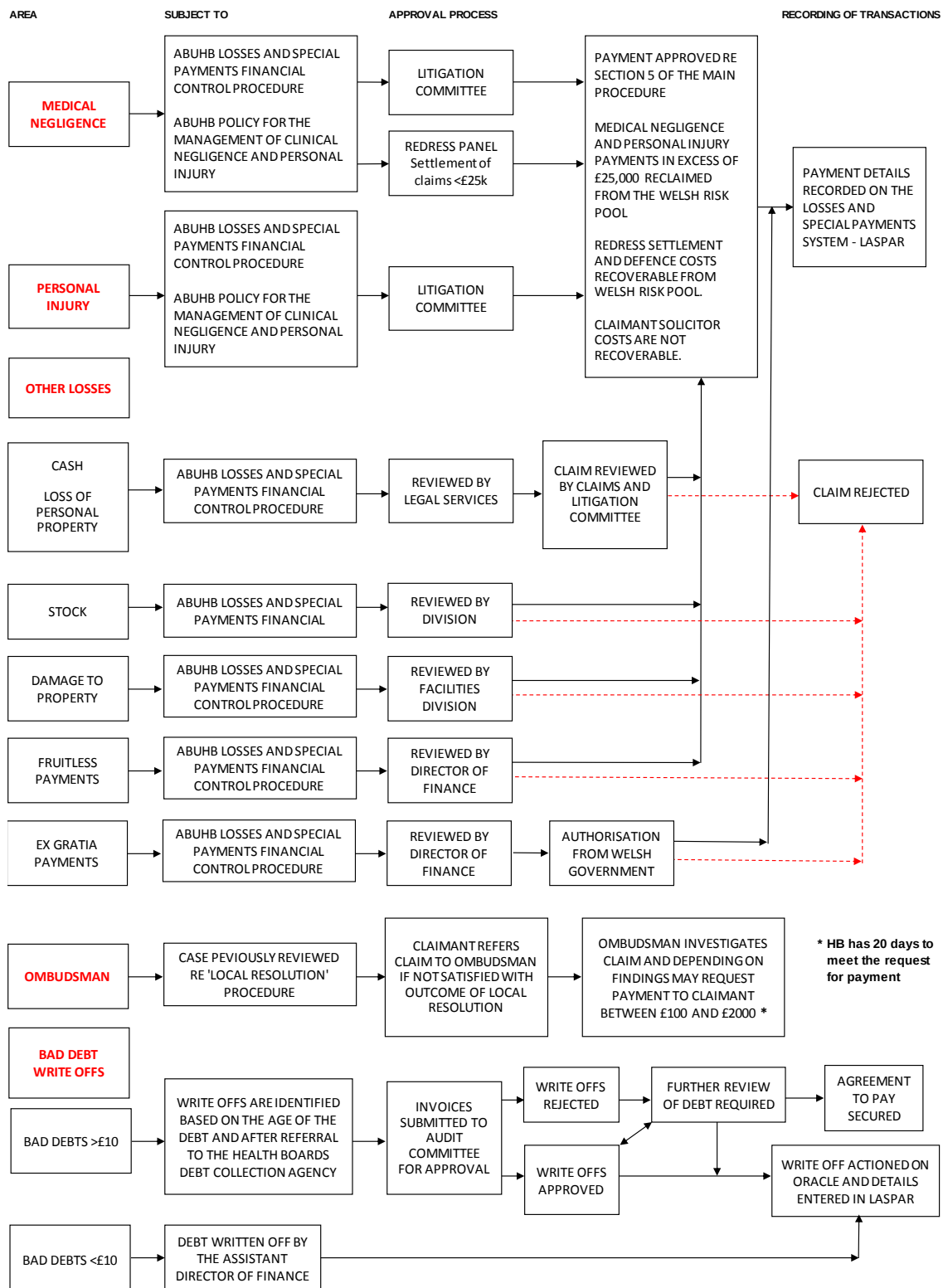
11.	Ex gratia payments	1,000
12.	Extra statutory and extra regulatory payments	
	a. to pharmacist contractors for drugs supplied in good faith in respect of forged, etc., prescriptions forms	1,000
	b. excusal of statutory charges for replacement dentures in certain circumstances	up to appropriate maximum statutory charge
	c. other	NIL

E Losses: Fraud cases under investigation

13.	a.	Losses in cases investigated by the health body in respect of prescription fraud.	1,000
	b.	Losses in cases investigated by the health body in respect of dental fraud.	1,000
	c.	Losses in cases investigated by the health body in respect of ophthalmic fraud.	1,000

All ombudsman and bad debt write off payments are charged to the budget of the department where the incident arose.

Appendix 2



For all Medical Negligence & Personal Injury claims please also refer to the IFRS NHS Wales Manual for Accounts – Chapter 6 Losses & Special Payments
For all Redress claims please also refer to the WG 'Putting Things Right' Framework.

Status: Issue x
Approved by: Audit Committee

Issue date: dd/month/year
Review by date: +3 dd/month/year

APPENDIX 3**LOSS REPORT – CATEGORY 1 LOSSES OF CASH**

Name	
Title of Reporting officer	
Department	
Date	
Type of Case	
Reference	

Checklist/report

Detail the amount involved and the reasons why the loss arose	
If applicable, provide detailed breakdown of salary or other errors. What were the errors made?	
Can the loss be recovered? Provide details of the attempts that have been made to recover the loss (including legal action) or explain why no action has been taken.	
In fraud cases, obtain and complete a fraud report from the ABUHB Local Counter Fraud Specialist. Enter dates of completion of fraud.	
Consider whether the police should be informed of other category 1 losses. If no police involvement is necessary please give reasons. If appropriate please forward the police report (if available) to the WAG HFM Division	
Identify any failings in the actions of employees, including supervisors. Having considered this, is there a need for disciplinary action? Record what action has been taken or is proposed, or, if no action	

Status: Issue x
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Issue date: dd/month/year
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is to be taken, explain why. Include dates, names of individuals and positions.	
Was there any apparent breakdown of procedures? Detail weakness or fault in system of control or supervision.	
What proposed improvements have been put forward to correct defects in the existing systems or procedures? Include the timetable for implementation of the improvements.	
What monitoring measures have been introduced to ensure the improvements are working effectively?	
Having completed the above steps, detail the general lessons which can be drawn from this case.	

I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above and on the attached case summary are complete and accurate and that all aspects of the checklist have been properly considered and actioned.

Signed:

Printed:

Position:

Date:

Is it necessary to inform the Board/Chief Executive?

Yes

☐

No

☐

If no, please give reason:

Status: Issue x

Approved by: Audit Committee

Issue date: dd/month/year

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Aneurin Bevan University Health Board
 Financial Control Procedure – Losses and Special Payments
 Owner: Finance Director

ABUHB/Finance/0240

Do the SFI's require a Board report for this case? If so enclose the report. If not consider whether in the light of this case your SFI's should be amended to require a Board report.	

I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that the write off of this loss offers the best value for money in this case.	
* <i>Delete as appropriate</i>	
* This case is within the delegated authority of this Health body and is not novel, contentious or repercussive. I therefore agree to write off the loss.	
* This case is above the delegated authority of this Health Body and is novel, contentious or repercussive and I therefore request formal approval from the WG Health Department	
Signed:	Printed:
Position:	Date:
Countersigned by:	Printed:
Position:	Date:
This section must be completed by two senior officers in accordance with the delegated limits set by the Board.	

Once completed this form should be returned to:-

**Head of Legal Services
 Headquarters
 St Cadocs Hospital
 Caerleon
 NP18 3XQ**

Status: Issue x
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Issue date: dd/month/year
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Appendix 4



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

LOSSES FORM

BANK CHARGES REIMBURSEMENT (Due to late payment of salary)

Name of Employee

Payroll Number

Amount claimed £.....

Evidence of charges incurred - 3 months bank statements ☐ (✓ if received)
 - copy of letter from bank ☐ (✓ if received)

Period Covered

Employee Error * Yes/No

Manager Error Yes/No

Payroll Error Yes/No

* If employee error no reimbursement to be made

Details of incident that led to charges being incurred

Prepared by:

Approved by:

Name

Name

Title

Title

Signature

Signature

Financial Code to be charged 040-xxxx- 37300

Status: Issue x
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Issue date: dd/month/year
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APPENDIX 5

**LOSS REPORT – CATEGORY 4 DAMAGE TO BUILDINGS, THEIR FITTINGS, FURNITURE
 AND EQUIPMENT AND LOSS OF EQUIPMENT AND PROPERTY
 IN STORES AND IN USE**

Name	
Title of Reporting officer	
Hospital/Clinic	
Department/Ward	
Date/Time	

Checklist/report

Please provide details of the loss/theft/criminal damage/arson:	
Please detail the total value of items. Is the value of loss reduced by insurance? If so, please record the value of the gross loss and the value of the amount recovered by insurance	
Account Code	040-
Have the Police been informed?	Yes ☐ No ☐
If the Police have been informed, please provide details of the notification. <i>Important Note: Details of the outcome of police investigations must be notified to the Finance Director as soon as they become available</i>	
Please detail: • Any identified failings in the actions of employees, including supervisors and whether there is a need for disciplinary action	

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 Review by date: +3 dd/month/year

Any apparent breakdown of procedures	
Please state any future security measures or other corrective action which you feel should be implemented to help prevent a similar incident. If none, please state "None".	

I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above are complete and accurate and that all aspects of the checklist have been properly considered and actioned.

Signed: Printed:

Position: Date:

Once completed this form should be sent to:-

Assistant Director of Finance – Financial Systems and Services
Finance Department
Block C
Mamhilad House
Mamhilad
NP4 0YP

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: +3 dd/month/year

APPENDIX 6



POLICY & PROCEDURE FOR EX GRATIA PAYMENTS

1. INTRODUCTION

- 1.1** This appendix details the policy and procedure for ex gratia claims, in respect of cases not pursued as civil law negligence claims. It provides guidance to both managers and claimants to ensure swift and fair adjudication of claims.

2. INVESTIGATION

- 2.1** A standard form (appendix 7) must be used where a claim for compensation is being made for special payment (ex-gratia) to patients, visitors and staff for loss/damage.
- 2.2** The incident of loss or damage must be thoroughly investigated by someone of sufficient seniority to establish all of the relevant facts.
- 2.3** Any claimant who wishes to pursue legal damages should be referred to the Legal Services Department.

3. RESOLUTION BY GENERAL MANAGER OR EXECUTIVE DIRECTOR

- 3.1** The formal recommendation to agree or reject compensation will be made by the General Manager (i.e. ABUHB second-in-line managers) or Director and recorded on the claim form. A recommendation for compensation may not be delegated to another manager.
- 3.2** The General Manager or Director may recommend to reject a claim, or agree full or partial compensation. Compensation must be based upon the second hand value of the item. Full replacement value may be offered where it can be shown that the item was purchased relatively recently.

4. PAYMENT

- 4.1** Completed claim forms (approved and rejected) will be forwarded to Head of Legal Services at Headquarters, St Cadocs
- 4.2** The Head of Legal Services will then make a final decision as to whether to confirm the offer of compensation or rejection of the claim. This is formally recorded on the Claim form, signed and approved within authorisation limits. If the offer is accepted, the claimant must complete and sign a Form of Discharge (Indemnity form) relating to the specific claim. Following receipt of this form signed by the claimant a cheque or BACS payment will be released from the finance department.
- 4.3** If the claimant wishes to appeal against the decision, appeals should be made to the Head of Legal Services. The matter will then be heard at the next Litigation Committee.

5. GUIDANCE ON COMPENSATION

5.1 General Loss and Damage

Compensation should be agreed where the investigation reveals on the balance of probability that there has been a failure of the ABUHB duty of care or of ABUHB procedures. Examples include patient property lost or damaged by staff; property lost or damaged after being handed in for safe keeping; and damage to staff property or clothing caused in the legitimate pursuit of their duties, providing that they were not themselves acting negligently e.g. not wearing protective clothing provided, or operating machinery or equipment against advice.

A judgement often has to be made about the state of capability or capacity of the patient. The ABUHB duty of care increases in respect of any patient, who is unconscious, has impaired mental capacity or is otherwise disabled in a way which compromises their ability to be responsible for their own affairs and security.

There may also be rare instances where, although the LHB cannot be described as negligent, justification may exist to support an ex-gratia payment to a claimant.

5.2 Lease Cars

A number of claims have been received in the past from lease car drivers seeking recompense for the excess insurance sum following an accident occurring during normal duties. To be consistent with the above general guidance, claims from any driver (lease car or owner driver) should be approved only where evidence exists that the damage relates to a failure on the part of the ABUHB or its staff. Accident claims against any third party for damage to a vehicle or contents should be pursued routinely via the driver's insurer, and will not therefore need to be considered by General Managers within the Losses procedure.

6. LITIGATION GROUP

The Litigation Group is chaired by the Chair of the Board and comprises of the Chief Executive, Medical Director, Two independent members with attendance by –The Head of Legal Services

6.1 The role of the Litigation Group will be:

- To monitor consistency of claims decisions against Health Board Guidance.
- To review the case of any claimant wishing to appeal against a decision not to offer compensation or the amount offered. No further formal route of appeal will be available.
- To ensure that payments are made.
- To review and monitor the whole of the losses process and to provide advice to General Managers and Executive Directors

APPENDIX 7**Report No.****(for Office Use Only)**

This form should be used to make a claim for compensation for:

- Financial loss resulting from an act or failure for Health Board or its staff which does not give rise to legal liability e.g. damage/loss to property belonging to a patient, staff member or visitor
- Hardship caused to persons by official failure or delay e.g. reimbursement of travel expenses following an appointment error

Sections A to J (excluding G) to be completed by staff member receiving the incident report

Section G to be completed, signed and date by Claimant (if present)

Section K to be completed by relevant Senior Manager

Section L to be completed by General Manager/Director

Section M to be completed by The Head of Legal services

Full name: :	Occupation & Band:	Division
Ward/Department	Contact No:	Date/Time reported:

Inpatient ☐	Outpatient ☐	Day patient ☐	Employee ☐	Visitor ☐	Contractor ☐
Full Name:					
Male ☐		Female ☐		Age	D.O.B.
Address:					
.....					
Contact No.			Bleep/Pager No.		
If Staff:					
Occupation			Band:		

Datix Incident Ref (if completed):	Provide sketch if applicable
Date of incident Time of incident:	
Hospital or premises address where incident occurred:	

Status: Issue x
Approved by: Audit Committee

Issue date: dd/month/year
Review by date: +3 dd/month/year

Aneurin Bevan University Health Board
 Financial Control Procedure – Losses and Special Payments
 Owner: Finance Director

ABUHB/Finance/0240

Location: Normal activity carried out where incident occurred: 	

(Please attach copies of any supporting evidence):

5.2

E Details of Property Stolen, Lost or Damaged

(Please attach receipts and quotations if available at time of completion)

Description of items including serial numbers	State whether Organisational or private/personal property	Approximate age of items	Estimated value at time of loss £

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: +3 dd/month/year

Aneurin Bevan University Health Board
Financial Control Procedure – Losses and Special Payments
Owner: Finance Director

ABUHB/Finance/0240

F Has claimant expressed a specific wish to be reimbursed?Yes ☐No ☐

If yes, amount claimed _____

Are these items covered by personal insurance?Yes ☐No ☐**G Signature of Claimant (if present)****I can confirm that the facts on the previous pages are correct:**

Signed: _____

Printed: _____

Date: _____

H Investigation and recovery action (Cross through any question not applicable)**Was property witnessed by a member of staff?**Yes ☐No ☐

Ownership verified by (full name): _____

Position/Band: _____

Search of ward/department carried out:

Date: _____

Name: _____

Position/Band: _____

Check of patients property book:

Date: _____

Name: _____

Position/Band: _____

Entry found in property book:Yes ☐

If yes, attach copy

No ☐**Check of central Laundry:**

Date: _____

Checked by: _____

Position/Band: _____

Police informed?Yes ☐No ☐**Crime No:** _____

Date: _____

Time: _____

Notified by: _____

Position/Band: _____

Date of Police Visit: _____

Name of Police Officer _____

Police Station: _____

Status: Issue x
Approved by: Audit Committee

Issue date: dd/month/year
Review by date: +3 dd/month/year

I Other investigatory action by ward/department *(Please attach copies of any supporting evidence):*
J Person completing this report

I can confirm that the facts on the previous pages are correct:

Signed:

Printed:

Position:

Date:

NB: All structural damage must be reported to the Works & Estates Department. **Send this completed form immediately to the Directorate Manager responsible for the service/location.** Copies of this form can be located on the intranet.

NOTES:

- (1) Special payments to staff for the loss of, damage to their personal items may only be made where:
 - (a) the incident occurs during the course of the employment.
 - (b) the articles lost or damaged are such as might reasonable be carried during the course of their employment
 - (c) the articles are sufficiently robust for the treatment they might reasonably be expected to bear.
 - (d) the loss or damage is not due to the staff member(s) own negligence.
 - (e) the loss or damage is not covered by insurance or by provision for free replacement
- (2) Where the article can be repaired, the payment should cover the actual cost of repair, but where it is lost or damaged beyond repair, the value of the property immediately before the incident should be paid. This will be the cost of a replacement less the estimated amount by which the property has depreciated since purchase.
- (3) The claim should be submitted as soon as possible after loss/damage has occurred. Any unreasonable delay could result in the claim being rejected.

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: +3 dd/month/year

K Senior Managers Report

(Please attach copies of any supporting evidence)

Provide detail of the lessons learnt and action taken:

Directorate Manager sign-off

Signature:

Printed:

Date:

L General Manager/Directors Approval

Yes

☐

No

☐

Cost Centre:

8560-37300

Please give your reasons:

I confirm that the details recorded are to the best of my knowledge accurate and that all aspects of this report have been properly considered and actioned.

General Manager/Director sign-off

Signature:

Printed:

Date:

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
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Aneurin Bevan University Health Board
 Financial Control Procedure – Losses and Special Payments
 Owner: Finance Director

ABUHB/Finance/0240

M Approval by Chair of the Claims & Litigation Group

(a) ☐ The claim was considered and rejected

or

(b) ☐ The claim was considered and approved for £

Signed: Printed:

Date:

For office use only:

☐ Receipt/Quote

☐ Memo to Finance

☐ To CCL

☐ Approved

☐ Rejected

Completed forms should be forwarded to:

Head of Legal Services

Headquarters

St Cadoc's Hospital

Lodge Road

Caerleon

NP18 3XQ

If the estimated loss value is in excess of £50K – the Health Board will need to seek approval to write off the loss and as such appendix 8 will also need to be completed and submitted to Welsh Government for approval.

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
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APPENDIX 8

FOR HEALTH BODY USE

Checklist to be used when compiling the summary of the case

Category – Type of case - Reference number - Health Body (name and code) -
1. Record the amount involved and the reasons why the loss arose.
2. Detail the background of case giving full reason why payment is necessary. Have other alternatives to the payment been investigated? If not, why not? If so, provide details.
3. Was fraud involved? If so complete a fraud report and ensure that the LCFS the relevant NHS CFS Wales team, Internal and External Auditors, and where relevant the police, are informed of the fraud in accordance with Welsh Government Directions to NHS Wales health bodies on Counter Fraud Measures and using the reporting system as specified by the NHS CFS Wales. Enter dates of completion of fraud report.
4. Was theft or criminal damage involved? If so have the police been informed? If not, give the reasons why not? All security related incidents must be reported to the Local Security Management Specialist once trained, accredited and in place in accordance with forthcoming guidance issued by NHS Security Management Service.

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 Approved by: Audit Committee

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5. **For abandoned works**, were detailed specifications identified before the scheme went ahead? How did the projected work compare to these detailed specifications? At what level, by whom, and why was the scheme approved? Why was the scheme abandoned and by whom? Could the scheme have been aborted earlier? Was the scheme joint financed? If so, was any agreement signed? Was legal advice taken in the drawing up of an agreement? Is the other party prepared to pay half of the costs of the scheme?
6. **For Bad Debts and Claims Abandoned.** Were invoices raised on a regular basis? Was the debt monitored and chased regularly? Were services withdrawn upon continued non-payment? Enclose report showing when invoices were raised and where relevant paid.
- For cases involving businesses – has the business gone into liquidation/receivership? If so, are you listed as a creditor and do you have confirmation of this from the liquidator /receiver? If not, why not? Are any dividends being paid out? Was the financial integrity of the business looked into before goods or services were supplied? If not, why not and have procedures been revised to ensure this is carried out in the future?
7. **For rental cases only** - did the tenant enter into lease agreements prior to occupation? If not, why not? If the lease was faulty investigate whether action can be taken against legal advisors who drew up the agreement? Provide an analysis of rent and services charges.

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 Approved by: Audit Committee

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8. **For private patients** cases was an undertaking to pay signed? If not, why not? Was a full estimate of potential costs given and full deposit taken to cover these costs? If not, why not?

For overseas private patients cases – have the relevant embassies been contacted for payment (if applicable)? For overseas visitors, are robust procedures in place in the NHS Body to identify and charge liable overseas visitors. If not, why not? Was the overseas visitor informed that he/she would be liable to pay for the full cost of treatment? Was treatment, in a clinical opinion, immediately necessary or urgent? If treatment was not urgent why was it given before obtaining a sizeable deposit?

9. **Stores (only)** - Are any linen losses calculated at 50% of the replacement value? Is this in accordance with the guidance? Is the total loss more than 5% of the total stock value? Confirm that the loss has been valued at book value less net disposal proceeds.

10. **For extra contractual payments to contractors.** Have other alternatives to the payment been investigated? If not, why not? If so, provide details. Provide detailed calculations on which the payment is based.

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: +3 dd/month/year

11. For ex gratia payments. Have other options been considered? If not, why not? Explain why an ex gratia payment offers the best value for money. Confirm that the proposed payment does not place the claimant in a better position than if the error had not occurred? If it does, why? In cases of hardship record what evidence exists on this. Provide detailed calculations to support the proposed payment and demonstrate why the proposed sum is in accordance with the relevant paragraphs of this guidance.

For settlements on termination of employment, has relevant central guidance on such payments been followed in all respects? If not, why not?

For clinical negligence and personal injury cases has the relevant central guidance for such cases been followed in all respects? If not, why not?

12. Is the value of the loss reduced by insurance? If so, record the value of the gross loss and the value of the amount recovered by insurance.

13. Have all reasonable steps been taken to recover the loss? Provide details of the attempts that have been made to recover the loss or explain why no action has been taken. Has appropriate legal advice been sought? If not, why not? If advice has been sought, what recommendations were made and have these been followed? If not, why not?

Status: Issue x
 Approved by: Audit Committee

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14. Identify any failings in the actions of employees, including supervisors. Having considered this, is there a need for disciplinary action? Record what action has been taken or is proposed, or if no action is to be taken, explain why. Include dates, names of individuals and positions.

15. Was there any apparent breakdown of procedures? Detail weakness or fault in system of control or supervision.

16. What proposed improvements have been put forward to correct defects in the existing systems or procedures? Include the timetable for implementation of the improvements. What monitoring measures have been introduced to ensure the improvements are working effectively?

17. Is it necessary to inform the board/chief executive? If not, why not?

18. Do your SFIs require a Board report for this case? If so, please enclose the report. If not, consider whether in the light of this case your SFIs should be amended to require a Board report in such cases.

19. Having completed the above steps, detail the general lessons that can be drawn from this case. If a system weakness has been identified which has possible implications across the NHS the LCFS or the NHS CFS Wales should report the problem to NHS Protect using either the intranet fraud prevention referral system for fraud or the Area Security Management Specialist for security matters so that measures can be taken nationally to amend policy or systems.

5.2

Status: Issue x
 Approved by: Audit Committee

Issue date: dd/month/year
 Review by date: +3 dd/month/year

20. Please give details of name and position of person forwarding this case for Welsh Government approval (if applicable). Give the date when this case was first brought to the attention of the Welsh Government DH&SS FD (if applicable).

Name -

Position -

Date Welsh Government DH&SS FD notified -

21. I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above and on the attached case summary are complete and accurate, and that all aspects of the checklist have been properly considered and actioned.

Signed by -

22. I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that write off of this loss offers the best value for money for this case.

* Note: Delete as appropriate.

* This case is not novel, contentious or repercussive. I therefore agree to write off of the loss.

* This case is novel, contentious or repercussive and I therefore request formal approval from the Welsh Government DH&SS FD

Signed by -

Date -

Countersigned by -

Date -

Please note this section must be signed by two senior officers in accordance with the delegated limits set by the board. Please print names and position held in the organisation.

Name -

Position held –

Countersigned by -

Position held -



Aneurin Bevan University Health Board

Financial Control Procedure

Stores and Stocks

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue x
Approved by: Audit Committee
Owner: Finance Director

Issue date: dd/month/year
Review by date: dd/month/=3 year
Policy Number: ABHB/Finance/0249

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1. Introduction

The procedure has been written to specify the control procedures needed within ABUHB for all items put in to stores and those treated as stock.

The procedure does not cover the detailed requirements of other control systems such as Oracle. Reference should be made to local operational procedures and user manuals for guidance on these.

The procedure should be read in conjunction with other financial procedures e.g. ordering and receipting.

2. Policy Statement

This financial procedure will provide detailed guidance and direction for those employees with direct responsibility for the requisitioning and issuing of stores and stock items within ABUHB to mitigate the risk of loss or potential fraud within the Health Board.

3. Aims

The financial control procedure will ensure that:

- Accurate records of the quantities of all items in stores and stocks are maintained.
- The values of stores items are properly evaluated and regularly validated.
- Reliable and accurate information about stores and stocks is generated to support the ABUHB accounts.
- Management information is made available to assist in the overall inventory control process.
- There is adequate security in place to prevent loss and assist with the detection of fraud.

4. Objectives

The procedure will clearly identify the requirements for recording and accounting for stores and stock items and will clarify the distinction between items classified as stores items and those classified as stock items.

5. Scope

The document should be read and applied by all ABUHB employees that are charged with the management of Stores and Stock items.

6. Roles and Responsibilities

All employees charged with the management of Stores and Stocks within the ABUHB must ensure that a proper standard of inventory control is applied, as identified within the aims section above.

7. Definitions

The procedure will address the treatment of those items classified as stores items and those items classified as stock items separately as the distinction between these two terms is an important part of the procedure and specified below.

Stores items are defined as those that are purchased/made where:

- a) Not all the items are used immediately,
- b) It is necessary to have a quantity on hand,
- c) There is a need to “control” the items in a secure place and record their receipt and issue.

Items to be controlled in this way will normally be higher value items, where the consequence of loss is greater, those which are susceptible to theft or damage, or those that have to be controlled from, a legal view point e.g. drugs.

Stock items are those items complying with both a) and b) above but not c).

They will typically be lower value items, or those requiring frequent issues e.g. ward held items, where controlling them as stores would be impractical and difficult to achieve.

Consignment Stock items are those items of stock that are physically held in ABUHB but does not pass into the ownership of ABUHB until it is paid for.

8. Principles of Control

One of the main requirements in effecting control over stores and Stock is to identify the following:

- a) Which items are to be regarded as stores/stocks?
- b) Where these items are located within the ABUHB.
- c) Who is responsible for stores/stock control?
- d) Which type of stocktaking system is to be used?

Effectively, the only items treated as Stores are drugs held by Pharmacy and Estate and Facilities building items held in the estates store. All other items such as those held at ward level are to be treated as Stock.

All items, whether treated as Stores or Stock, must be subjected to the principles covering the acquisition, receipt of goods, and their subsequent storage and issue.

Particular controls to be observed are as follows:

8.1. Receipt of goods

Where practical, irrespective of the source of external supply, items must, on receipt be checked against the Supplier's documentation and the purchase order to ensure that the quantities are correct and that no items are damaged or missing.

Where it is not practical to verify all items immediately on delivery, e.g. where a large number of items are delivered in boxes on pallets, the verification must be carried out within 48 hours of receipt and the supplier's paperwork endorsed as "not verified".

Care should be taken to ensure that quantities are properly checked before the items are accepted because errors are difficult to rectify at a later time.

These checks must be performed by someone other than the requisitioning officer to ensure that the principle of segregation of duties is maintained.

Any discrepancies found must be recorded and notified as soon as possible to the Supplier.

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 Approved by: Audit Committee
 Owner: Finance Director

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Goods delivered including consignment stock must always be stored in a secure place, e.g. where deliveries are made to a central store they must not be left outside pending checking for quantities etc.

Where items are delivered within the ABUHB, e.g. Drugs from the Pharmacy to the Wards, they must be signed for in the same way as if they were delivered from an outside supplier. All supplies of pharmaceutical stock items will be accompanied by a computer generated delivery note which must be signed by both the Pharmacy when the supplies are sent out and the receiving department/area e.g. a Ward when received. The Pharmacy delivery note must be retained on file by receiving department for two years to comply with legislation.

8.2. Storage of goods

The ABUHB will maintain a list of items it intends to treat as Stores.

Where stores are maintained within both Pharmacy and Estates and Facilities the following principles need to be adhered to. In general items in stores must be capable of being reconciled according to the following formulae:

OPENING BALANCE OF ITEMS (quantities)	= O
Add receipts for a period	= R
Deduct issues made during the period	= (I)
Deduct any items scrapped or disposed of	= (S)
CLOSING BALANCE OF ITEMS	= C

Goods held in both the Pharmacy and Estates and Facilities Estates Stores should be on shelving or pallets to avoid damage in the event of a flood. The seals on the goods should be examined to ensure that the contents have not been tampered with or removed.

8.3. Security

Items must be secured at all times e.g. kept under lock and key and access to the key must be properly controlled where there is any possibility of physical loss. This is to ensure that the items in stock can be identified as the responsibility of a named individual(s).

Security of stocks is particularly important for Pharmacy items that are subject to legal as well as financial constraints.

In view of the need to protect items against fire hazards, advice should be

obtained from the local ABUHB Fire officer and that advice must be complied with.

8.4. Receipts and Issues

Receipts of items into the store, and issues from it, must be fully documented. A system must be maintained and each entry in it must be supported by Supplier’s documentation (for receipts) or issues notes (for issues). The signature of a responsible officer is needed to support all receipts and issues.

The list of responsible officers is regularly reviewed and updated.

A periodic reconciliation is carried out between the value of receipts, issues and stocks held.

Similarly, any items that are to be scrapped or decommissioned e.g. due to obsolescence, or broken/damaged beyond repair, must be fully documented and authorised and recorded as part of the year end stock taking exercise.

8.5. Stocks and Stores Records

A record needs to be maintained of items kept in store showing product details, dates of receipts and issues and the physical quantities on hand (where product has a shelf life, those with the earliest expiry date must be issued first).

This ensures that maximum and minimum stock levels are adhered to and that any discrepancies are revealed at the earliest possible stage. It is also important to monitor any changes in use.

8.6. Reordering and maximum/minimum levels

Items kept in Pharmacy and Estates and Facilities stores need to have maximum and minimum levels set so that the numbers on hand do not become excessive, or do not fall to such a low level that the ABUHB runs out of stock.

Maximum and minimum levels are established automatically by the system utilised by the Service responsible for the stores and reviewed at an interval not exceeding 6 months. The maximum and minimum levels should be authorised by a responsible officer and should only be changed by the signed authority of that officer.

8.7. Stocktaking

A full stocktaking exercise must be carried out at least annually. To improve control of stock items it is necessary to carry out checks of the more important items held more frequently and a full stocktaking exercise will normally be carried out twice yearly. This is to ensure that the stock values needed to support the ABUHB balance sheet can be calculated, and to ensure that any irregularities are found at the earliest stage.

The Pharmacy and Estates and Facilities Stores merit a regular stock checking programme and consideration should be given to a perpetual inventory system. This system involves the following steps:

- a) Identifying the stores items that need regular stock checks, because, for example, of their high ABUHB value or the possibility of loss.
- b) A plan is produced to show which of these items are to be counted at regular intervals during the year.
- c) Items are then counted according to this plan and the results compared with the stores records. Discrepancies need then to be investigated for write off as necessary.

Two of the major advantages of the perpetual system are that:

- a) It ensures that irregularities are shown up earlier than with the annual stocktaking system.
- b) If the processes are accurately carried out, the annual stock check can be made easier.

Where it is clear that items have been physically lost or otherwise need to be written out of the accounts, the Assistant Director of Finance – Financial Systems and Services should be advised with full details in accordance with Control procedure Losses and Special Payments.

All documents e.g. requisitions and issue notes, must be properly "underscored" after completion to ensure fraudulent additions cannot be made.

All stores records shall be in such a form and shall comply with such a system of control as the Director of Finance may approve.

8.8. Consignment Stock

All consignment stock agreements must be approved and signed by the following:

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Approved by: Audit Committee	Review by date: dd/month +3 year
Owner: Finance Director	7 of 15

- Procurement Manager
- The Company
- The Divisional Manager

A copy of the agreement must be signed and kept by all of the above.

All consignment stock agreements must clearly detail:

- a) The number, description and value of consignment stock items supplied,
- b) The detailed methodology to be adopted when consuming and therefore paying for the stock items,
- c) The procedure by which replenishment stock is to be supplied,
- d) That responsibility for the out-of-date stock rests with the supplying company and that ownership of the stock rests with the supplying company.

The user department must ensure the physical segregation of consignment stock in order that it does not become confused with other stock for the purposes of stocktaking.

The user department must ensure the physical security of the consignment stock.

9. Accounting for Stores and Stocks

When stores are issued stock and non-stock items are purchased they are charged to the cost centre that requested /acquired them.

At each year-end a full stock check must be undertaken of all items of stores and stocks. This must list all items held in store and be priced according to the principles issued by the Finance department.

The date of the annual stock-take will be agreed between the BPA and the service manager and then notified to the Central Management Accounting Team.

To ensure that the stocktaking processes are properly complied with, the Finance Department issue detailed instructions to all concerned detailing procedures that have to be observed. Appendix 1 provides details of the procedures issued which in summary include:

- a) The identification and treatment of obsolete stock,
- b) The means to avoid counting stock twice,
- c) The means to ensure that all stock is counted, including that in transit at the time of the stock-take,
- d) The requirement for all stock to be counted by 2 employees,
- e) Proper preparation of the area containing the stock so that the stocktaking is made easier. This will include such activities as the grouping of like items together,
- f) The date and times of the stock-take,
- g) The basis of pricing of stock including the accounting for VAT,
- h) The treatment of consignment stocks.

The stock sheet must be kept for audit purposes.

At each year end the value of the stores and stocks must be compared with the previous year's value, and the increase or decrease accounted for in the ABUHB financial accounts.

10. Responsibilities

The Director of Finance is primarily responsible for the accounting for the stores and stocks and for the accurate statement of their value in the accounts. The management in charge of the department that controls the stocks, e.g., Directorate Managers, Estates and Facilities Department, and Ward Managers is responsible for the proper custody of items under their control, and for the accurate recording of receipts and issues and taking stock in line with guidelines.

11. Ward Stock Procedures

Maximum and minimum stock levels have been set for all wards. It is the responsibility of divisional managers to ensure ward managers are aware of their responsibilities in this area and they comply with the audit protocol on Appendix 2. A system of spot checks must be carried out and the checks should be evidenced in accordance with the protocol.

12. Obsolete Stock

During the stocktaking procedures items identified as being unused for a period greater than 12 months should be recognised and the Responsible

Officer must determine where stock is slow moving or obsolete.

If items have not moved for a period greater than 24 months or have been identified as obsolete after 12 months then they should be segregated from the remaining stock and stores and not included in the periodic stocktaking procedures.

The Responsible Officer must approve disposal of obsolete stock. The Procurement manager must be informed prior to disposal in an effort to ensure that any disposal proceeds are maximised. Any obsolete/written off stock should be recorded along with the value on the year end stock taking sheets.

Checks should be carried out on a regular basis to ensure that there is no 'out of date' stock on the shelves.

Where stock has a shelf life the stock should be rotated when restocking.

13. Implementation

The procedure will go to Executive group to be reviewed and signed off with further sign off by Audit Committee. The procedure will be available under the 'Financial Procedures' section on the internet and distributed to all employees for review and implementation where required.

14. Equality

An equality impact assessment is not required for this procedure.

15. Audit

Annual audits are carried out in relation to stores and stocks by the internal department with further review if required undertaken by the Wales Audit Office as part of the annual accounts sign off.

16. Review

This procedure will be reviewed every three years unless a requirement arises earlier.

Status: Issue x
 Approved by: Audit Committee
 Owner: Finance Director

10 of 15

Issue date: dd/month/year
 Review by date: dd/month +3 year

Appendix 1

Aneurin Bevan University Health Board Controlled and Non-Controlled Stores Stock Takes

Example of email sent to managers

I am writing to request that you arrange for controlled, non-controlled and consignment stock takes to be undertaken in the areas within your delegated budget.

The stock takes should be undertaken in accordance with the attached guidance procedure, and the results of the stock takes will be incorporated in the Health Boards Annual Accounts for the year ended xx March xxxx.

Please be reminded that stock takes should only include items currently in use. Obsolete stock should be identified separately and written off as part of the stocktaking process.

Key requirements that must be adhered to.

- The **stock take must** be undertaken during the period 01st February to xx February xxxx
- You must provide us with planned dates of the stocktakes by xx January XXXX. (please send E Mail to [ABB_CMATeam](#))
- **Once stock take dates have been notified to finance these must be adhered to.**
 (Late changes to the dates of inventory counts should be avoided. If unavoidable the change of date should be notified to Finance: Central Management Accounts Team via the above email address immediately and must allow sufficient time for either Internal or External Audit to attend the revised stock taking date)
- **Where possible please can you request budget holders to start and complete stock takes during the same day to prevent anomalies in the stock takes arising as a result of stock being issued and deliveries received.**

Completed stock take sheets should be returned to ABB_CMATeam by xxxxxxxxxxxx. This is so the charge/credit to expenditure and posting the results of the stock take to the Oracle General Ledger Month 11 (Guidance on the stock taking process is attached)

Finally during week commencing xx March xxxx, you will be asked to provide **written confirmation that there have been no material differences in stock levels on non-controlled stores between the dates of the stock take and xx March xxxx.** These should be received by the CMA Team no later than 1pm on xx April 20XX

Please contact either xxxxxx (ext xxxxx) or XXXX (extxxx) of the central Management Accounts Team if you have any queries

Xxx
 Title

Date

Status: Issue x
 Approved by: Audit Committee
 Owner: Finance Director

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Issue date: dd/month/year
 Review by date: dd/month +3 year

Controlled and Non-Controlled Stores

1. Stocktaking Process

- 1.1 Items purchased for controlled stores are charged to the store when purchased.** Goods are issued from controlled stores on production of a requisition, the goods are valued at average cost and Budget holders are charged with the cost of goods issued.
- 1.2 Items purchased for uncontrolled stores are charged to Budget holders when purchased.**
- 1.3 The value of Stocks and Work-in-Progress has to be shown in the Annual Accounts. The Manual for Accounts states that stocks, of consumable stores, raw materials and manufactured items held at the year end, are to be valued at the lower of cost or net realisable value.
- 1.4 A stocktake of all stores must be undertaken at least once per annum to provide a valuation of stock and work-in-progress for the annual accounts.
- 1.5 Stores should be kept tidy at all times and items stored should be clearly labelled, stored in storage containers (e.g. bins, drawers, shelves etc.) to aid the stock taking process.
- 1.6 Internal and External Auditors may attend the actual stocktake to carry out sample checks.

2. Stocktaking Process

- 2.1. The Finance Director or Delegated Finance Officer shall notify Budget holders, in writing, when and how stocktakes are to be undertaken.
- 2.2. All stock held on both controlled and non-controlled stores must be counted. Consignment Stock must be counted separately from ABUHB Stock. The count must be undertaken by two members of staff, one employed in the department and another member of staff (either within the department or external to the department) to verify the count. The members of staff undertaking the stock take count must ensure the accuracy of the count.
- 2.3. Consignment stock must be counted separately and should be clearly identifies so not to be mixed in with normal stock. The count must be undertaken by two members of staff, one employed in the department and another member of staff (either within the department or external to the department) to verify the count. The members of staff undertaking the stock take count must ensure the accuracy of the count.
- 2.4. Supervisors are required to undertake a sample check of the counted stock to ensure the accuracy.
- 2.5. All items must be counted and verified by both members of staff. It is not acceptable for 1 member to count the stock and for the 2nd member of staff to undertake a sample check on a number of items counted.
- 2.6. The count is to be recorded on stock sheets of an approved and acceptable design, the attached excel file includes a worksheet as a pro-forma. Budget holders who wish to use a different stock sheet should check with the CMA Team that the design of the stock take sheet they propose to use is acceptable.

Status: Issue x
 Approved by: Audit Committee
 Owner: Finance Director

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Issue date: dd/month/year
 Review by date: dd/month +3 year

- 2.7. All items of stock should be populated on the stock take sheets prior to the stock take being undertaken to ensure that all items have been recorded and to prevent any unnecessary delays whilst undertaking the stock take. This will facilitate more accurate and time effective counting.
- 2.8. Stock should be counted based on the issues made e.g. if a box of gloves is issued per box and priced per box then the box should be counted. In a situation where individual gloves have been issued staff should count full boxes and half full boxes only – not the individual gloves remaining in an open box.
- 2.9. All inventory must be counted regardless of the value.
- 2.10. Staff are reminded to keep an organised storage area where by items with similar packaging are not mixed together.
- 2.11. Any stock decanted from the main storage area must be included within the stock take count.
- 2.12. The stock sheets are to be:-
- **Completed in ink** or typed or a computer print out
 - Different types of stock should be clearly identified and listed on separate sheets
 - The officer undertaking the stocktake must sign any alterations. The use of correction fluid is not permitted
 - The unit of stock must be clearly stated
 - **Unit cost must be shown against each item and whether the costs include VAT or exclude VAT**
 - Sequentially numbered in the format **1 of 6, 2 of 6**, etc.,
 - Dated and signed by the Officer taking stock and the Officer verifying the stocktake
 - Dated and signed off by a Senior Manager or the Budget holders.
- 2.13. The consignment stock sheets are to be:-
- **Completed in ink** or typed or a computer print out
 - Different types of stock should be clearly identified and listed on separate sheets
 - The officer undertaking the stocktake must sign any alterations. The use of correction fluid is not permitted
 - The unit of stock must be clearly stated
 - **Unit cost must be shown against each item and whether the costs include VAT or exclude VAT**
 - Sequentially numbered in the format **1 of 6, 2 of 6**, etc.,
 - Dated and signed by the Officer taking stock and the Officer verifying the stocktake
 - Dated and signed off by a Senior Manager or the Budget holders.

2.14. The original stocktaking sheets are to be forwarded to the CMA Team for valuation. Photocopies are unacceptable.

2.15. Stock sheets not completed in accordance with these instructions will be returned to Budget holders for correction.

2.16. The CMA Team will:-

- Ensure that stock sheets are completed in accordance with this procedure.
- Calculate the value of the stock.
- Calculate the amount to be charged to/credited to expenditure.
- Post the change in stock value to the ledger.
- Notify the Budget Holder of the effect of the stocktake.
- Enter the results of the stocktake on the worksheet in the excel file.
- Provide access to all details of controlled stock, non-controlled stock and Consignment stock to the Financial Accounts Team.

Appendix 2

ANEURIN BEVAN UNIVERSITY HEALTH BOARD AUDIT PROTOCOL FOR MINIMUM AND MAXIMUM STOCK LEVELS

- 1) On receipt of stores/stock from the NWSSP Central Stores, it should be checked and stored away on the same day.
- 2) No stock should be stored at floor level without the support of a pallet unless stored in a racking system.
- 3) All bulk stock should be kept under lock and key.
- 4) No stock should be crammed into storage areas to prevent damage and risk implications.
- 5) Stock should be kept in one area only other than what may be in use at any one time.
- 6) There should not be any stock held over the Maximum agreed level.
- 7) Stock should be kept in original boxes etc., where possible, especially Syringes (Needles) to identify expiry dates and to identify stock levels (Blood Bottle).
- 8) Each Ward and Department should be able to give two names of nominated staff who control the ordering.
- 9) Any member of staff, if approached, should know the procedure on how to obtain a credit from Stores using the appropriate correspondence.
- 10) Staff should be aware of the procedure used for requisitioning and ordering via Oracle.
- 11) Staff should be aware of the Protocol should they have a complaint about any item of stock.
- 12) The storage areas should be in a clean and tidy environment.
- 13) Stock which is used the greatest should be stored the closest to the Store-Room entrance.
- 14) NO STOCK e.g. Universal Containers etc., should be stored in the sluice area.
- 15) Each Ward/Department Manager should encourage Junior Staff to keep the Store Room in a manageable condition. This will also allow them to have an understanding of stock and what it is used for.
- 16) There should not be more than one box/package of any one item opened.
- 17) Stock should be rotated. Last in at the back. (Possibly numbering or dating boxes etc.)
- 18) Where possible, blood bottles should be ordered x 5 packs. Each pack contains 20 blood bottles. 1 box contains 5 packs. All Blood bottles should be stored in the original boxes. This enables easier identification of expiry dates.

5.2

Status: Issue x
 Approved by: Audit Committee
 Owner: Finance Director

15 of 15

Issue date: dd/month/year
 Review by date: dd/month +3 year

 GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit Committee 18 th July 2019 Agenda Item: 5.3

Audit Committee
Losses and Special Payments Report

Executive Summary

- Purpose**
 To provide Audit Committee with information in relation to financial losses and special payments made by the Health Board between March and June 2019.
- Background and context**
 Losses and Special payments are reported in the financial position each month monthly relating to cash payments for clinical negligence, personal injury claims, ex gratia payments and bad debt write offs. Losses are to be reported to the Audit Committee in line with the Committee's terms of reference.
- Assessment and Conclusion**
 Audit Committee is asked to note that the net charge to the accounts at the end of June 2019 was £522k (inclusive of defence fees) which consisted of:

Clinical Negligence	£423k
Personal Injury	£87k
Minor Losses	£11k
- Recommendation**
 Audit Committee is asked to note the content of this report.

The Audit Committee is asked to: (please tick as appropriate)

Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Glyn Jones, Director of Finance and Performance
Report Author: Estelle Evans, Head of Financial Services and Accounting
Report Received consideration and supported by :

Executive Team	n/a	Committee of the Board	n/a
		[Committee Name]	

Date of the Report: 2nd July 2019
Supplementary Papers Attached:

Appendix 1 – Assurance Framework

5.3

Purpose of the Report

The purpose of the paper is to provide the Audit Committee with information in relation to financial losses and special payments made by the Health Board for the period March to June 2019. The report covers clinical negligence, personal injury and other payments that constitute a loss to the organisation.

Background and Context

1 Background

Losses and special payments are reported in the financial position each month. The amount charged to the accounts each year consist of cash payments for clinical negligence, personal injury claims, other ex gratia payments and bad debt write offs. An assessment is also made about the level of outstanding financial liability at the period end date and any increase or decrease in this 'provision' is charged to the accounts together with cash payments.

This report will provide information as at 30th June 2019.

2 Issues

2.1 Assurance Framework

The current organisational structure and membership for the review of losses and special payment cases is set out in Appendix 1 which also identifies any significant issues highlighted in recent meetings.

2.2 Financial Analysis of Losses

Table 1 below shows analysis of the estimated liability for losses as at 30th June 2019 compared to the position reported at 31st March 2019 and 28th February 2019. It also identifies the out turn position for March 2018.

Table 1

Clinical Negligence & Personal Injury Provision				
	31-Mar-18 £000	28-Feb-19 £000	31-Mar-19 £000	30-Jun-19 £000
Clinical Negligence	89,822	121,454	120,797	136,354
Personal Injury	3,674	3,622	3,835	3,820
	93,497	125,076	124,632	140,173
Income From Welsh Risk Pool	-88,034	-119,836	-119,033	-134,482
Net Liability	5,463	5,240	5,599	5,691

Table 1 reflects the estimated liability in relation to cases advised by NWSSP Legal Services for both clinical negligence and personal injury with the provision updated to reflect new or changed cases.

The key points are:-

- The net provision required for Clinical Negligence and Personal Injury cases as at 30th June 2019 compared to the 28th February 2019 has increased by £451k.
- There was an increase of £14,900k in the Clinical Negligence provision since February 2019 as a result of the revised assessment of the likely outcome of these cases by NWSSP Legal Services with an associated increase in the anticipated income from the Welsh Risk Pool.

The number of cases provided for are shown in Table 2.

Table 2

	31-Mar-18	28-Feb-19	31-Mar-19	30-Jun-19
	No. of cases	No. of cases	No. of cases	No. of cases
Clinical Negligence	288	235	240	248
Personal Injury	68	76	76	78
	356	311	316	326
Income from Welsh Risk Pool	96	99	99	111

The amount charged to the revenue budget of the Health Board comprises of the cash paid out in the period as interim or final settlement of cases together with the overall

movement in the provision from the previous year. Table 3 summarises the total amount charged:

Table 3

YTD Expenditure Charged to the Accounts (incl Defence Fees)				
	31-Mar-18	28-Feb-19	31-Mar-19	30-Jun-19
	£000	£000	£000	£000
Clinical Negligence	7,857	6,209	7,029	1,450
Personal Injury	326	401	404	105
Irrecoverable Debts	0	0	0	0
Other	141	41	285	11
	8,324	6,651	7,718	1,566
Income From Welsh Risk Pool	-7,069	-5,262	-5,925	-1,044
Net Expenditure	1,255	1,390	1,793	522

The net charge to the accounts as at the end of June 2019 was £522k. This compares to a net charge to the accounts of £1,793k for the 2018-19. There is currently an underlying increase in the net expenditure compared to last year due to higher revaluations of provisions.

The following table 4 illustrates more clearly the figures up to the end of June 2019. The figures are inclusive of defence costs:

Table 4	Payment Made	Accrued Income from WRP	Net	Change in Provision	Net Charge to Accounts
	£000	£000	£000	£000	£000
Clinical Negligence					
Previously Reported					
Apr 18 To Feb 19	6,255	-5,150	1,104	-46	1,058
Previous Year					
Apr 18 To Mar 19	6,991	-5,812	1,179	38	1,217
Current Year to Date					
Apr 19 To Jun 19	1,359	-1,027	333	91	423
Personal Injury					
Previously Reported					
Apr 18 To Feb 19	316	-111	204	86	290
Previous Year					
Apr 18 To Mar 19	332	-113	219	71	290
Current Year to Date					
Apr 19 To Jun 19	37	-17	20	68	87
Other					
Previously Reported					
Apr 18 To Feb 19	41	0	41	0	41
Previous Year					
Apr 18 To Mar 19	285	0	285	0	285
Current Year to Date					
Apr 19 To Jun 19	11	0	11	0	11
Total					
Previously Reported					
Apr 18 To Feb 19	6,612	-5,262	1,350	40	1,390
Previous Year					
Apr 18 To Mar 19	7,608	-5,925	1,683	110	1,793
Current Year to Date					
Apr 19 To Jun 19	1,408	-1,044	364	158	522

Commentary on Table 4

During the period March to June 2019 the following payments have been made:

Payments have been made totalling £2,095k for Clinical Negligence cases. Some of these payments were above the Welsh Risk Pool threshold of £25k enabling the Health Board to accrue £1,689k of income.

The £2,095k paid is analysed as follows:

- £931k (18 payments) – Settlements
 - £490k – lack of information provided to patient regarding hip resurfacing and total hip replacement.
 - £122k – delay in patient having gall bladder removed.
 - £115k – failure to act on test history in relation to an infected hip replacement.
 - £204k related to 15 payments ranging in value up to £35k.
- £973k (32 payments) – Claimants Solicitors Fees
 - £380k – fees relating to a patient who deteriorated whilst in ITU and suffered cardiac arrest during which they suffered a significant hypoxic injury resulting in brain damage.
 - £593k related to 31 payments ranging in value up to £100k.
- £131k (100 payments) - Providing medical expertise.
- £46k (44 payments) – Counsel fees incurred.
- £6k (4 payments) – Professional fees incurred.
- £8k (20 payments) – Other payments.

Payments have been made totalling £53k for Personal Injury cases. Some of these payments were above the Welsh Risk Pool threshold of £25k enabling the Health Board to accrue £19k of income.

The £53k paid is analysed as follows:

- £3k (1 payment) - Settlements
- £13k (2 payments) - Claimants solicitors fees
- £2k (2 payments) – Providing medical expertise

- £30k (11 payments) – NWSSP Legal & Risk costs
- £5k (7 payments) – Counsel Fees

Other Losses

Minor losses recorded during the period March to June 2019 totalled £255k. This is made up of £21K minor losses payments made in month, £169K losses payments to HMRC and £65K in relation to Write offs as detailed below.

- £5k – Employment Tribunal Settlement
- £4k – 2 Payments to HMRC relating to interest charged following VAT Contracted Out Services Reviews as part of HMRC compliance review
- £1k – Petty Cash Losses
- <£1k – Payment to NHS Business Services Authority relating to late payment of NHS pension
- £11k - 11 Ombudsman cases and 17 other minor losses including patients' property. Lessons learnt reviews have been undertaken for each case and the Divisions and Departments of the organisation are actively responding to these reviews.
- £151k – Payment to HMRC relating to benefit in kind deduction for Salary Sacrifice Schemes up to 2016/17 as approved by Welsh Government
- £18k – Payment to HMRC relating to interest charged relating to the default interest for underpaid VAT on foreign payments following review
- £65k – Write off of 128 outstanding accounts receivable debts which have been assessed as unrecoverable

2.3 Redress

During the period March to June 2019, 23 payments were made in relation to redress cases totalling £114k. Funding will be requested from NWSSP to cover the costs incurred by the Health Board in relation to these redress cases with the exception of £9k in relation to claimant's solicitor's costs which are not reimbursable by NWSSP.

Recommendation

The Audit Committee is asked to note the contents of the report.

APPENDIX 1

Losses and Special Payments Assurance Framework

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
Audit Committee	<i>Board</i>	Independent members only: <i>Chair – TBC</i> <i>Vice Chair – Shelley Bosson</i> <i>IM – Emrys Elias</i> <i>David Jones</i>	<i>Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the LHB's assurance framework - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the LHB's objectives, in accordance with the standards of good governance.</i>	Quarterly	3rd April 2019	
Quality & Patient Safety Committee	<i>Board</i>	<i>Chair – Professor Dianne Watkins</i> <i>Vice Chair – Frances Taylor</i> <i>IM – Emrys Elias</i> <i>Pippa Britton</i> <i>Louise Wright</i>	Receive at each meeting: • Bi Monthly complaints reports Contains details of total numbers, numbers by Division , trends, performance and details of second stage complaints • SI reports Contains new serious incidents by area and date, current under investigation including details of remedial actions and closed incidents with details of actions taken and lessons learnt. Receive Twice Yearly • Six Monthly Claims Report	Bi Monthly	12th June 2019	The PTR annual report was presented at QPS Committee on 7th February, 4th April and 12th June and received well. Performance reported from January through to April was variable, however hit high points of 68% in March for Incidents and 65% in April for Complaints. Further work is underway through the improvement plan to

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
			Total numbers, numbers by area, trends and themes and lessons learnt following claim. Receive Annually Annual Summary from Learning Committee re key lessons learnt and actions taken to reduce risks resulting from patient safety concerns across the Health Board. Periodically WAO Reports WRP Reports PTR/Redress Reports			sustain consistent performance.
Litigation Committee	Board	<i>Chair – Ann Lloyd</i> <i>Vice Chair – Emrys Elias</i> <i>IM – Professor Dianne Watkins</i> <i>CEO – Judith Paget</i> <i>Medical Director – Dr Paul Buss</i> <i>Director of Nursing – Rhiannon Jones</i> <i>Director of Therapies and Health Science</i>	• To review and approve in conjunction with Welsh Health Legal Services major claims (exceeding £100K). • Consider inquests • Approve policies in relation to claims • Consider cases referred to trial	3 meetings a year	21 May 2019 Cases received and approved. Next planned committee 11 July cancelled, new date being sourced.	Review of claims. Consideration of appeals for minor losses

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
		– Peter Carr				
Quality & Patient Safety Operational Group	<i>Quality & Patient Safety Committee</i>	Operational group no non officer members	Highlight reports from each Division. Progress reports from Learning Committee, WRP and complaint /SI reports which need to be highlighted to the group for consideration re escalation	Bi Monthly	12th June 2019	The bi-monthly performance report for complaints and SI's was presented on the 12th June. The top three risks for each division were discussed and documented.
Learning Committee	<i>Divisional QPS Meetings</i>		• Discuss themes and trends and take learning across all Divisions of the Health Board to ensure health Board wide learning • Agree solutions and ensure escalation as needed. • WRP Claims Reviews • Claims trends/themes • SI and Serious complaint Action plans to cascade learning across Health Board • Second Stage Action Plans – (themes) •	Quarterly	30th April 2019	Concerns workshops was held on the 9th January; 19th March and 30th April and a lead has been identified to take the Learning Committee forward. This is now part of the PTR Service Improvement Plan.
Divisional / Locality Quality & Patient Safety	<i>Learning Committee</i>		• Ensure divisions take their learning forward through review of Divisional Concerns and claims • Trends and themes and agree remedial actions		30th April 2019	Concerns workshops were held on the 9th January; 19th March and 30th April with attendance from all Divisions. A Concerns

Name of Committee	Reporting to	Membership	Role in Relation to Review of Losses and Special Payments	Meeting Frequency	Date of Last Meeting	Issues Highlighted
						Quality Improvement Group was established to further develop and drive implementation of a Service Improvement Plan to sustain performance and quality in the concerns pathway.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	N/A
Financial Assessment	<i>Financial implications stated in Table 3 above</i>
Quality, Safety and Patient Experience Assessment	<i>See Appendix 1</i>
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	<i>See Appendix 1</i>
Link to Integrated Medium Term Plan/Corporate Objectives	N/A
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	N/A
Glossary of New Terms	<i>None</i>
Public Interest	<i>Report to be published in the public domain.</i>



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



GIG
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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Risk Management

Internal Audit Report 2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A	Management Action Plan
Appendix B	Assurance opinion and action plan risk rating
Appendix C	Responsibility Statement
Review reference:	ABU-1819-03
Report status:	Final
Fieldwork commencement:	17 th January 2019
Fieldwork completion:	5 th April 2019
Draft report issued:	24 th April 2019
Management response received:	1 st May 2019
Final report issued:	2 nd May 2019
Auditor/s:	James Quance, Head of Internal Audit Chris Scott, Internal Audit Manager Clare Shaw, Principal Auditor
Executive sign off	Richard Bevan, Board Secretary
Distribution	Judith Paget, Chief Executive Kay Barrow, Acting Head of 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.

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 Aneurin Bevan 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 Risk Management was completed in line with the 2018/19 Internal Audit Plan. The review sought to provide the Health Board with assurance that operational procedure is compliant with the key corporate policies within Aneurin Bevan University Health Board ('The Health Board').

2. Scope and Objectives

Our review of risk management in 2017/18 found that the Health Board had recognised that it needed to strengthen aspects of its risk management arrangements further as it entered a period of significant change through the Clinical Futures Programme and work was ongoing in this respect.

As a general theme, we reported that the Health Board needed to review the resources applied to risk management and whether these are being applied effectively and whether they are sufficient for the future.

The 2018/19 audit sought to provide reasonable assurance over the following areas:

2017/18 follow up

- resources applied to risk management have been reviewed and are being applied effectively;
- resources applied to risk management are sufficient for the future; and
- risk management has been given a greater emphasis as part of the planned approach to developing and delivering Clinical Futures.

Risk management strategy, policy and procedures

- an up to date, comprehensive risk management strategy and policy is in place and has been appropriately communicated to all members of staff; and
- documented risk management procedures are in place to support the delivery of the risk management policy.

Risk awareness

- risk management is being led and supported throughout the organisation, particularly by divisional/directorate risk champions/leads in order to ensure that risks are captured, evaluated and escalated effectively; and
- staff and board members receive appropriate training and guidance on risk management.

Risk mitigation, monitoring and reporting

- mitigating measures are identified to identify and address risks and prompt action is taken to reduce threats identified;
- regular risk review and monitoring cycles are in place across the different levels of the organisation, operating to appropriate frequencies, in which risks are captured;
- escalation procedures are in place for risks that cannot be resolved at the original level; and
- risk reporting systems are in place, understood and owned by staff throughout the Health Board and there is a framework of reporting groups and committees through which corporate level risks reach board level.

The audit incorporated the testing of a number of risk registers within divisions and a review of work undertaken by the Health Board recently to understand the organisation's risk landscape.

3. Associated Risks

The risks considered in the review were as follows:

- lack of awareness of the Risk Management Strategy and supporting processes;
- risks are not being identified, assessed or included on appropriate risk registers;
- risks are not being actively addressed; and
- risks are not being escalated through the Health Board as appropriate.

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 Risk Management is **Reasonable** Assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	2017/18 Follow-up			✓	
2	Risk management strategy, policy and procedures			✓	
3	Risk awareness	Not rated–covered in Landscape Review			
4	Risk mitigation, monitoring and reporting			✓	

* 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 classified as a weakness in the system control/design for risk management.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for risk management.

6. Summary of Audit Findings

The Health Board commissioned a review in response to the findings of the 2017/18 audit. The 'Risk Management Landscape Review' was undertaken between September 2018 and March 2019. The messages identified during the Landscape Review were discussed with the Board at the Board Development Session held on 6 March 2019 and an action plan has been developed which will be implemented during 2019/2020. The outputs from the Landscape Review and the action plan have also been presented to the Audit Committee.

The commissioning of the Landscape Review demonstrates commitment from the Board Secretary and Chief Executive to understanding the current level of risk management expertise in the organisation and its effectiveness in order to make informed decisions regarding the approach to be taken to improvement going forward. The messages from the Landscape Review re-enforce previous Internal Audit findings regarding the variability of the maturity and effectiveness of the risk champion framework and the need for greater coordination and oversight of risk management within the Health Board.

We were kept informed by the Board Secretary as the Landscape Review developed, attended one of the feedback sessions to risk champions and the Board Development Session on 6 March. We have also reviewed the action plan and concluded that it should address the high priority recommendation made in 2017/18 regarding the need to set out the developments required over risk management and resources and timescales are set and monitored to ensure their achievement. We will continue to monitor the implementation of the action plan.

The review identified two **Medium priority** issues that we consider require management's attention and provide scope for improvements to be made.

These concerned the following:

(i) Management oversight of risk

- A risk register is not included as a standard item on the meeting agendas of the Information Governance Committee and here is scope to increase the level of scrutiny of risks relevant to the Committee.

In contrast, the Public Partnerships and Wellbeing Committee follows a standardised agenda that promotes the discipline of reviewing risks at each meeting. There is therefore inconsistency between sub-committees regarding the scrutiny of risk.

- Divisional assurance meeting minutes of two of the four divisions examined in the audit did not provide evidence of review of the divisions risk registers which suggests a lower level of risk review by these divisions.

(ii) Risk Registers

- A range of issues was identified with the form and content of risk registers at all levels below the corporate register. These included a lack of uniformity, the inclusion of issues rather than risks, incomplete risk details and poor cross-referencing.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding 1 Management Oversight of risk (Operation)	Risk
The audit conducted a review of agendas, papers and meeting minutes from sub-committee and directorate management meetings for evidence of their regular review of risks and that risk registers had been updated following discussion. Findings are recorded below: 1. Board sub-committee oversight: A sample of sub committees were selected from the Board risk dashboard and minutes, agendas and papers were reviewed to confirm if these risks had been discussed at the committees assigned. In the results of this testing we recorded that a risk register was not included as a standard item on the October 2018 and February 2019 meeting agendas of the Information Governance Committee and the risk register was not discussed at the meetings. Information Governance Committee meetings that were tested had a lower level of risk management content than those of their counterpart sub-committees. In contrast, the Public Partnerships and Wellbeing Committee follows a standardised agenda, which promotes the discipline of reviewing risks at each meeting. There is therefore inconsistency between sub-committees regarding the scrutiny of risk.	The Health Board may over / under assess risks to the achievement of their objectives. Board / Sub-Committees of the Board may be unsighted on risks Lack of support for departments / service areas to manage their risks. The Health Board may not assess the significant risks it faces at the appropriate level in the organisation.

2. Divisional management meetings: Estates and Facilities and Mental Health & Learning Disabilities divisional assurance meeting minutes do not give evidence of review of the divisions' risk registers which suggests a lesser level of risk review by these divisions.	
Recommendation 1	Priority level
We recommend that the areas where audit testing has identified an apparent lesser level of management review of risk ensure that discussions regarding the review of risk at divisional management meetings are both taking place and are recorded. In addition, the Health Board should review the level of scrutiny applied to risk in Board sub-committees in order to ensure greater consistency.	Medium
Management Response 1	Responsible Officer/ Deadline
Agreed. Part A: The Board Secretary will liaise with the Director of Primary, Community and Mental Health and the Director of Operations to ensure that the active review of risks is a key documented feature of all Divisional Management Meetings. Part B: The standardisation of the format of risk registers for committees will be reviewed and applied consistently. The Information Governance Committee Risk Register will be re-introduced at its next meeting in June 2019.	Board Secretary/Director of Primary, Community and Mental Health and Director of Operations – May 2019 Board Secretary – June 2019.

Finding 2 Risk registers (Operation)	Risk
The previous risk management audits in April 2017 and March 2018 reported the following issues in our review of the organisation's risk registers and these have been observed again across the four operational risk registers that were provided for this 2018/19 audit: • there remains a lack of uniformity of risk registers templates in use across the Health Board. Register formats continue to vary; • entries described in the division registers are not all true risks. Some of those reviewed describe issues or recognised problems that are present and need to be addressed rather than possible future threats that may impact the organisation; • the risk's key details are not always present for each risk entry i.e. clear description of what the risk is: date risk identified, link to corporate objectives, individual risk owner, current and historic risk rating, mitigating action, action owner, action target date; and • there is a lack of risk entry referencing to evidence escalation from lower to higher level registers.	Risks in the Health Board are not promptly and effectively addressed in all areas of its activity.

Recommendation 2	Priority level
We recommend that prescribed divisional risk register formats and key content requirements are re-iterated to Executive leads and that divisional and directorate registers are brought into line with corporate requirements. The specific points identified in the finding above should be taken into account and addressed as part of the continuing development work being undertaken by the Health Board.	Medium
Management Response 2	Responsible Officer/ Deadline
Agreed. Parts A and B: The Board Secretary will liaise with all Executive Directors to ensure the active review of risks is a key documented feature of all Divisional and Corporate Directorate Management Meetings and that formats of registers are standardised in line with requirements. This will be applied as part of the implementation of the Action Plan from the Risk Review.	Board Secretary/Executive Leads – by September 2019 (in line with the Action Plan)

Audit Assurance Ratings



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



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



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



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

Prioritisation of Recommendations

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

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

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

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The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.



Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

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

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Health and Care Standards

Internal Audit Report 2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix B	Assurance opinion and action plan risk rating
Appendix C	Responsibility Statement
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Distribution	Kate Hooton, Assistant Director - Quality and Patient Safety
Committee	Quality and Patient Safety 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 Aneurin Bevan 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 Health and Care Standards has been completed in line with the 2018/19 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board'). The review sought to provide the Health Board with assurance that operational procedures were compliant with key corporate policies within Aneurin Bevan University Health Board.

The Health and Care Standards set out the Welsh Government's common framework of standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings. They set out what the people of Wales can expect when they access health services and what part they themselves can play in promoting their own health and wellbeing. They set out the expectations for services and organisations, whether they provide or commission services for their local citizens.

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

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

2. Scope and Objectives

Internal audit assessed the adequacy and effectiveness of internal controls in operation. Any weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The objectives of this audit were to ensure that:

- the Quality and Patient Safety Committee are provided with assurance, through regular reporting, over the management and progress of the Health and Care Standards;
- suitable oversight of the Health and Care Standards throughout the Health Board is in place, through the Health and Care Standards Group;
- staff receive appropriate information and induction in respect of the Health and Care Standards; and

- previous audit recommendations raised, have been fully implemented.

3. Associated Risks

The risks considered in the review were as follows:

- insufficient governance and oversight of Health and Care Standards throughout the Health Board;
- non-adherence to the relevant requirements of the Health and Care Standards; and
- a lack of awareness of the Health and Care Standards within the Health Board.

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 Health and Care Standards is **Reasonable** Assurance.

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

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

5. Assurance Summary

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

Assurance Summary					
1	QPS Committee Assurance			✓	
2	Suitable Oversight through the Health and Care Standards Group			✓	
3	Training and Awareness				✓
4	Previous actions raised completed and additional actions identified			✓	

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

The previous review of 2017/18 identified three medium priority issues. Although the current audit identifies three similar medium priority issues, the audit found good progress in the actions from the previous recommendations.

Design of Systems/Controls

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

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Health and Care Standards.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

In 2018-19, the following progress was made in developing the Health Board's Health and Care Standards framework:

- The Terms of Reference for the Health and Care Standards Group was updated and published.
- The "Health and Care Standards Assurance, Self-Assessment and Improvement Planning Guidance" was reviewed and re-written and is currently in Draft format. This guidance will provide Health and Care standards assurance within the Quality Assurance Framework.
- The driver diagram guidance for Health and Care Standards was reviewed, updated and published.
- The intranet site for Health and Care Standards was reviewed and updated.
- The Health and Care Standards Implementation Plan was amended to distinguish between periodic and singular actions.

We identified three **Medium priority** issues. We consider that these issues require management attention and provide scope for improvement.

1) Quality and Patient Safety (QPSC) Committee Assurance

We reported last year that neither the QPSC nor the Health and Care Standards Group (HCSG) had defined the frequency or details of assurance reporting requirements to the QPSC in respect of Health and Care Standards compliance within the Health Board. It was therefore not possible to confirm if sufficient assurance had been provided to the QPSC. Whilst this has now been addressed through revisions to the Health and Care Standards guidance document and the terms of reference of the HCSG, the former has not been finalized and as such the defined requirements remain of draft status.

It is therefore recommended that the Health and Care Standards - Assurance, Self-Assessment and Improvement Planning Guidance is finalised and approved for publication. **(see Recommendation 1)**

2) Suitable Oversight - Health and Care Standards Group

We reviewed the minutes of the meetings held by both the Health and Care Standards Group and QPS Operational Group over the last 12 months. As noted in our 2017/18 audit review (where attendance issues and lack of

escalation were identified), there continues to be an overall lack of attendance with an average attendance of 52% and 50% respectively.

We appreciate that a number of those expected to attend are senior managers and it may not be appropriate for them to attend every meeting. However, we observed that the terms of reference for the Health and Care Standards Group was recently updated and now clarifies the leads responsible for each of the Health and Care Standards and includes minimum attendance requirements.

Whilst this may help improve future attendance, there is still a correlation between members not attending the Group meetings and a lack of progress in addressing the outstanding actions assigned to them.

We therefore again recommend that attendance is monitored and where actions are outstanding beyond an agreed deadline, these should be escalated to the QPSOG. **(see Recommendation 2)**

3) Previous Outstanding Actions

The Health Board utilises Health and Care Standard driver diagrams as a tool for staff to identify which policies or procedures apply to each standard/theme requirement.

In the 2017/18 audit of the Health and Care Standards, we raised a medium priority recommendation that the Health Board complete the outstanding driver diagrams.

Whilst several driver diagrams are yet to be completed, we assess that the Health Board has made good progress in this area. Out of 34 driver diagrams originally required, we noted that only for Standard 4.1 Dignified Care had these not been completed.

Additionally, we were informed that four standards were deemed unsuitable for a driver diagram and that these standards will be discussed at future QPSOG meetings to determine the best alternative means of illustrating the standard's requirements.

We examined a sample of 10 driver diagrams in detail and our findings are recorded in Appendix A. Whilst we are content that progress is being made with the driver diagrams, we note that several in this sample have not been completed.

(see Recommendation 3)

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	0	3	0	3

Action Plan

Finding 1 Quality & Patient Safety Assurance (Design)	Risk
To determine whether the Health Board received appropriate assurance over the management of the Health and Care Standards, we reviewed meeting minutes the Quality & Patient Safety Committee (QPSC), Health and Care Standards Group (HCSG) and the Quality & Patient Safety Operational Group (QPSOG) over the last 12 months. Terms of reference for the HCSG were also reviewed. As reported last year, neither group had defined the frequency or details of assurance requirements to the QPSC members for the Health and Care Standards within the Health Board. It was therefore not possible to confirm then if sufficient assurance had been provided to the QPSC. Whilst previously there was a lack of clarity in the level of assurance required by the QPSC in this area, this has now been clarified in the two documents "Health and Care Standards - Assurance, Self-Assessment and Improvement Planning Guidance" document (although draft and yet to be published) and the HCSG terms of reference. Regarding inclusion of Health and Care Standards matters in the business of the appointed oversight committee/ group, we noted that Driver diagrams were discussed at only one of the four meetings held by the QPSC throughout 2018/19 (this mirrors the finding in the prior year audit) although in addition, an overview report of progress with the Health Board's implementation of the Standards was also given at their meeting of February 2019.	Obsolete documentation provides incorrect guidance to staff.

Action Plan

Going forward, we anticipate more regular reporting in compliance with the requirements set out in the updated "Health and Care Standards - Assurance, Self-Assessment and Improvement Planning Guidance" and the HCSG terms of reference.	
Recommendation 1	Priority level
The Health Board should finalise and approve for use the recently reviewed and amended "Health and Care Standards - Assurance, Self-Assessment and Improvement Planning Guidance" document.	Medium
Management Response 1	Responsible Officer/ Deadline
The "Health and Care Standards - Assurance, Self-Assessment and Improvement Planning Guidance" document will be finalised and approved through QPS Operational Group.	Assistant Director – QPS June 2019

Finding 2 Representation at Groups (Design/ Operation)**Risk**

We reviewed the minutes of the meetings held by both the HCSG and QPSOG over the last 12 months to assess levels of attendance.

From this we noted there continues to be a low level of attendance (52% and 50% respectively) at the meetings of these groups and the table below indicates the number of people who attended the 3 HCSG meetings held during 2018/19.

Health and Care Standards Group	
Total Meetings Attended	Number of People
3	4
2	8
1	16
0	21

The "Health and Care Standards Group - Terms of Reference" (ToR) has recently been reviewed and amended and explicitly identifies both the Divisional/Locality and Corporate leads to whom a Health and Care Standard has been assigned and the minimum meeting attendance requirements of the leads, although we note a small number remain unassigned.

Whilst the minimum attendance requirements that have now been documented may improve future attendance, we note that in 2018/19 this has been low. We noted too a correlation between members not attending the Group meetings and a lack of progress in outstanding actions assigned to them.

There is a risk of divisional representatives / standard leads not fully embedding the Health and Care Standards and a lack of mitigation and escalation of risks.

Action Plan

Recommendation 2	Priority level
The Health Board should finalise the assignment of Health and Care Standards to the leads documented in the Health and Care Standards Group terms of Reference. The Health Board should specifically identify the most appropriate employee for membership of the groups and closely monitor attendance at both the HCSG and QPSOG meetings. Where actions assigned members are outstanding beyond an agreed deadline, these should be escalated to the QPSOG.	Medium
Management Response 2	
Terms of Reference and Assignment of Health and Care Standards lead finalised Monitoring of Attendance at HCSG and escalation of actions assigned to members that are beyond their deadline to QPS Operational Group.	Assistant Director – QPS June 2019 Ongoing from April 2019

Finding 3 Health and Care Standard driver diagrams (Design/ Operation)	Risk
The Health Board utilises Health and Care Standard driver diagrams as a tool for staff to identify which policies or procedures apply to each standard / theme requirement. During the 2017 / 18 audit of the Health and Care Standards, we raised a medium priority recommendation requesting that the Health Board complete the outstanding driver diagrams. Whilst there still remain a number of driver diagrams to be completed, we assess the Health Board has made good progress in this area. Out of 34 driver diagrams originally required, we noted that only Standard '4.1 Dignified Care' and its four driver diagrams are still outstanding and incomplete. Additionally, we were informed that 4 standards were deemed unsuitable for a driver diagram and that these standards will be discussed at future QPSOG meetings to determine the best alternative means of illustrating and communicating the standard's requirement. We examined 10 driver diagrams in detail and the results of this are shown in the table below:	There is an increased risk of the Health Board being unable to manage and monitor the true position against the Standards. There is an increased risk of non-adherence to the Health and Care Standards.

Action Plan

Driver Diagram	Observation	
2.1 b – Civil Contingencies and Emergency Planning	The overall 'aim' of the standard stated in the guidance is not included in the driver diagram. The flow lines provide confusion as it is not clear to which box they relate. The Driver Diagram encapsulates this Health and Care Standard.	
2.2 - Preventing Tissue Damage	The Driver Diagram encapsulates this Health and Care Standard.	
2.4 Infection Prevention and Control and Decontamination	The Primary and Secondary drivers do not provide the level of detail defined within the guidance. The Driver Diagram does not encapsulate this Health and Care Standard.	
2.5 - Nutrition and Hydration	The overall 'aim' of the standard is not included. The Primary and Secondary drivers do not provide the level of detail defined within the guidance although the Actions are explicit and provide appropriate detail. The Driver Diagram does not encapsulate this Health and Care Standard.	
2.6 - Medicines Management	The Driver Diagram encapsulates this Health and Care Standard.	
2.9 - Medical Devices, Equipment and Diagnostic System	The driver diagram omits one of the standards primary drivers: <i>Suitable and sustainable systems, policies and procedures are in place for medical device</i>	

Action Plan

	<i>decontamination by competent staff in an appropriate environment.</i> The Driver Diagram does not fully encapsulate this Health and Care Standard.	
3.3a - Participating in Quality Improvement	Minor amendment required – the arrows showing linkage are pointing the wrong way so either remove arrow head or rotate so they are correct. The Driver Diagram fully encapsulates this Health and Care Standard.	
3.5 - Record Keeping	Minor amendments required include rearrangement of the information provided in the driver diagram and inclusion of 1 omitted Primary driver. These amendments are as follows: 1 x Primary Driver omitted was as follows: • Care, treatment and decision making is supported by structured, accurate and accessible patient records documenting the conversations between people and health professionals and the resulting decisions and actions taken and reflects best practice founded on the evidence base. The 1 x Primary Driver included as an Aim was as follows: • Record keeping supports the delivery of services, patient care and communications.	

Action Plan

	The 2 x Primary Drivers included as Secondary Drivers were as follows: • Evidence shows how decisions relating to patient care were made. • Identification of risks enables early detection of complications. The Driver Diagram does not fully encapsulate this Health and Care Standard.	
6.1 - Planning Care to provide independence	The driver diagram produced is not as per guidance and requires updating. The Driver Diagram does not encapsulate this Health and Care Standard.	
7.1b - Workforce Recruitment & Employment Practices	The Driver Diagram encapsulates this Health and Care Standard.	
Whilst we are content that progress is being made in respect of the driver diagrams, there remain areas that have not been completed.		
Recommendation 3		Priority level
The Health Board should ensure that the remaining driver diagrams are completed.		Medium

Action Plan

Where driver diagrams remain incomplete, this should be escalated to the QPSOG for assistance in prioritising the actions.	
Management Response 3	Responsible Officer/ Deadline
Driver Diagrams for all Standards where a DD is appropriate to be completed and published on the intranet. Driver Diagrams to be reviewed by Standard Holders Annually	Assistant Director QPS and Standard Holders Sept 2019 Initiate Review Sept 2019 to be completed by Jan 2020

Aneurin Bevan University Health Board

Health and Care Standards

Audit Assurance Ratings



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



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



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

Prioritisation of Recommendations

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

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

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

Aneurin Bevan University Health Board

Health and Care Standards

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Audit

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Aneurin Bevan University Health Board

Health and Care Standards

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

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NHS Wales Audit & Assurance Services

Well-being of Future Generations (Wales) Act 2015

Internal Audit Report 2018/19

Aneurin Bevan University Health Board

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Audit and Assurance Services

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Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating
Appendix C	Responsibility Statement

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Committee	Audit Committee Public Partnerships and Well-being Committee

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1. Introduction and Background

The review of the Well-being of Future Generations (Wales) Act 2015 ('the Act') has been completed in line with the 2018/19 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board'). This review has sought to provide the Health Board with assurance that arrangements are in place and operating effectively to deliver the requirements of the Act. The relevant Executive lead for the assignment is the Executive Director of Public Health.

The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

The Act is unique to Wales attracting interest from countries across the world as it offers a huge opportunity to make a long-lasting, positive change to current and future generations.

To make sure we are all working towards the same purpose, the Act puts in place seven well-being goals. The Act makes clear that the listed public bodies must work to achieve all of the goals, not just one or two.

The Act defines Sustainable Development in Wales as: "The process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals." It sets out five ways of working needed for public bodies to achieve the seven well-being goals. This approach provides an opportunity for innovative thinking, reflecting the way we live our lives and what we expect of our public services.

2. Scope and Objectives

The objective of the review was to evaluate and determine the adequacy and effectiveness of the arrangements that the Health Board has in place to ensure that the Act is being taken into account in its major service development activities.

Any weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and controls improved to minimise future occurrence.

The internal audit sought to provide assurance over the following areas:

- the Act features prominently in the strategic planning and performance management activities of the Health Board;
- the Act is being taken into account in the Health Board's major investment and service development decisions;
- a programme is in place to embed the five ways of working;
- the well-being objectives of the Health Board are being actively pursued and performance is being monitored through the Health Board's governance processes; and
- robust arrangements are in place to prepare for public reporting of performance against the Health Board's well-being objectives with a particular focus on outcomes.

3. Associated Risks

The potential risks considered in the review were as follows:

- the Act is not a core part of the Health Board's strategic planning and performance management activities;
- the Act is not being appropriately taken into account in the major investment and service development decisions of the Health Board;
- the five ways of working are not being embedded into the activities of the Health Board;
- the well-being objectives of the Health Board will not be achieved; and
- the Health Board is unable to fulfil its obligations for reporting under the Act.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with implementation of the Well-being of Future Generations (Wales) Act 2015 is **Reasonable Assurance**.

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

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

5. Assurance Summary

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

Assurance Summary					
1	The Act features in strategic planning and performance activities.			✓	
2	The Act is taken into account in investment and service development.			✓	

Assurance Summary					
3	A programme is in place to embed the five ways of working.				✓
4	Well-being objectives are monitored.		✓		
5	Arrangements are in place for reporting on outcomes.			✓	

* 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 weaknesses in the system control/design for the implementation of the Act. This is highlighted in Appendix A as (D).

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for the implementation of the Act. These are highlighted in Appendix A as (O).

6. Summary of Audit Findings

The Health Board has made reasonable progress in preparing to meet its obligations under the Act. The Health Board's well-being objectives are detailed within its IMTP which is in line with the guidance issued that advises sustainable development should not be treated as an add-on; instead, it should be included within the Corporate Plan / Strategy. The objectives are due to be revisited in 2019, to ensure they remain fit for purpose.

The IMTP in 2018/19 – 2020/21 includes a summary of the approach to the Act, with examples of how the five ways of working are being applied throughout the Health Board. The draft IMTP 2019/20 – 2021/22 includes an Appendix detailing the well-being objectives and examples of activities that support the progress of these.

The Clinical Futures work ongoing within the Health Board includes the requirement that the design of clinical models is based on a number of principles, including prudent healthcare and sustainability, which link in with the requirements of the Act.

The Health Board has a Pre-Investment-Panel (PIP) in place to provide an objective analysis of the planning, workforce and financial information in business cases prior to their submission for consideration by Executive Board. There is a Business Case template in place, which was revised in August 2018 to include requirements in relation to the Act. There has been one business case approved by the Board since the template was introduced, which has considered the five ways of working prescribed by the Act in the proposal.

A Programme Board is in place with representatives from a cross section of the Health Board divisions and corporate functions, although attendance at this is generally poor (see finding 1). The Programme Board has oversight of the Embedding Programme, which is in place to embed the five ways of working across the Health Board. Divisions and functions are going through a self-assessment process and creating ambition narratives, which are shared at the Programme Board. At the time of reporting, all divisions/functions were working through the self-assessment process and it is planned that all divisions / functions will have completed this by March 2020.

The Health Board submitted a self-assessment to the Future Generations Commissioner for Wales in January 2019. The self-assessment recognises that there are still areas that require development, such as:

- embedding objectives into current planning and performance arrangements;
- embedding the Act into corporate processes such as risk management and corporate governance and corporate planning and performance; and
- reviewing the relationship and alignment between the various strategic drivers within the Health Board.

One **high priority** finding was identified that requires management action:

1) WBFGA Programme Board effectiveness

The main focus of the WBFGA Programme Board ('the Programme Board') has been on the embedding programme for the five ways of working throughout the Health Board. This is a key area and is fundamental to the Health Board's approach to meeting the requirements of the Act. This work is progressing well and the engagement with the Act throughout the Health Board continues to grow. The latest update on the embedding programme (January 2019) shows that 100% of divisions are engaged in the self-assessment process.

However, there are a number of areas where the Programme Board could be more effective.

After initial focus on producing the first set of well-being objectives, there has been limited discussion on the activities required to meet them or of progress in general.

In order to ensure that the objectives are appropriate and deliverable, these should be regular items on the agenda of the Programme Board in preparation for onward reporting through the Health Board's governance processes.

Attendance at the Programme Board continues to be poor, consistent with a previous internal audit recommendation as part of our 2017-18 internal audit of Public Health (Ref AB-1718-10) regarding the predecessor Steering Group.

We reviewed the minutes of the Programme Board from April 2018 to date, and there is still low attendance at the meeting from divisions and functions.

The following divisions /functions have attended one or no meetings between April 2018 and January 2019:

- Unscheduled Care
- Mental Health & Learning Disabilities
- Planning and Performance
- ABCi

An action was recorded at the November Programme Board meeting to follow up with the divisions not routinely attending the Programme Board to understand why, which remains outstanding and attendance does not appear to be improving.

Whilst there is limited attendance at the Programme Board, all divisions are engaging through the self-assessment process. However, there are many informative updates provided at the Programme Board which should be disseminated throughout divisions. These messages are only being received by a small number of committed individuals, primarily based in corporate functions. It is particularly important that there is greater representation as the understanding and approach to the Act is developing across the public sector in Wales and management in each division needs to understand the latest developments.

There has also been limited executive representation at the meeting during this time, we understand due to issues of scheduling. Each meeting should

be chaired by the Executive Lead in order to ensure that issues of non-attendance are taken forward with the Executive and rectified.

Two **medium priority** findings were identified that require management action:

1) Outcomes and actions

The well-being objectives that the Health Board have set are in their infancy and are by definition long term. There are inherently significant challenges for the Health Board and its partners to ensure that these objectives can be achieved because in many cases they require major transformation. The self-assessment provided to the Future Generations Commissioner for Wales in January 2019 demonstrates that work has started on referencing specific activities within the IMTP to the relevant well-being objectives.

Whilst this is a step in the right direction, the Health Board has not documented any time-frames or responsibility for implementation of activities to meet the well-being objectives. For example, for each well-being objective, outcomes and the actions required to reach those outcomes should be identified, with appropriate milestones / timescales captured or performance measures to ensure there is a clear plan in place to meet each objective.

2) Monitoring and reporting

Well-being objectives are reported annually through existing processes within the Health Board, namely the IMTP, the Public Partnerships and Well-being Committee, and the Health Board's Annual Report.

The Public Partnerships and Well-being Committee ('the Committee') has responsibility for oversight of the implementation of the Act. A detailed progress review, which provided examples of work ongoing within the Health Board and how these contribute to well-being objectives, was reported to the Committee in May 2018. However, there has been no further detailed update provided to the Committee since then. There has also not been any reporting on the Act to the Executive Team during this time.

The assessment to the Future Generations Commissioner in January was based on discussion between the Executive Director of Public Health, Public Health Lead and the Programme Manager, and built on the progress update provided to the Public Partnerships and Well-being Committee in May 2018.

Following a review of Programme Board papers and minutes, it is evident that there is continued monitoring of the embedding programme, and the steps that divisions / functions are taking, including a review of ambition

narratives. However, there has not been reporting to the Programme Board on specific progress against the well-being objectives. It is recognised that in order to monitor progress effectively, there needs to be further work to identify specific activities and outcomes, as stated in the finding above.

Detailed findings and recommendations are in Appendix A.

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	-	3

Finding 1: Programme Board effectiveness (O)**Risk**

There is a Well-being of Future Generations Act Programme Board in place, which meets regularly. A terms of reference for the Board includes the following responsibilities:

- To oversee the quarterly/annual reporting of progress/steps taken towards achieving the well-being objectives and the activities that demonstrate the five ways of working – (Note that individual Leads will take responsibility for this within their Division).
- To provide quarterly/annual Progress reports to the Public Partnerships and Well Being Committee.

The discussions at the Programme Board focus on divisions and functions, and the progress with the embedding programme. Whilst this is a key area to ensure the Act is embedded within the Health Board, there has been little discussion on the activities required to meet the objectives, and the objectives themselves. In order to ensure that the objectives are appropriate and deliverable, these should be regular items on the agenda.

As part of a Public Health internal audit in 2017/18 (Ref AB-1718-10), it was reported that attendance at the Board was poor. The management action focused on ensuring that there was adequate programme management resource to drive the embedding programme as well as re-enforcing the importance of engagement.

Key messages at the Programme Board are not fed back to divisions and functions, affecting the implementation of the embedding programme across the Health Board.

Action Plan

The latest update on the embedding programme (January 2019) shows that 100% of divisions are engaged in the self-assessment process.

We reviewed the minutes of the Board meetings from April 2018 to January 2019 to assess whether attendance had improved. The table below gives an overview of attendance, with more detail provided for each meeting below.

	Apr-18	Jun-18	Jul-18	Sep-18	Nov-18	Jan 19
Number of divisions/ functions represented (out of 18)	7	9	6	6	8	4
Percentage	39%	50%	33%	33%	44%	22%

The following divisions /functions have attended one or no meetings since April 2018:

- Unscheduled Care
- Mental Health & Learning Disabilities
- Planning and Performance
- ABCi

There has also been limited executive representation at the meeting during this time.

Whilst the embedding programme is progressing well and there is evidence of engagement in all divisions, it is clear from the above that low attendance at the Programme Board is still an issue that requires attention.

Action Plan

Recommendation 1	Priority level
1) The Programme Board should include a review of the objectives and the progress against them as part of its agenda, to ensure objectives are fit for purpose and the activities required to meet them are identified and monitored. 2) Each Programme Board should be chaired by the Executive Lead in order to provide leadership, monitor effectiveness and highlight the importance of attendance. 3) Poor attendance at the Programme Board should be taken forward by the Executive Lead in order to ensure that it is rectified.	High
Management Response 1	Responsible Officer/ Deadline
Agreed 1. The review of the Wellbeing Objectives will be undertaken in conjunction with a broader review of where these objectives sit in the context of other Organisational priorities and ambitions. A landscape review/mapping of these various aspects will need to be undertaken in conjunction with the ABUHB Planning Team to inform the review of Well-being Objectives as part of the IMTP process. The Programme board will include a review of progress against objectives as part of its agenda.	Director of Public Health & Strategic Partnerships December 2019

Action Plan

2. Programme Board meetings will be moved from a monthly to a quarterly basis and will be chaired by the Executive Director of Public Health and Strategic Partnerships. This will be supported by sub-Board meetings.	Eryl Powell Consultant in Public Health April 2019
3. The Executive Director of Public Health and Strategic Partnerships will provide WbFGA update reports to the Executive Team, which would include attendance at Programme Board.	Director of Public Health & Strategic Partnerships November 2019

Action Plan

Finding 2: Outcomes and actions (D)

The self-assessment to the Future Generations Commissioner for Wales in January 2019 demonstrates that work has started on referencing specific activities within the IMTP to the relevant well-being objectives.

The Health Board has not documented any time-frames or responsibility for implementation of activities to meet the well-being objectives and there are no performance metrics in place.

Risk

The Health Board is unable to effectively monitor progress against each objective.

Recommendation 2

- 1) Outcomes for the well-being objectives should be identified, with milestones and time frames / responsibilities documented and monitored, together with performance metrics.
- 2) The Programme Board should ensure performance management of the well-being objectives is included in divisional reporting processes in order to ensure there is no duplication of effort when assessing progress against the well-being objectives and that there is alignment with other objectives of the Health Board to support the IMTP. Progress should be monitored by the Programme Board.

Priority level

Medium

Action Plan

Management Response 2	Responsible Officer/ Deadline
Agreed 1) The well-being objectives will be embedded into ABUHB planning and performance mechanisms, linked to the IMTP. In doing so, outcomes, milestones, responsibilities and performance metrics will be identified for each objective. 2) The Programme Board will work with the Planning and Performance Teams to ensure that the performance management of the well-being objectives is embedded with the divisional reporting processes and that there is alignment with other objectives of the Health Board to support the IMTP.	Director of Public Health & Strategic Partnerships September 2019 Director of Public Health & Strategic Partnerships September 2019

Action Plan

Finding 3: Monitoring and reporting (O)**Risk**

The IMTP 2018/19-2020/21 states responsibility for oversight of the Act sits with:

- Public Partnerships and Wellbeing Committee, which has responsibility for oversight of the implementation of the Act
- Programme Board (formerly the Steering group), which has a responsibility to focus on the agenda and system change required, and ongoing scrutiny of progress.

The Public Partnerships and Well-being Committee was provided with an update on the progress that the Health Board was making towards its ten well-being objectives, and also progress on the Health Board's WBFGA Embedding Programme. There has been no further detailed update to the Board since May. There has also not been any reporting on the Act to the Executive Team during this time.

The Programme Board terms of reference includes the following responsibilities:

- To oversee the quarterly/annual reporting of progress/steps taken towards achieving the well-being objectives and the activities that demonstrate the five ways of working – (Note that individual Leads will take responsibility for this within their Division).
- To provide quarterly/annual progress reports to the Public Partnerships and Well Being Committee

A review of the papers and minutes of the programme board demonstrates regular updates and discussions of the Embedding Programme, including updates from divisions / functions on ambition narratives. However, there is no overall monitoring of

Progress against well-being objectives is not monitored and reported regularly.

Action Plan

the progress being made against the well-being objectives at the board (i.e. the specific activities and milestones that are required in order to measure progress against the Objectives).

Recommendation 3**Priority level**

1) As per the Programme Board Terms of Reference, there should be regular reporting of progress at the Programme Board and to the Public Partnerships and Well-being Committee. This reporting should focus on the outcomes required to meet the objectives and the progress against specific actions.

2) The WBFGA programme Board Terms of Reference will be updated to include the frequency and format of reporting to the Public Partnerships and Well-being Committee. The format/structure of the WBFGA reporting to the PP&WB Committee will be informed by the work proposed in the Management Responses to recommendation 2.

3) The reporting requirements to the Executive Team should be clarified.

Medium

Action Plan

Management Response 3	Responsible Officer/ Deadline
Agreed 1.Regular reports on the progress made against the Well-being objectives will be provided to the Public Partnerships and Well-being Committee. 2. The WbFGA Programme Board Terms of Reference will be updated to include the frequency of reporting to the Public Partnerships and Well-being Committee. 3. The WbFGA Programme Board Terms of Reference will be updated to clarify the reporting arrangements to the Executive Team.	Director of Public Health & Strategic Partnerships In line with the updated terms of reference Director of Public Health & Strategic Partnerships April 2019 Director of Public Health & Strategic Partnerships April 2019

Audit Assurance Ratings



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



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



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



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

Prioritisation of Recommendations

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

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

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

Confidentiality

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NHS Wales Audit & Assurance Services

Clinical Futures - Progress against July OGC Gateway Review Action Plan

Final Internal Audit Report 2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix C	Responsibility Statement

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Committee	Audit Committee

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1. Introduction and Background

The review of Clinical Futures – Progress Against July OGC Gateway Review Action Plan was completed in line with the 2018/19 Internal Audit Plan.

Clinical Futures is the key strategic direction within Aneurin Bevan University Health Board (the 'Health Board'). It is the Health Board's plan for a sustainable health care system across the Gwent area.

In summary, it seeks to:

- deliver most care close to home;
- create a network of local hospitals to provide routine diagnostic and treatment services; and
- centralise specialist and critical care services, within the Grange University Hospital.

Within the transformation programme and by the end of December 2018, a complete refresh of the 54 (subsequently revised to 47) clinical models (e.g. neurology, critical care and ENT) within the Health Board had taken place. Each model was formally reviewed and challenged as part of a structured challenge and support process. Our first phase of Clinical Futures audit work focused on this process and was reported separately to this audit.

This audit focused upon the progress made by the Health Board against the action plan produced in response to the OGC Gateway Review (the 'Review') undertaken by the Welsh Government and reported to the Health Board in July 2018.

The overall rating of the Review was an amber delivery confidence assessment, defined as 'Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun.'

The Review identified 11 key areas for improvement, with further action required by the Health Board. We tested the recommendations in line with the audit objectives, where possible. We have highlighted which recommendations we examined as part of this audit.

This is summarised below:

Recommendation	Action Owner(s)
1. Integrate and raise the profile of Level 1 / Out of Hospital Care activities within the programme.	Director of Public Health
2. Further develop clinical engagement including addressing key buy-in requirements.	Medical Director Director of Nursing Director of Therapies
3. Develop the Clinical Futures programme structure for the delivery phase, including defining key projects and the extent to which change will be driven through the programme.	Programme Lead
4. Enhance leadership capacity and identify specific SROs for the two sub-programmes and other projects such as future GUH services, eLGHS and out of hospital services.	Programme SRO
5. Develop and communicate non-financial benefits measurement and management including clinical outcomes and patient experience at a service and programme level.	Programme Manager
6. Develop and communicate financial benefits and finance systems processes for resource allocation to support new models and guarantee financial sustainability of the programme.	Finance Director
7. Complete and share widely the proposed new acute medical model.	No assigned action owner
8. Accelerate the work on surgical and orthopaedic service models.	No assigned action owner

9. Further develop the new eLGH models for the Nevill Hall and Royal Gwent sites.	Director of Planning
10. Review timing and content of commissioning options for GUH.	Programme Lead with Director of Operations
11. Develop the high-level roadmap for the next 3 years setting out clear delivery milestones across key aspects of the programme.	Programme Manager

Key	Description
	Tested in detail, in line with audit objectives
	Partially tested, in line with audit objectives
	Not tested, due to implementation date not yet passed

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of the controls in operation, for ensuring that the prompt attention recommended by the Review is being given by management and sufficient progress against the action plan is being achieved.

Any weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The review provided an overall assessment of progress and looked in detail at the more significant areas of clinical engagement and financial and non-financial benefits realisation.

The specific objectives reviewed were:

- to ensure that the Action Plan (the Health Board's expected actions to address the recommendations raised within the Gateway Review) will address the findings of the Review;
- to ensure that sufficient progress has been made against the action plan;

- to ensure that progress is reported accurately and on a timely basis through appropriate governance mechanisms;
- to ensure that clinical engagement has improved as a result of management action;
- to ensure that finance system processes are developed to support new clinical models and guarantee financial sustainability of the programme; and
- to ensure that non-financial and financial benefits are being developed and where appropriate communicated.

3. Associated Risks

The potential risks considered in the review were as follows:

- insufficient progress is being made to implement the action plan in order to ensure that the recommendations of the Review are implemented;
- service delivery issues caused by delays in the delivery of Clinical Futures;
- the local population does not receive the full benefits of the Clinical Futures programme; and
- reputational damage for the organisation.

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 Clinical Futures – Progress against July OGC Gateway Review Action Plan is **Reasonable Assurance**.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Action plan			✓	
2	Action plan progress			✓	
3	Governance and reporting process		✓		
4	Clinical engagement			✓	
5	Finance system and financial sustainability			✓	
6	Non-financial and financial benefits			✓	

* 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 weaknesses in the system control/design for Clinical Futures – Progress against July OGC Gateway Review Action Plan. These are highlighted in Appendix A as (D).

Operation of System/Controls

The findings from the review have highlighted no issues that are classified as a weakness in the operation of the designed system/control for Clinical Futures – Progress against July OGC Gateway Review Action Plan.

6. Summary of Audit Findings

The Health Board accepted the recommendations raised as part of the Gateway Review and developed an Action Plan accordingly. In some cases, actions to be completed were already underway by the Health Board. For example, the financial sustainability of the Clinical Futures project has been incorporated into the three year plan of the established IMTP process.

However, whilst progress has been documented against the majority of the recommendations sampled, we were unable to determine what actions were still outstanding or the progress made in respect of recommendation one (integration of Level One and other out of hospital care activities, including the raising of the overall profile). It is also unclear how it will integrate with the rest of the Clinical Futures programme. We have raised a recommendation regarding improvement required to the accountabilities and responsibilities of members of the Clinical Futures Delivery Board and other applicable staff.

Finally, we have recommended an improved definition of quoracy requirements for the Clinical Futures Delivery Board.

Detailed Findings

For each audit objective, further analysis has been provided below within two parts. The first part focuses on audit objectives one to three and the second part, audit objectives four to six.

Action Plan and Progress

An action plan with appropriate executive action owners was presented to the Clinical Futures Delivery Board during November 2018.

We examined whether the actions sampled would address the original recommendations and we believe that they will.

However, in one case there was no implementation date provided or details of expected completion of the actions. Action one, 'Integrate and raise the profile of Level 1 / Out of Hospital Care activities within the programme' has no delivery dates detailed, but yet has significant actions listed for delivery. There are some instances where actions for other recommendations are yet to commence and some partially underway.

However, these are being tracked via the Programme Risk Log, workstreams or are yet scheduled to commence.

Whilst at an individual level, action owners have progressed with implementing recommendations, accountability for the Action Plan was absent.

Executive directors and senior managers have responsibility for implementing the actions. However, there is no escalation process to the Clinical Futures Delivery Board for non-delivery or process for setting out expected responsibilities of each of the members. This has been raised as a recommendation within Appendix A.

Finally, we reviewed the terms of reference for the Clinical Futures Delivery Board (the 'Board'). In particular, we tested the quoracy requirements of the Board and found that these were not clearly stipulated. Whilst most meetings examined are well attended, the meeting during December 2018 only had seven of 12 members and two deputies present. It was not possible to determine if the meeting was quorate for decision making purposes. This has been raised as a recommendation within Appendix A.

Actions for Delivery on the Plan

We focussed on three recommendations raised as part of the Gateway Review, including:

- clinical engagement;
- finance system processes; and
- non-financial and financial benefits.

In all cases, we found that sufficient work had been completed on implementing the agreed action(s). Further detail is supplied below of the evidence identified.

Action	Status
Clinical Engagement	Since the Gateway Review a regular event is held with key clinical staff from throughout the Health Board, who are personally invited by the Chief Executive. In addition, the number of clinical staff directly involved within the Clinical Futures project has increased, with accountability delegated to senior clinical staff. This has led to the formation of a leadership cohort, which target clinical areas and pathways of care and act as system leads. The leadership cohort is led by a nominated Clinical Futures Lead.

		To support the above initiatives, clinical staff have been involved with a series of 'lock-ins'. These sessions were facilitated externally, to serve as a method of resolving clinical issues and undertaking professional discussion. The sessions entitled, Senior Clinical Leadership events help to address clinical concerns as they arise.
Finance Processes	System	The Gateway Report raised several key themes within recommendation 6, including: • to ensure that there is a clear financial plan for achieving a balanced position, particularly with the addition of a new hospital site; • to ensure that there is a system for approving changes to service models, costs and resource allocation (for example, staff and bed numbers); and • the approach to managing financial benefits, including supporting the development of new, cost effective service models. The Clinical Futures programme has moved into the three year IMTP process, which sets out the requirement for a sustainable and clear financial position. To achieve this, the balanced position relies upon financial savings and cost avoidance of c. £15m per annum over the next three years. Within the audit report, Clinical Futures – Service Redesign, we raised a high priority finding on the financial implications within the divisions to realise the savings required to fund the additional costs brought about by Clinical Futures. The sustainability of the project requires this level of savings to be achieved each year. Alongside this, the service re-design process has moved onto the next stage of assessing each clinical model. This operates as the key control environment for approving cost variances, savings, staff numbers, bed reductions, capital requirements and variances to the First Business Case. Each service model is scrutinised

	individually and assessed as a whole within the Health Board to allocate resources accordingly, with the involvement of the Clinical Futures Delivery Board. This process was still ongoing at the time of the audit.
Non-financial and financial benefits	The non-financial benefits of the Clinical Futures project have been established, which were presented to the Board during December 2018. Examples include reduced referrals into secondary care, reduced accident and emergency waiting times, reduced infection rates, reduced length of stay for patients and higher staff retention rates. The financial benefits are integrated with the IMTP process referred to above and may be as a result of the non-financial benefits. For example, reducing the length of stay for patients increases the through flow of patients and reduces the number of beds required, thus maximising the efficiency of the total number of nursing staff required on a site.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	-	2	-	2

Action Plan

Finding 1: Accountability and Responsibilities (D)

There is no guidance provided to Clinical Futures Delivery Board members regarding their expected engagement in the Clinical Futures Programme either as workstream sponsor, action owner or as a provider of subject matter expertise. This would be utilised to ensure each member is held accountable for relevant deliverables.

For example, recommendation one from the Gateway Review, 'Integrate and raise the profile of Level 1 / Out of Hospital Care activities within the programme', has made some progress, but there was no plan of the deliverables yet to be completed or indeed sufficient detail of the timeline for delivery / completion. Therefore, we have not been able to determine if the Clinical Futures Delivery Board has been monitoring the progress made by the action owner(s) and held them to account accordingly, where insufficient progress has been made.

Risk

Clinical Futures Delivery Board Members are not engaged in the Clinical Futures Programme at a sufficient level to facilitate the progress required, resulting in delay/non delivery of elements of the Programme.

The lack of required support/input is not identified in a timely manner and rectified promptly, resulting in delay/non delivery of elements of the Programme.

Action Plan

Recommendation 1	Priority level
All Clinical Futures Delivery Board members should be provided with guidance on the level of engagement required as the Programme moves from planning to transformation, particularly regarding the time involvement required and examples of support to be provided. All staff responsible for the delivery of actions to progress the Clinical Futures project, should be held to account by the Clinical Futures Delivery Board for non-delivery / insufficient progress made.	Medium
Management Response 1	Responsible Officer/ Deadline
The findings and recommendations from the 2018 Programme Gateway 0 review formulated an action plan that was subsequently agreed by the Executive Delivery Board in November 2018. The recommendations have been tracked utilising current programme control mechanisms. This has included the use of programme risk/issue logs as well as through routine monitoring and control forums and dashboards, such as Workstream Boards and standardised Highlight Reporting. The programme team are content that there is full visibility and understanding of the progression of key actions. In the Summer of 2018 it was agreed by the programme team to utilise an internal audit review to conduct a follow up on the Gateway review. As this has now taken place there will be a bespoke agenda item at the Delivery Board once the review is finalised. This	Assistant Programme Director - July/Aug 2019 (as soon as this review is finalised).

Action Plan

will focus on the progress made since July 2018 and the areas which require additional focus. The findings highlighted in this review will also be discussed.

It is agreed that Delivery Board members should be provided with guidance on the level of engagement required as the Programme moves from planning to transformation, particularly regarding the time involvement required and examples of support to be provided. This will be made much more explicit and will tie in with the second finding and the update of the terms of reference for the Delivery Board. The Programme team will work with the Senior Responsible Owner to ensure guidance is appropriate and communicated at the Delivery Board.

Action Plan

Finding 2: Terms of Reference (D)

The Clinical Futures Delivery Board has approved terms of reference that lists the members who should attend, but there is no clarification over what constitutes a quorum.

A review of the minutes of the Clinical Futures Delivery Board meetings held in 2018 indicated that most meetings were well attended. However, in December only seven of the 12 listed members were present, with an additional two deputies also attending.

Risk

The absence of any one listed member could impact the value of monitoring and decisions made by the Board.

Recommendation 2

1. The Clinical Futures Programme SRO, in conjunction with the Clinical Futures Delivery Board, should define what constitutes a quorate meeting.
2. Deputies should be identified, to attend the meeting in the absence of the members.
3. There should be a standing instruction to postpone a meeting and / or decisions if the Clinical Futures Delivery Board is not quorate.

Priority level

Medium

Action Plan

Management Response 2**Responsible Officer/
Deadline**

Agree to all recommendations. The programme team will work with the Senior Responsible Owner and Board Secretary to ensure the terms of reference are updated to reflect what constitutes a quorate meeting.

Assistant Programme Director, July/Aug 2019 (as soon as this review is finalised).

Audit Assurance Ratings



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



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



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



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

Prioritisation of Recommendations

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

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

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

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

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Cyber Security

Final Internal Audit Report 2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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

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Auditor/s:	James Quance, Head of Internal Audit Martyn Lewis, IT Audit Manager

Executive sign off	Nicola Prygodzicz, Director of Planning and Performance

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Committee	Audit Committee Information Governance 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 Aneurin Bevan 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 Cyber Security at Aneurin Bevan University Health Board (the Health Board) was completed in line with the 2018/19 Internal Audit Plan.

Cyber-security is the protection of information assets by addressing threats to information processed, stored, and transported by internetworked information systems. It is the protection of computer systems from the theft or damage to their hardware, software or information, as well as from disruption or misdirection of the services they provide.

Cyber-security includes controlling physical access to the hardware, as well as protecting against harm that may come from malware, viruses and unauthorised or inappropriate software.

A strong cyber awareness culture is one of the best defences against cyber-attacks. Regulations such as the Network and Information Security (NIS) Directive and the General Data Protection Regulation (GDPR) have increased the burden on organisations to ensure they have effective cyber-security strategies and culture in place, in addition to robust controls and policies, to prevent and remediate attacks.

In October 2017, Stratia Consulting was commissioned by Velindre NHS Trust, on behalf of NHS Wales, to carry out external cyber security assessments for its organisations.

For each organisation, a cyber-security assessment report and security improvement plan (SIP) was produced. Additionally, an overarching security assessment and SIP for NHS Wales as a whole was produced.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of internal controls in operation. Weaknesses were then brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The internal audit sought to provide reasonable assurance over the following areas:

- Governance: An appropriate governance and management structure is in place to ensure cyber-security.
- External review awareness: Information contained within the Health Boards cyber-security assessment report and SIP has been discussed and monitored by an appropriate group or committee.

- Implementing actions: any actions contained within the previous cyber-security report and SIP have been completed within the agreed timeframes.

3. Associated Risks

The risks considered in the review are as follows:

- poor or non-existent stewardship in relation to cyber-security;
- failure to comply with regulations such as the GDPR and NISD;
- loss of data and inappropriate access to information from entities internal to the organisation;
- risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities; and
- inappropriate / unauthorised software installed / increased risk of infection from introduction of malware.

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 Cyber Security is **Reasonable** Assurance.

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

It is worth noting that this review of cyber-security arrangements within the Health Board focused on the governance and visibility of the Stratia

assessment report and SIP. We evaluated evidence to support the organisation's current positional statement on its action plan developed from the SIP; as such, our follow-up work was limited to the areas contained in the original Stratia report.

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.

There is a good framework in place for protecting the Health Board from cyber security risks. Cyber security risks are recorded within the Informatics risk register and issues are discussed at operational group and committee level. These topics are more commonly raised when issues occur. However, and there is no standard monitoring process, or KPI monitoring for cyber security.

Increased resource has been provided to Informatics in order to create a cyber security team. However, recruitment has been problematic with staff being recently appointed. The previous lack of defined cyber security resource has mean that although the Health Board has security tools, it hasn't been able to maximise the use of these, and there has been no active monitoring of the cyber security status of the Health Board.

The Stratia report stated that, for the most part, the security controls around the five technical control themes examined by the Cyber Essentials scheme were found to be adequate and well implemented. The report included actions for improvement and progress has been made on implementing these, including improving the patching process and the identification of old software with an associated plan in place to update. Other controls in place to protect the Health Board include firewalls, network segmentation and anti-virus.

5. Assurance Summary

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

Assurance Summary					
1	Governance			✓	
2	External review awareness			✓	

Assurance Summary					
3	Implementing actions			✓	

* 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 a weakness in the system control/design for cyber security.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system/control for cyber security.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Three **Medium priority** issues were identified which require management's attention and provide scope for improvements to be made. These concerned:

1) Reporting Process

There is currently no reporting process for cyber security or KPI reporting. The status of patching is known. However, there is no regular review of incidents / event logs / vulnerabilities which feeds into an active KPI process.

2) Active Security

Although the Health Board has security tools in place, it has not maximised the benefits of these:

- Nessus (a vulnerability scanner) has only been run on an ad hoc basis and not as part of any structured process;
- Firepower (a firewall with intrusion detection capability) and Solar Winds are running but in a reactive manner and are not actively monitored; and

- currently there is no active Intrusion Detection System (IDS) operating within the Health Board.

In addition, the organisation does not have the ability to efficiently deal with a cyber incident as it has not yet enacted the national Security Incident and Event Management (SIEM) product, and there is no incident response plan in place.

Without these products being used, the organisation is not fully able to quantify and fix its vulnerabilities, and there is no intrusion detection running which would make it difficult to identify and prevent a malicious actor gaining access to the network.

3) Staff Awareness

Although there is an Information Security Policy, together with other related policies, there is no structured mechanism for providing regular updates / reminders to staff on good practice related to cyber security. Studies have shown that in general, employee actions / mistakes have led to approximately 50% of breaches. As such, this leads to an increased risk to the Health Board.

Good Practice

We identified the following areas of good practice:

- cyber security is monitored at a national level by the (Infrastructure Management Board (IMB) with representation from the Health Board attending these meetings;
- cyber security is overseen by a formal Board sub-committee and is also included in discussions within operational groups;
- an executive briefing on cyber security has been requested by the non-officer member responsible;
- the overall risks regarding cyber security, both for IT systems and for medical devices are tracked onto the Informatics risk register;
- there is an Information Security Policy, and other associated policies are in place;
- funding for additional resource has been provided to create a cyber security team within the Health Board;

- the cyber security team is set up with defined roles and fits within the Informatics structure;
- the patching process and compliance has improved with an increasing use of automated patching for servers (approx. 75% automated);
- patching of desktops shows good compliance;
- work is ongoing to remove old / outdated versions of software, with a Windows 10 rollout programme underway;
- there is a plan in place to update the older versions of SQL Server used within the Health Board;
- the Health Board has security tools such as Nessus; Cisco Firepower and Solar Winds;
- the network is segmented, using switches / firewalls into different VLANs;
- the network uses access control based on supplier id; and
- a record is kept of IT Assets.

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	0	3	0	3

Action Plan

Finding 1 Reporting Process (Operational)	Risk
There is currently no reporting process for cyber security or KPI reporting. The status of patching is known. However, there is no regular review of incidents / event logs / vulnerabilities which feeds into an active KPI process. We note that the cyber security team is new in post and that this will be part of the role.	Poor or non-existent stewardship in relation to cyber-security.
Recommendation 1	Priority level
The cyber security team should develop an active monitoring process which feeds into KPI reporting.	Medium
Management Response 1	Responsible Officer/ Deadline
Accepted. ABUHB are about to take delivery of LogRhythm as the NHS Wales' SIEM system. LogRhythm is considered amongst the best in class Security Incident and Event Monitoring systems (SIEMs). This will provide us with many KPIs including traffic levels, selected failures such as repeated logins, and accesses to resources. Implementation of the SIEM product has begun and is expected to be completed by the end of Q2.	Head of ICT September 2019

Action Plan

Finding 2 Active Security (Operational)	Risk
Although the Health Board has security tools in place, it has not maximised the benefits of these: • Nessus (a vulnerability scanner) has only been run on an ad hoc basis and not as part of any structured process; • Firepower (a firewall with intrusion detection capability) and Solar Winds are running but in a reactive manner and are not actively monitored; and • currently there is no active IDS operating within the Health Board In addition, the organisation does not have the ability to efficiently deal with a cyber incident as it has not yet enacted the national Security Incident and Event Management (SIEM) product, and the incident response plan has not been updated. Without these products being used, the organisation is not fully able to quantify and fix its vulnerabilities, and there is no intrusion detection running which would make it difficult to identify and prevent a malicious actor gaining access to the network. We note that developing these processes will be part of the role of the cyber security team.	Risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities.

Action Plan

Recommendation 2	Priority level
The cyber security team should develop the processes for actively monitoring the security status within the Health Board, together with an incident response plan.	Medium
Management Response 2	Responsible Officer/ Deadline
Accepted. The Cyber Security Team is actively working on a response plan, developing on lessons learned from previous events such as NATO and the Ryder Cup, as well as templates provided via the Welsh Cyber Assurance Programme (WCAP) with our Operational and Security Service Management Board (OSSMB) partners. The Cyber Response plan will be escalated for approval at Health Informatics Delivery Group in Q1. As detailed in response 1, ABUHB is in the early stages of implementing the national SIEM solution and expects to have an operational service during Q2 2019-20.	Head of ICT September 2019

Action Plan

Finding 3 Staff Awareness (Operational)	Risk
Although there is an Information Security Policy, together with other related policies, there is no structured mechanism for providing regular updates / reminders to staff on good practice related to cyber security. Studies have shown that in general, employee actions / mistakes have led to approximately 50% of breaches. As such, this leads to an increased risk to the Health Board.	Loss of data and inappropriate access to information from entities internal to the organisation.
Recommendation 3	Priority level
Regular cyber security "bulletins" should be published via the intranet, with reminders of good practice.	Medium
Management Response 3	Responsible Officer/ Deadline
Accepted. The Cyber Security Team recognises the importance of regular updates and user engagement. The team is currently forming and developing a strategy to improve user awareness and competence via multiple digital channels, including the Intranet as well as the development of e-learning packages. The strategy is currently in development and the team are planning on taking this through appropriate approval channels during Q2 2019-20.	Head of ICT September 2019

Audit Assurance Ratings



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



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



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



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

Prioritisation of Recommendations

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

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

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

Confidentiality

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

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

Aneurin Bevan University Health Board

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NHS Wales Audit & Assurance Services

General Data Protection Regulations (GDPR)

Final Internal Audit Report 2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership Audit and Assurance Service

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Appendix A	Management Action Plan
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Committee	Audit Committee Information Governance Committee

ACKNOWLEDGEMENT

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1. Introduction and Background

The review of the arrangements in place for ensuring compliance with the General Data Protection Regulations (GDPR) at Aneurin Bevan University Health Board (the Health Board) was completed in line with the 2018/19 Internal Audit Plan.

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), with the government intending to incorporate GDPR into UK law after Brexit.

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 global turnover, whichever is higher.

In October 2017, Stratia Consulting was commissioned by Velindre NHS Trust on behalf of NHS Wales, to carry out external cyber security assessments for its organisations. The review included an assessment against the GDPR requirements included in the IASME standard (an Information Assurance Standard). The IASME Governance standard is based on international best practice, is risk-based and includes aspects such as physical security, staff awareness, and data backup. The IASME governance self-assessment includes the Cyber Essentials assessment within it as well as an assessment against the requirements of the GDPR.

For each organisation, a cyber-security assessment report and security improvement plan (SIP) was produced. Additionally, an overarching security assessment and SIP for NHS Wales as a whole was produced.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of internal controls in operation. Weaknesses were then brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

Over the last 12 months there has been a great deal of work carried out at a senior level within the organisation to prepare for the GDPR. This review seeks to establish how these arrangements have been embedded within the organisation and seeks to provide assurance that the arrangements at the operational level are extant and thus that the organisation is enabling compliance with GDPR in relation to:

- 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 to enable compliance with the GDPR; and
- a register of information assets is maintained that identifies the source, responsibility and sharing arrangements for each asset.

3. Associated Risks

The risks considered in the review are as follows:

- insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation;
- controls not operating resulting in non-compliance with GDPR; and
- 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 **Reasonable Assurance**.

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

The 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.

We found that the Health Board has completed a significant amount of work to achieve compliance with the GDPR/ the Data Protection Act 2018.

Guidance documentation, training and support has been provided across the divisions by the Information Governance Unit. An implementation plan based on ICO guidance has been created, and although no strict targets were set, the Health Board is making good progress in working through this towards full compliance, with the majority of items having been closed off.

The Health Board has a centrally held Information Asset Register (IAR) in place, and has developed a process for ensuring the divisions submit data for inclusion in the central register in a standardised and consistent approach.

It was noted that the IAR was a work in progress at the time of audit and that some updating of processes and procedures, including the Data Protection policy and supporting procedures and Data Breach reporting processes were required as a result of the changes to requirements arising from GDPR, however the Health Board awaiting national guidance for this.

The audit did not identify any findings that we would consider to be high priority during our audit fieldwork.

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	IARs			✓	

** 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 a weakness in the system control/design for GDPR.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses 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.

Three **Medium priority** issues were identified which require management's attention and provide scope for improvements to be made. These concerned:

1) Record of Processing Activity

It was found during the audit that, whilst work was ongoing, there was not yet a complete a record of processing activity in place that includes information asset registers and data flows for all of the services. The Information Governance Unit is compiling this information through the compilation of Information Asset registers, backed up and managed via the use of divisional information governance groups. We recognise that completion of the record of processing activity is a significant undertaking, and it was found that a large amount of work has been done to compile the data. Management estimate that work on the asset registers and data flows is approximately 75% complete. Once finished this work will be used as the basis for a complete record of processing activity.

2) Data Protection Process Documentation

The current Information Governance policies and procedures were found to require review and updating to reflect changes required as a result of new GDPR requirements.

3) Personal Data Breaches

There is a need to further develop the documented process defining the procedures to be followed when assessing, categorising and reporting on data breaches to ensure that the Health Board can comply with the enhanced reporting requirements.

Two **Low priority** issues were identified which require management's attention and provide scope for improvements to be made. These concerned:

4) Data Protection Officer

There is no deputy in currently in place to handle data protection responsibilities during the absence of the DPO.

5) Subject Access Requests

There are currently two teams involved in the processing of SARs. It may be beneficial that these be combined and that a single process be put in place to help ensure that SARs are dealt with in a standardised and efficient manner.

Good Practice

We identified the following areas of good practice:

- there is an Information Governance Committee in place to provide assurance to the board around GDPR compliance;
- there is good central management and ongoing activity in place to ensure the Health Board complies with GDPR requirements;
- an e-learning package incorporating GDPR requirements has been developed and implemented;
- compliance with the required information governance module in e-learning is monitored and regularly reported on;
- the Information Governance Unit has developed guidance documents and undertaken appropriate awareness raising actions in preparation for GDPR;
- a GDPR implementation plan based on the ICO's 12 Step Plan for GDPR was created and used in monitoring the progress of GDPR activities;
- divisional IG groups (IGDGs) and local IG stewards have been established to deal with the IG agenda;
- divisional IG meetings were reviewed and found to be supporting the implementation of GDPR controls in several ways including the monitoring of training and managing the process of completing the local Information Asset Registers;

- relevant actions from the Stratia report were incorporated into the Board's work plan for GDPR and good progress is being made on completing these actions;
- posters from the information governance unit have been developed and distributed across the divisions;
- there is a centrally held IAR in place for GDPR with a process for all departments to submit their asset information;
- the IG unit has developed a process for ensuring the divisions submit data for inclusion in the central register in a standardised and consistent format;
- the data protection section of the intranet has been updated with extensive GDPR related guidance and factsheets;

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	0	3	2	5

Action Plan

Finding 1 Data Protection Process Documentation	Risk
A key requirement of GDPR is that "each controller and, where applicable, the controller's representative, shall maintain a record of processing activities under its responsibility". This record of processing activities must include significant information about all data processed by the Board, including data categories, the group of data subjects, the purpose of the processing and the data recipients. It was found during the audit that, whilst work was ongoing, there was not yet a complete a record of processing activity in place that includes information asset registers and data flows for all of the services. The Information Governance Unit is compiling this information through the compilation of Information Asset registers, backed up and managed via the use of divisional information governance groups. Management estimate that work on the asset registers and data flows is approximately 75% complete. Once finished this work will be used as the basis for a complete record of processing activity.	Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation.
Recommendation 1	Priority level
The record of processing activity should be completed and maintained.	Medium

Action Plan

Management Response 1	Responsible Officer/ Deadline
Accepted. The Health Board will review its needs regarding an Information Asset Register. The Information Asset Register was created using a Health Board-wide survey several years ago and was updated with a similar survey prior to GDPR. The IGDG's are important to maintain the information asset register and will be important in order to update and maintain it. Accordingly all IGDGs will be asked to ensure that the IAR for their area is complete. The current Information Asset Register is a simple spreadsheet for what is a complex process which needs to include a broad range of device assets across the Health Board, including medical devices, telephony (smartphones etc), digital devices (notebooks, ipads, laptops, desktop pc's, servers etc) in order to assign information and its flow to various devices and staff. The Health Board has recognised this and has accepted that this a long term commitment and considers that the fluidity of change within the flow of information means that flows already recorded may also change considerably over time. It is also difficult to measure the volume of flow processes and therefore, any target is an estimate of known processes.	Head of IG Sept 2019.

Action Plan

Finding 2 Data Protection Process Documentation	Risk
It was noted during the audit that management was aware of the need to review and update the Information Governance policies and procedures relating to Data Protection as a result of changes required as part of GDPR/ the Data Protection Act 2018. It is understood management was awaiting national guidance before updating documentation at the time of audit, however this has not been received.	Controls not operating resulting in non-compliance with GDPR.
Recommendation 2	Priority level
In the absence of the national guidance the Health Board should review and update the Data Protection Policies and Procedures to reflect changes required as per GDPR and the Data Protection Act 2018.	Medium
Management Response 2	Responsible Officer/ Deadline
Accepted. The Health Board will discuss the policy development timetable with the NHS Wales Information Governance Management Advisory Group (IGMAG) to determine which policies the Health Board will need to develop independently. These will then be developed and can then be proposed to IGMAG as a potential all-NHS Wales policy. The Health Board contributes to the IGMAG and the NHS Wales Health Records Management Advisory Group (HRecMAG) to review and update policies in order to provide a consistent policy framework across NHS Wales.	Head of IG Sep 2019

Action Plan

Finding 3 Data Breaches	Risk
Under GDPR requirements all organisations have a duty to report particular types of personal data breaches to the Welsh Assembly Government and the Information Commissioners Office (ICO) within 72 hours. A breach is defined as a <i>“breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure, or access to personal data”</i>. Although breaches are tracked and recorded it was noted during the audit there was a need to further develop the documented process defining the procedures to be followed when assessing, categorising and reporting on identified breaches to ensure that the Health Board complies with the enhanced requirements It is understood this was being developed at the time of audit.	Controls not operating resulting in non-compliance with GDPR.
Recommendation 3	Priority level
Complete documentation of breach reporting standard operating procedures.	Medium

Action Plan

Management Response 3	Responsible Officer/ Deadline
Completed. This was completed March 2019. The IGU has developed its own departmental standard operating policy (SOP) and guideline for breach reporting and consideration of reporting to the ICO and Welsh Govt. This was provided to the NHS Wales Information Governance Management Advisory Group (IGMAG) in March 2019 and is being considered as the national NHS Wales template.	Head of IG n/a - completed

Action Plan

Finding 4 Data Protection Officer	Risk
We found during the review that there is a nominated Data Protection Officer (DPO), as required by new GDPR regulations. DPOs are responsible for monitoring internal compliance with data protection obligations and act as contact point for data subjects and the supervisory authorities. However, it was noted that there is no official deputy currently in place to handle data protection responsibilities during the absence of DPO, representing a potential single point of failure which may delay processing of SARs and/ or any required data breach reporting given the size of the organisation and the number of records dealt with (over 2 million).	Controls not operating resulting in non-compliance with GDPR.
Recommendation 4	Priority level
Management should consider the appointment/ nomination of a deputy DPO.	Low
Management Response 4	Responsible Officer/ Deadline
Accepted. ABHUB will consider nominating a deputy DPO	DPO & Director Digital, Planning & Perf June 2019

Finding 5 2018 Subject Access Requests	Risk
Subject Access Requests are currently handled by two teams within the Health Board; Information Governance and Access to Health Records. Each has its own process and procedures for dealing with these requests. It was noted that requests have increased significantly since the introduction of GDPR due to increased awareness and the removal of the ability to charge for the requests. GDPR requirements have also meant a reduction in the timescales requests must be processed within, which now stand at 28 days rather than 40. As a result of this increase in requests combined with reduced processing time there was a fall in the compliance rate of SAR requests dealt with by Access to Health Records between March and November 2018. It would be beneficial for the two existing processes to be combined and that a single process be put in place to help ensure that SARs are dealt with in a standardised and efficient manner.	Controls not operating resulting in non-compliance with GDPR.
Recommendation 5	Priority level
Management should consider consolidating the processes in place for the handling SAR of requests.	Low

Management Response 5	Responsible Officer/ Deadline
Accepted. The Health Board will consider the way in which SAR's are managed and identify potential ways in which this can be accommodated, including SAR management consolidation. The Access to Health Records Department is currently part of the Health Records function and deals with the vast majority of SAR's for copies of patient records. A small number of SARS which are more complex, in depth and require a very sensitive appraisal are referred to the IGU. The process is the same and both departments liaise very closely with each other to fulfil the SAR requirements. Both departments are managed within the Informatics Directorate. There is also a third element where Workforce manages SAR's for staff records. The GDPR has changed the compliance rules whereby, SAR's must now be responded to within 28 days when previously it was 40 days. In addition, the cost has increased as the Health Board can no longer charge for the copy of the records. This incurred a loss of over £130k to the Access to Health Records Department. The department should be commended on achieving a 94% success rate (of responding within 28 days) especially with no commensurate increase in resource to accommodate the reduced response time and loss of a funding stream.	Head of IG June 2019

Audit Assurance Ratings



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Prioritisation of Recommendations

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

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High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
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NHS Wales Audit & Assurance Services

Clinical Futures – IT Work Stream

Final Internal Audit Report 2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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

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Auditor/s:	James Quance, Head of Internal Audit Martyn Lewis, IT Audit Manager

Executive sign off	Nicola Prygodzicz, Director of Planning and Performance

Distribution	Nicola Prygodzicz, Director of Planning and Performance; Mike Ogonovsky, Assistant Director - Informatics;

Committee	Audit Committee

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1. Introduction and Background

The review of Clinical Futures (IT Work Stream) at Aneurin Bevan University Health Board (the Health Board) was completed in line with the 2018/19 Internal Audit Plan.

Clinical Futures is the key strategic direction within the Health Board. It is the Health Board's plan for a sustainable health care system across the Gwent area.

In summary, it seeks to:

- deliver most care close to home;
- create a network of local hospitals to provide routine diagnostic and treatment services; and
- centralise specialist and critical care services, within the Grange University Hospital (GUH).

The IT Work Stream contains two strands which relate to the Grange University Hospital build, and to Informatics.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of internal controls in operation. Weaknesses were then brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The internal audit considers both the GUH and Informatics work streams and sought to provide reasonable assurance over the following areas:

- GUH work stream - to ensure that the appropriate technical specifications are developed to meet current and future needs, that the stakeholders are involved in defining their needs and that plans for implementation are reasonable, achievable and monitored.
- Informatics work stream - to ensure that services are engaged in redesigning IT systems requirements and that appropriate plans are in place to ensure implementation within timescales.
- Monitoring - to ensure an appropriate monitoring framework is in place for the IT work stream, both within clinical futures and the wider organisation and that appropriate risk management is in place.
- Resources - to ensure that appropriate funding is available to meet the technical requirements, that budgets and outturns are monitored; and appropriate staffing resource and knowledge is available to meet the demands of the IT work stream and revised clinical models.

3. Associated Risks

The risks considered in the review are as follows:

- insufficient resource available for the development and implementation of the IT work stream;
- key milestones are not met, resulting in delayed implementation of Clinical Futures; and
- insufficient engagement from key personnel within the Health Board, including clinicians.

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 Clinical Futures (IT Work stream) is **Reasonable** Assurance.

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

It should be noted that the scope of the assurance is limited to the IT work stream and not for the Clinical Futures Programme overall. The success of the IT work stream is contingent on management of the risks identified within this report but on risks to the wider Clinical Futures programme.

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.

Clinical Futures is a wide ranging and complex programme and this is reflected in the informatics aspects. Overall, there are significant risks to the IT work stream of Clinical Futures, in particular related to the lack of secured funding, both in terms of ongoing revenue funding and of capital funding for informatics projects. In addition, the complex nature of the programme leads to a wide range of interdependencies, which although identified and monitored, lead to a systemic risk throughout the programme.

In terms of the IT work stream, there is a good monitoring and risk management structure in place, along with plans for implementation of the GUH IT and wider informatics work streams, although it should be noted that some of the work stream plans are not fully mapped out yet. The development of the technical specification for GUH included ICT and the final responsibility rests with the Head of ICT, with the specification including the current relevant standards for IT.

5. Assurance Summary

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

Assurance Summary					
1	GUH work stream			✓	
2	Informatics work stream			✓	
3	Monitoring				✓
4	Resources		✓		

** 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 a weakness in the system control/design for Clinical Futures (IT Work stream).

Operation of System/Controls

The findings from the review have highlighted six issues that are classified as weaknesses in the operation of the designed system/control for Clinical Futures (IT Work stream)

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Five **Medium priority** issues were identified which require management's attention and provide scope for improvements to be made. These concerned:

1) Revenue Implications

The funding available for the IT aspects of Clinical Futures is subject to risks with funding not secured:

- There is no increased revenue funding for GUH to support the ongoing costs associated with the new IT equipment. This issue is exacerbated by the global trend with IT towards a revenue model for IT as opposed to capital.
- The IT equipment requirements have not been fully defined (currently approximately 80% complete). In addition funding is only available for approximately 50% of IT equipment needed, with the intent being to use discretionary monies to top up.
- There is no additional funding, either capital or revenue, for the Clinical Futures Programme as a whole, including the service redesign process with each project or redesign being subject to a business case requirement as dictated by the Welsh Government.

The lack of increased revenue funding for GUH may lead to increased service pressures and funding needs to be available for the ongoing revenue costs for support and maintenance of IT equipment. This may need to come from reduction in budgets elsewhere in the Health Board.

The lack of funding for the Clinical Futures Informatics work stream may mean that the use of technology may be restricted and impact on the delivery of the Informatics work stream. In turn non delivery of these projects may impact on the successful operation of GUH.

2) Redesign Process

Although services are being redesigned as part of the Clinical Futures programme, the design principles of which include "Innovative and

Transformative”, there is a disconnect between this and the translation into technical requirements / specifications as the involvement by ICT is limited due to resource constraints and there were no business analysts included.

As the service staff involved are not fully aware of what IT is currently in place, or what its functionality is, they may not maximise the use of technology. Conversely they may place over reliance on technology and assume or request a technically infeasible or prohibitively expensive solution.

3) Implementation Plans

Although the required ICT projects to ensure the successful operation of GUH have been defined, and are subject to ongoing monitoring arrangements, there remain risks to the delivery of some of these:

- The decision to utilise the current Vitalpac patient flow system used within the Health Board and not wait until the national system has been procured has not been formally agreed yet. The improvements and ongoing implementation of this will take time and currently there is no finalised plan to take this forward.
- The diagnostics modernisation project has been previously under resourced, and technical problems have impacted on penetration in Primary Care, with the use by GPs for electronic requesting currently being relatively low.
- The increased functionality and associated service requirements related to the Vocera hands free communication system have not been fully defined. Again, although Vocera is already used within the Health Board, the roll out of improved functionality will need time to ensure this is successful.

Delays to these projects have the potential to adversely impact on the successful operation of the GUH.

4) ICT Staff

There is an increasing need for ICT staff to support the GUH project and the ongoing operating requirements of GUH, which will increase when the new hospital is finished both due to number of desktops supported but also due to the inclusion of increased use of technology and bringing in items such as the nurse call system into the ICT support realm. Although these requirements are being worked though there is a risk that the Health Board will not be able to recruit.

Without adequate recruitment, ICT will not be able to fully support the operation of the new hospital in addition to the current position.

5) Mobile Telephony

Currently there is no funding for the mobile provision and boosting within the technical specification.

Without mobile provision and boosting, the signal strength within the hospital may be poor. The effect of this is that patients will increase their use of WIFI which may in turn cause it to be overloaded and result in performance issues.

Good Practice

We identified the following areas of good practice:

- there is a GUH project plan developed by the contractor and reported at each project meeting and on a 2 weekly basis to Welsh Government. This plan includes a high level view of the IT plan;
- there is an IT programme / plan in place for GUH, which is monitored by the project group;
- the IT plan notes the possible early handover and it is clear that component parts are working to this date;
- the timelines within the IT plan appear reasonable and are appropriately scheduled;
- regular meetings are held (SCRUMs and project meetings) to track the progress of the IT element of the GUH project. from reviewing notes of these it is clear that key issues / risks are discussed and tracked;
- ICT have fed into the technical specification and it is clear that changes have been made on this basis;
- the Head of ICT is ultimately responsible for the technical specifications for GUH;
- the approvers of the technical specification are clearly stated and appropriate;

- the stakeholders (users) have been involved in setting their needs in terms of equipment and room layouts;
- the technical specification contains appropriate requirements for standards of resilience, networking, risk management etc;
- a paper on the GUHs reliance on informatics was tabled at the GUH project board;
- there is a reporting / monitoring structure for projects within the wider informatics aspect of Clinical Futures;
- the projects are moving forwards and are explicitly linked to the GUH timeframes;
- the risks and issues related to the IT aspects of the GUH project and wider informatics projects are appropriately identified, monitored, treated and are escalated where appropriate;
- funding is available for the core IT requirements within GUH;
- the IT lead monitors and tracks expenditure for GUH;
- the Capital Finance Team receive information on the financial phasing of GUH;
- financial reporting is included in the PM reporting framework; and
- the needs for ICT staff are subject to discussion and assessment at the ICT project team.

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	0	5	1	6

Action Plan

Finding 1 Revenue Implications (Operational)	Risk
The funding available for the IT aspects of Clinical Futures is subject to risks with funding not secured: • There is no increased revenue funding for GUH to support the ongoing costs associated with the new IT equipment. This issue is exacerbated by the global trend in IT towards a revenue model for IT as opposed to capital. • The IT equipment requirements have not been fully defined (currently approx. 80% complete). In addition funding is only available for approximately 50% of IT equipment needed, with the intent being to use discretionary monies to top up. • There is no additional funding, either capital or revenue, for the Clinical Futures programme as a whole, including the service redesign process with each project or redesign being subject to a business case requirement as dictated by the Welsh Government. The lack of increased revenue funding for GUH may lead to increased service pressures and funding needs to be available for the ongoing revenue costs for support and maintenance of IT equipment. Audit does note that this is subject to ongoing discussions. The lack of funding for the Clinical Futures Informatics work stream may mean that the use of technology may be restricted and impact on the delivery of the Informatics work stream. In turn non delivery of these projects may impact on the successful operation of GUH.	Insufficient resource available for the development and implementation of the IT Work stream.

Action Plan

Recommendation 1	Priority level
The increased revenue requirements for GUH should be established and funded accordingly. The final IT equipment requirements should be defined and funding allocated accordingly. The Health Board should seek to secure funding for its key IT programmes within Clinical Futures.	Medium
Management Response 1	Responsible Officer/ Deadline
Accepted. An indicative revenue requirement for GUH has been established. The next step will be to produce a supporting paper to be raised at the GUH project board. Work on the IT equipment list continues and is 80% complete. The remaining is subject to the finalisation of the redesign work. We will then have a clearer view of the shortfall in budget. Application for additional discretionary budget could be from year end 2019/20 Funding for key IT programmes relating to Clinical Futures is included in business cases submitted to the Health Board investment panel	Helen Hughes-Tait April 2019 IT equipment budget July 2019 Complete

Action Plan

Finding 2 Redesign Process (Operational)	Risk
Although services are being redesigned as part of the Clinical Futures programme, the design principles of which include “Innovative and Transformative”, there is a disconnect between this and the translation into technical requirements / specifications as the involvement by ICT is limited due to resource constraints and there were no business analysts included. As the service staff involved are not fully aware of what IT is currently in place, or what its functionality is, they may not maximise the use of technology. Conversely they may place over reliance on technology and assume or request a technically infeasible or prohibitively expensive solution.	Key milestones are not met, resulting in delayed implementation of Clinical Futures.
Recommendation 2	Priority level
There should be increased liaison between ICT staff and service users / redesign in order to maximise the use of appropriate technology. The health board should seek to use business analysts to translate user requirements into digital solutions.	Medium

Action Plan

Management Response 2	Responsible Officer/ Deadline
Accepted. Work with Clinical Futures and the Executive team will be undertaken as part of the LHB Digital strategy governance process and Business Change managers and Exec sponsors will be identified with an agreed induction, clear role profile and training (where this is identified as needed). These clear roles and accountabilities will be agreed at the exec level and reinforced through the Clinical Futures and Digital Governance to ensure business change owners are identified, trained and supported in transformation change and MSP. This is beginning to be addressed through the Transformation to Digital Delivery Board where the top 10 digital priorities have been identified with Exec sponsors and Business Change Managers. The role of analysis and design (architecture) and information requirements needs to be fully recognised and resourced as part of 'mainstream' transformational change. It is generally accepted that digital is the key enabler to change, but the mechanism, expertise and governance requires clarity and refinement to ensure a successful outcome.	Mike Ogonovsky Q2 2019

Action Plan

Finding 3 Implementation Plans (Operational)	Risk
Although the required ICT projects to ensure the successful operation of GUH have been defined, and are subject to ongoing monitoring arrangements, there remain risks to the delivery of some of these: • The decision to utilise the current Vitalpac patient flow system used within the Health Board and not wait until the national system has been procured has not been formally agreed yet. The improvements and ongoing implementation of this will take time and currently there is no finalised plan to take this forward. • The diagnostics modernisation project has been previously under resourced, and technical problems have impacted on penetration in Primary Care, with the use by GPs for electronic requesting currently being relatively low. • The increased functionality and associated service requirements related to the Vocera hands free communication system have not been fully defined. Again, although Vocera is already used within the Health Board, the roll out of improved functionality will need time to ensure this is successful. Delays to these projects have the potential to adversely impact on the successful operation of the GUH. Audit does note that the issues related to these projects are understood by the ICT lead for Clinical Futures and are subject to ongoing monitoring and mitigating actions.	Key milestones are not met, resulting in delayed implementation of Clinical Futures.

Action Plan

Recommendation 3	Priority level
The Health Board should ensure that appropriate resource is provided for these projects and that formal approval to commence is given.	Medium
Management Response 3	Responsible Officer/ Deadline
Accepted. Subsequent to writing of this report, the health board has confirmed a decision that it cannot wait for the national procurement of a patient flow system. A case is in development to pervasively implement the incumbent flow solution to remaining areas with business change and project management to support this. Maximum scope option will be desired and the Exec Team are well engaged in terms of providing leadership for this. The role out of GP test requesting software has been adequately resourced and is being closely monitored. On current estimates it should complete in time for GUH opening. The use of Vocera by the health board is being reviewed to see how best to make use of the functionality and to support it in a sustainable way as part of going live with GUH in the short term and for Clinical Futures going forward. A Technical Design Options paper is being drafted that will enable an architecture strategy to “join” disparate applications	Mike Ogonovsky April 2019 Jan 2020 July 2019

Action Plan

Finding 4 ICT Staff (Design)	Risk
There is an increasing need for ICT staff to support the GUH project and the ongoing operating requirements of GUH, which will increase when the new hospital is finished both due to number of desktops supported but also due to the inclusion of increased use of technology and bringing in items such as the nurse call system into the ICT support realm. Although these requirements are being worked though there is a risk that the Health Board will not be able to recruit. Without adequate recruitment, ICT will not be able to fully support the operation of the new hospital in addition to the current position.	Insufficient resource available for the development and implementation of the IT Work stream.
Recommendation 4	Priority level
This issue should be included on risk registers and monitored.	Medium

Action Plan

Management Response 4	Responsible Officer/ Deadline
Accepted. This risk is included on the Informatics Risk Register. Additional resource requirements for GUH have been identified and funded in the implementation budget and in the FBC for ongoing operational support staff. Appropriate resource that are currently on FTC have been identified as potential for moving onto the GUH project with a view to them taking up a permanent role once GUH goes into operations. This will also ensure we keep staff who are knowledgeable of working in the health board.	Matthew Mahoney Complete

Action Plan

Finding 5 Mobile Telephony (Operational)	Risk
Currently there is no funding for the mobile provision or boosting within the technical specification. Without mobile provision and boosting, the signal strength within the hospital will be poor. The effect of this is that patients will increase their use of WIFI which may in turn cause it to be overloaded and result in performance issues. Audit notes that this issue has been raised with discussions ongoing and it is included within the contingency list. In addition the build includes ducting in order to fit this without retrospective works.	Insufficient resource available for the development and implementation of the IT Work stream.
Recommendation 5	Priority level
Funding should be provided for mobile provision and boosting.	Medium
Management Response 5	Responsible Officer/ Deadline
Accepted. Mobile telephony is on the GUH project risk register and is prioritised on the list for contingency budget. Duct work has been put in place and further small change requests are being identified and submitted relating to cabling that will assist in delivering mobile later on.	Helen Hughes-Tait October 2020

Action Plan

Finding 6 Technical Specification (Operational)	Risk
Although the technical specification includes up to date standards for IT facilities, the specification may not have fully incorporated the most modern technologies to future proof the hospital: - There was no consideration of the use of fibre to desktop. Although the cost of cabling would have increased, there would have been a corresponding decrease in the need for multiple rooms and network equipment which would offset this. - The wireless standard is 802.11ac however an improved standard is due to be finalised in 2019 with improved performance (802.11ax). Without the use of up to date technologies the GUH build may not benefit from the maximum possible performance from IT equipment.	Insufficient resource available for the development and implementation of the IT Work stream.
Recommendation 6	Priority level
The new wireless standard should be considered for the GUH.	Low

Action Plan

Management Response 6	Responsible Officer/ Deadline
GUH was designed to the latest standards at a point in time that had to be frozen in order to cost the contract. As we are in implementation – it is too late to make changes as this would incur huge costs The Wifi cabling will have been implemented before the next version of the Wifi standard has been published. But GUH is working to the latest standard that it could do. However the recommendations for cabling to desktop and the latest standards for anything – not just Wi-Fi will be taken into account with subsequent new builds such as the health and wellbeing centres in Tredegar and Ringlands.	Matthew Mahoney 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. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.



A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

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

Aneurin Bevan University Health Board

Clinical Futures – IT Work Stream



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NHS Wales Audit & Assurance Services

Use of Digital Technology, Fit for the Future

Final Advisory Report 2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Committee	Audit Committee Information Governance Committee

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Please note:

This advisory 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.

Our 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 Aneurin Bevan 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 advisory review to provide an assessment of Aneurin Bevan University Health Boards' (the Health Board) position and preparedness for the current and future provision of services using digital technology was completed in line with the 2018/19 Internal Audit Plan.

Digital transformation is a process of using technology to radically change service delivery. This transformation includes changing how the organisation works at every level and technology underpins all digital transformation projects. The technology changes as time goes on, but organisations need to adopt technologies that help them harness and make sense of the vast quantities of data they are sitting on, as well as preparing for trends like the Internet of Things (IoT) and mobile.

These technologies have the potential to transform health care and organisational service delivery. In a digital world the patient or service user is the centre, surrounded by the patient-facing technologies providing them with opportunities to manage their health and engage with health care providers. Technologies that provide tools for health care professionals are embedded within the organisation, such as decision support, the capacity to access other professionals' expertise, tools to prioritise and manage their clinical workload and tools to identify the patients at greatest risk.

2. Scope and Objectives

The objective of the advisory review was to evaluate and determine the ability of the Health Board to move to a digitally enabled organisation and ensure that it drives value from investment in new technology.

The review seeks to follow the following key questions that act as signifiers for organisational readiness for Digital and provide recommendations for actions which will improve the organisations position.

- Is the Health Board re-imagining service delivery and business processes?
- Is the Health Board redefining the relationship with the service user?
- Is the Health Board leveraging the wider ecosystem in Health and Social Care?
- Do UHB staff have the right technology skill-set and mind-set?
- Does the Health Board have leaders who see the bigger picture?
- Does the Health Board have a good system for prioritising digital transformation initiatives?

The review also seeks to assess the current position of the Health Board against items identified as barriers to digital transformation, in particular these are:

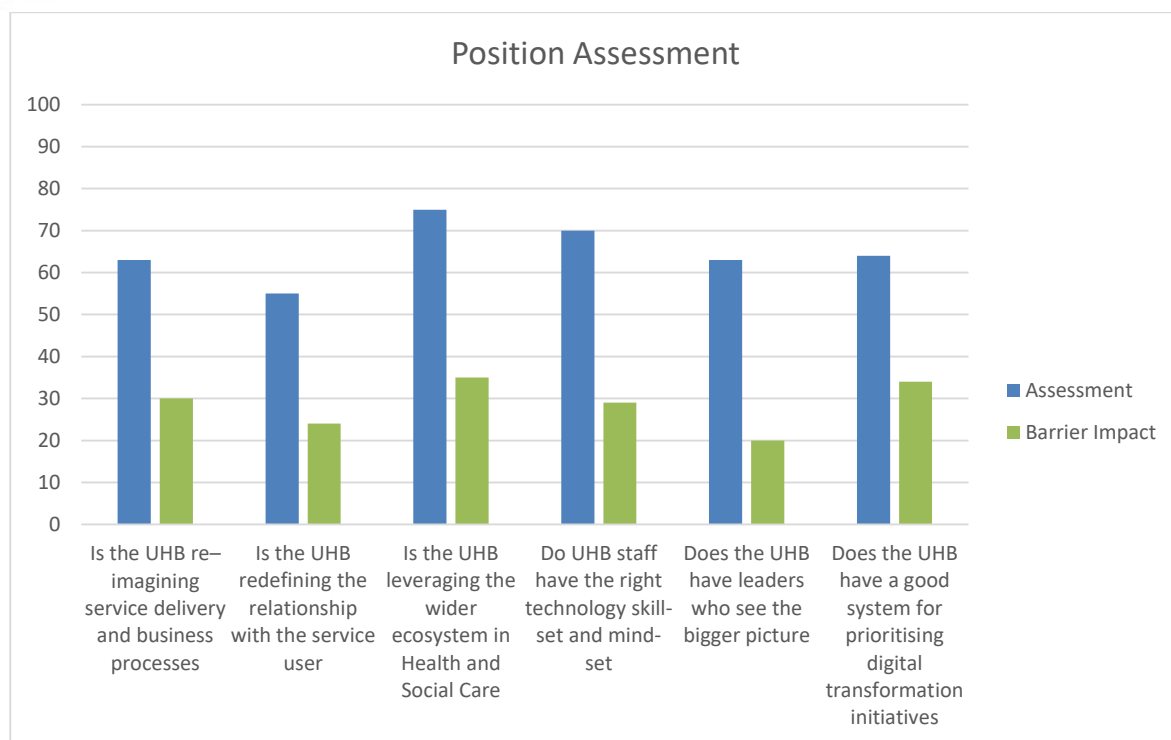
- lack of a corporate vision for digital;
- insufficient budget;
- risk-averse culture;
- lack of talent/skills required;
- inability to experiment quickly;
- legacy systems;
- cybersecurity;
- inadequate collaboration between IT and lines of business;
- inability to work across silos; and
- change management capabilities.

3. Conclusion

Overall, the Health Board is well positioned to take forward the use of digital technologies. There are structures in place for redefining service delivery linked to the Clinical Futures Programme, together with an increasing level of working across sectors, with projects involving local authorities and third sector organisations. A vision of how technology can be used to support service delivery is taking shape and key ICT priorities have been identified and there is a consideration of digital technologies in these. Staff across the Health Board are generally positive about the potential benefits of technology and there is an appetite for increased use of this.

However, this position is impacted by a number of barriers to progress. The chief of these is the lack of funding as this is sought on a case by case basis. The level of resource in ICT is not fully sufficient to allow for full collaborative working with users. In particular, there is a lack of business analyst skills and of skills in the most current technology. This also contributes to a lack of agility in terms of an ability to rapidly develop and trial new solutions. This issue is exacerbated by the legacy systems position and the nature of the NHS in Wales with systems and services being provided by a mixture of local ICT and national systems provided by NWIS.

The chart below indicates the current position assessment against each of the key questions within the report, together with an assessment of the extent to which the barriers may affect the success of each point.



4. Summary of Audit Findings

Is the Health Board re-imagining service delivery and business processes?

The Health Board is well placed for reimagining service delivery, as the Clinical Futures programme is specifically considering the redesign of services. As part of this process clinical and operational staff are involved in defining requirements. The Health Board has also implemented other actions that can enable the development of digital services, in particular the establishment of a local TEC (tech enabled care) team and the hosting of the national team provide a mechanism for developing digital service redesign, and this is working across sectors.

However, there are limitations to the redesign work. Services are being redesigned as part of the Clinical Futures programme, the design principles of which include “Innovative and Transformative.” The involvement by ICT is limited, with no routine participation in the redesign workshops by technical staff. As the service staff involved are not fully aware of what IT can do they may not maximise the possibilities of digital technology. Conversely they may place over reliance on technology and assume or request a technically infeasible or prohibitively expensive solution.

Is the Health Board redefining the relationship with the service user?

Recommendation 1: The Health Board should seek to increase the level of participation of technical staff, or business analysts in the service redesign work.

The Health Board has a framework for improving engagement with ICT users, in particular there is a Clinical Informatics Council for engagement with medical and nursing staff. In addition there are other examples within the Health Board such as a forum for district nurses to discuss mobilisation. There are also pockets, and groups of staff who can be termed enthusiasts who could act as champions and trailblazers for driving forward the digital agenda.

Although this framework is in place it is not functioning to its full potential as the impact of the Clinical Informatics Council is reduced by a lack of attendance from the clinical staff group, and many of the IT enthusiasts are within the junior doctor group who cannot commit to ICT developments due to the nature of their work load.

Recommendation 2: The Health Board should seek to encourage and facilitate participation at the Clinical Information Council by providing protect time for medical and nursing staff to attend.

In terms of engaging with service users, this is at an early stage with only isolated examples provided such as the use of Quick Response (QR) boards in clinics. A framework is in place for this engagement as there is a Stakeholder Reference Group extant. However, at present this has not fully covered the wants and needs of service users in terms of ICT.

Recommendation 3: The Health Board should seek to identify key "champions" within divisions and formalise this role. The champions should be a key conduit for identifying possible digital developments and leading on pilots and implementations.

One of the identified ICT priorities is the patient portal by which patients can access information and services provided by the Health Board. There is a national work stream for development of this, although this is at an

early stage and at present there is no proper understanding of user requirements at any level.

The Health Board is aware of this gap. However, as the draft ICT IMTP notes, there is a need to involve service users in the design and configuration, and further it notes that there is no full understanding of patient wants.

Recommendation 4: The Health Board should improve its assessment of service user wants and needs for digital technology. The Stakeholder Reference Group should feed into this process and consult with service users.

Is the Health Board leveraging the wider ecosystem in Health and Social Care?

The Health Board can show areas where it is starting to leverage the wider health and care information ecosystem, in particular the WCCIS project involves closer working and information sharing with local authorities and some third sector organisations. The Health Board also hosts the national Tech Enabled Care Team, and has established a local team. The purpose of these teams is to identify and trial new, technology enabled care delivery that links to the wider ecosystem such as working with care homes to provide telemedicine services.

The Health Board can also show that lessons have been learned from previous projects and is implementing processes to enable smoother future working such as greater collaboration with ICT and the use of business change teams.

The integration of the wider ecosystem is at the start of the process however, with the examples identified above being themselves siloed and not embedded across the organisation.

The ICT ecosystem within the Health Board also continues to have silos, with a large number of small, departmental systems. Services are able to procure their own ICT without a formal requirement to liaise with the ICT department. Whilst this does allow services to prioritise and fund their own developments, this leads to the risks that inconsistent data sets are collected, increased difficulties to integrate and unexpected increases in support requests to ICT. There is also a risk of “digital fragmentation”

whereby a large number of inconsistent or competing processes are piloted within the Health Board.

Recommendation 5: The Health Board should issue an executive level directive that states that all purchases or commissioning of ICT services and equipment should be required to be notified to the ICT department. This will ensure that ICT can act as a gatekeeper or coordinator and ensure a consistent approach is taken.

The role of NWIS as national provider causes some tension within the system. There is a risk to the Health Board's delivery of new digital services related to the requirement for NWIS to provide connectivity and support. In addition NWIS do not always progress national developments at a sufficient pace to meet the needs of the Health Board. This is also compounded by a lack of clarity / agreement over the meaning of "Once for Wales". At present information is not being fully shared across Wales between organisations with boundaries being maintained in the digital sphere, as the nature of IT is still individual "system" focussed and not integrated.

Recommendation 6: The Health Board should continue to work with NWIS and ensure the dependencies are escalated and commitment to delivery is received.

Do Health Board staff have the right technology skill-set and mind-set?

There has been work within the ICT department to quantify the numbers and skills of staff needed and some recruitment has occurred, along with some restructuring to try to maximise the use and development of staff already in place.

There is a widely held view that there is a skills gap within ICT, both in terms of the number of staff in post and in terms of staff with skills in new technologies. There is also a shortage of business analyst skills within ICT. These individuals work with user groups to redefine processes and translate user needs into technical solutions / outlines. Without these skills the Health Board will not be able to ensure full collaboration between ICT and user departments and will not be able to maximise the use of new technology. It should be noted that, although funding is an issue, in some cases recruitment has been problematic even when funding is available and the salaries payable under Agenda for Change have impacted on recruitment.

Recommendation 7: The Health Board should undertake a full assessment of the future need for ICT staff, this should include the number of staff required for ongoing support and also the numbers and skill types needed to increased use of new technology and the development of this.

Accordingly, a formal workforce plan should be developed for ICT to ensure that the establishment matches the aims of the organisation. This should consider recruitment issues and the possibility of improving and enhancing current staff skills.

The view of the wider staff groups' skills and appetite for technology from within ICT is mixed, with some areas stated as being very positive and receptive to technology input and change. In these cases work has been undertaken to manage expectations to avoid any future roll out being impacted by unmet and unrealistic expectations.

Where staff groups have been resistant or showed lower skills, the Health Board has utilised change managers and has recognised the benefits of these is looking to include in an increasing number of projects.

From the staff perspective, in general the results of a survey (Appendix B) show that staff across the Health Board have a positive outlook on digital, recognise the benefits and have an appetite to move forward. In addition, staff are generally confident in their skills for working with technology, particularly within the current paradigm.

However, the user survey we undertook identified a tranche of staff who don't fully understand the benefits of digital technologies and who have concerns over the impact of increasing use of technology on face to face care time and the risks of confidentiality together with a lack of understanding of how choice can be improved using digital technologies. This staff group also self identified as not being fully confident in working in new ways. If this significant minority staff group are not fully engaged and upskilled the Health Board will encounter resistance to implanting new technology solutions and will not gain the benefits of these.

Recommendation 8: The organisation should increase the communication of the benefits of digital technologies and how care can be improved without increased risk to confidentiality.

Related to this work, a series of training sessions should be offered to staff to ensure they are comfortable in working with technology.

As digital projects are rolled out, the organisation should continue the use of change managers / agents to ensure all users are engaged.

Does the Health Board have leaders who see the bigger picture?

The key senior level staff within the Health Board have a consistent overall vision of how the Health Board should move forward with digital technology. This includes the Assistant Director of Informatics (ADI), Executive Board Lead and Clinical Lead for Informatics.

Currently however, the articulation of the Health Board vision / Strategy for development of IT services and use of digital technology is incomplete. There is no final ICT Strategy in place and the updated IMTP has not yet been finalised and issued. Consequently the vision has not been fully communicated to the Health Board as a whole and staff cannot therefore fully engage to move the digital agenda forward. The results of the staff survey support this as they show that the message regarding digital and the Health Board's vision and aims are not being properly communicated and staff do not feel the Health Board is pushing or using digital fully yet. This implies that there is a greater appetite for digital than is being exploited within the Health Board.

Whilst this vision is not fully articulated, the Health Board does have a process for moving this forward and communicating. The draft ICT IMTP focusses on digital change and synchronises with the Clinical Futures Programme, with 10 ICT priority work streams set out in order to move forward.

Recommendation 9: The vision for digital technologies should be fully articulated within a strategy and/ or the IMTP and communicated to all staff across the Health Board.

The Health Board does not contain a member with detailed technical knowledge and background apart from the lead non officer member for ICT. This is recognised and a mechanism is being developed to improve knowledge and ownership of ICT with each of the 10 ICT priorities being assigned a different director. However, the lack of technical knowledge may mean that board members do not fully understand the possibilities of ICT and may not be fully able to drive it forwards.

Recommendation 10: Work should be undertaken with Board members to ensure they understand the possibilities of digital technologies and have the appropriate knowledge and skills to take their priority areas forward.

Does the Health Board have a good system for prioritising digital transformation initiatives?

The Health Board has a framework for assessing and prioritising digital initiatives. It has defined the Transformation to Digital (T2D) Delivery Board as the main governance forum for considering and prioritising new or major changes to information systems based on benefits and value, and thus directs the Health Board Health Informatics Strategy and work programme. In addition the Health Board operates a pre investment panel which is attended by the ADI / ICT representation which allows for tracking and pushing business cases for digital improvements.

There are also examples at lower levels within the Health Board where fora have been established in order to progress digital initiatives. These include the Digital Technology Group within Primary Care, and the Clinical Informatics Council.

The mechanisms for idea and initiative generation are not so well defined, although there are numerous methods by which these can be identified and escalated such as via service point or CWS suggestions. In addition there have been workshops within the Health Board focussing on specific areas e.g. Telehealth in Family and Therapies. However, these are not so well developed across the Health Board, thus the “conveyor belt” is not operating and the Health Board is to some extent locked into its stated priorities.

Recommendation 11: A process to get new ideas into frame should be established. This should engage divisional champions and seek user ideas.

Barriers

This section discusses the current status of the Health Board against identified barriers to adoption of digital technology.

Lack of a corporate vision for digital

As noted above, although a vision is taking place, and there is a draft ICT IMTP, this has not been completed, communicated to staff and publicised.

Inability to experiment quickly

The Health Board has developed a process for prototyping eforms which allows rapid development following a request, however the Health Board does not generally have a rapid, agile mechanism to prototype and experiment with new ideas and technology. The establishment of the TEC teams, both local and the hosted national team do start to mitigate this, as it does allow a forum for trying new things. At present there isn't much of a process to generate ideas to feed into this. However, a form has been developed which will allow assessment and triaging of ideas and so the beginnings of a framework are in place.

Legacy systems

Given the nature of the Health Board, and of the NHS in Wales, legacy systems are inevitably going to be an issue, and will likely remain so for some time. There are a large number of multivariate systems in place, with control of these being spread across divisions, ICT and NWIS. These systems are older, often using inflexible technologies that were emplaced to meet the previous demands. They often have long lifespans and can be difficult to integrate with new cloud and web-based services. The Health Board is working on integration which will mitigate the impact of the legacy systems and the ongoing national programme will also help to move towards a consistent position.

Lack of talent/skills required

There is a shortage of ICT staff with the right skills. However, there is recruitment underway and there has been some restructuring to try and mitigate this. This issue is compounded by the lack of ability to successfully recruit and previous attempts have not always been successful.

In terms of user skills, staff in general feel confident in taking up digital technologies and there appears to be a large appetite for increasing the use of technology within the Health Board. There is a subset of staff who, as previously noted are not so supportive and these should be addressed as per the previous recommendation.

Insufficient budget

The move to digital technologies will need funding and the Health Board has utilised a variety of alternative sources for funding including Efficiency Through Technology Fund (ETTF), Welsh Government monies and unlocking funding due to opting to lead on national projects. In addition, there is transformation funding available, some of which is spent on technology.

However, the Health Board does not have sufficient allocated funding to progress all of the identified prioritised work streams and the Clinical Futures programme does not have additional funding for service redesign. This is a key barrier to moving forward with digital technology and the Health Board will have to continue to seek funding for its future developments.

Cybersecurity

It is vital to ensure that the move towards digital technologies is accompanied by appropriate security and, in order to protect the organisation, the Health Board has opted to establish its own cybersecurity team which will remove this barrier and allow new technologies to be implemented in a secure manner. However, the Health Board has had difficulties in recruiting to posts. There is a general skills shortage in cyber security and the pay offer from the NHS in Wales may not be sufficient to attract interest from this limited pool. For this reason the Health Board should look to develop an IT Workforce plan which should include upskilling staff already in place. (as per recommendation 7)

Inability to work across silos

There are silos in place, both within the Health Board and external to the Health Board. The use of digital technologies will require a greater flow of information and collaboration across silos. The Health Board is working on breaking down some of these silos however this remains a work in progress.

Inadequate collaboration between IT and lines of business

The Health Board is showing a move to greater collaboration between ICT and the services and this will improve further as compliance with the Information Technology Infrastructure Library (ITIL) framework increases. The ICT resource available does not include enough business analyst skills to enable continuous collaboration, with most resource being taken up with the day to day support required to services. There is also a lack of engagement from users with poor attendance at the Clinical Informatics Council which impacts on this.

Risk-averse culture

In order to take advantage of new technology, the Health Board has to have a certain appetite for risk, in particular the risk of project or product failure.



Whilst the Health Board is highly risk averse in terms of harm to patients, it can demonstrate an appetite for risk of failure by being early adopters of national projects and by the TEC teams.

Change management capabilities

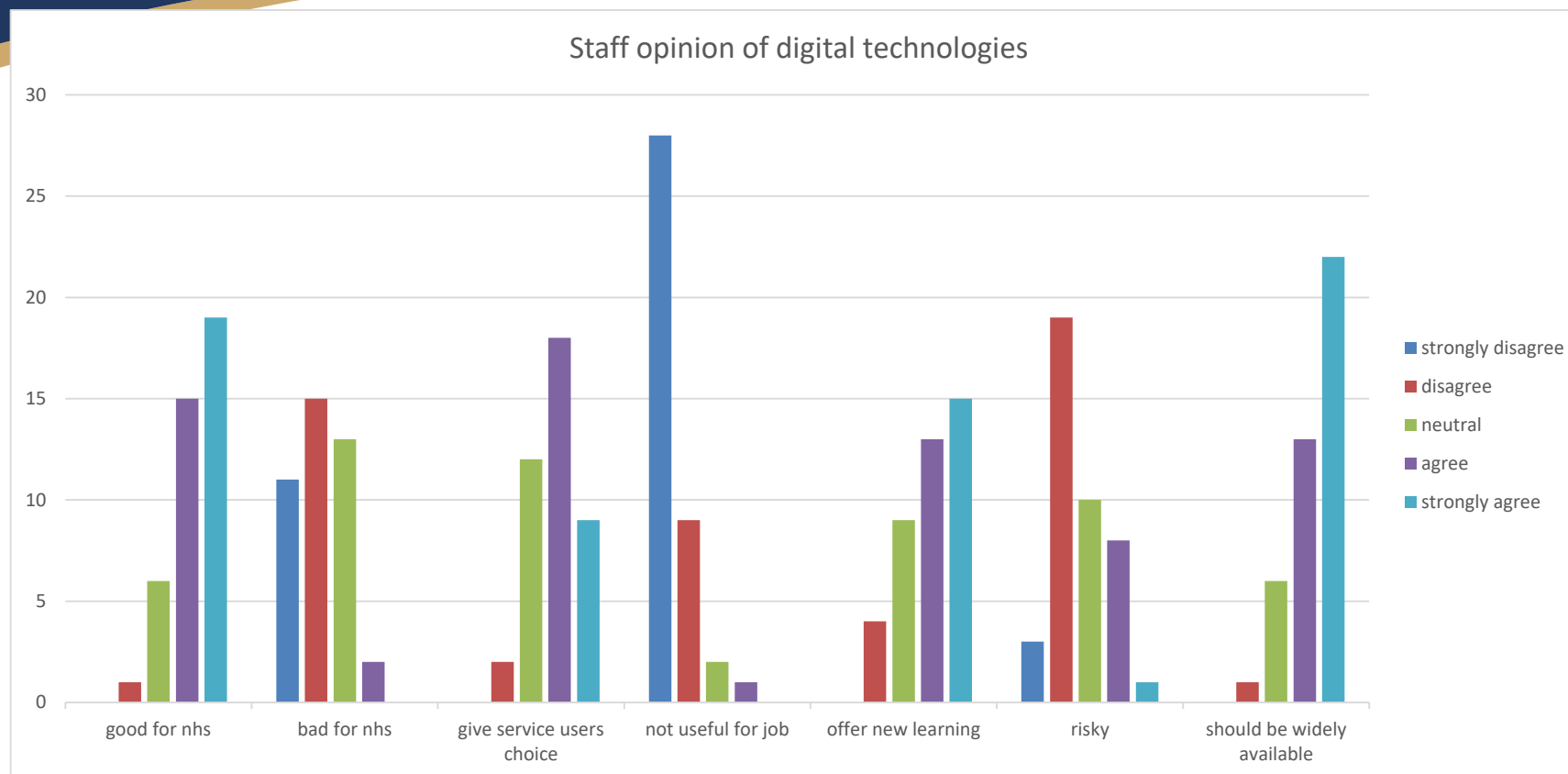
The move to new way of working with new technology will by necessity involve change and users can be highly resistant to change. The Health Board has recognised this barrier and utilised change managers within projects in order to facilitate the introduction of new way of working. The Health Board is therefore cognisant of this barrier and has implemented actions to address it. However, it should be noted that the resource available is limited.

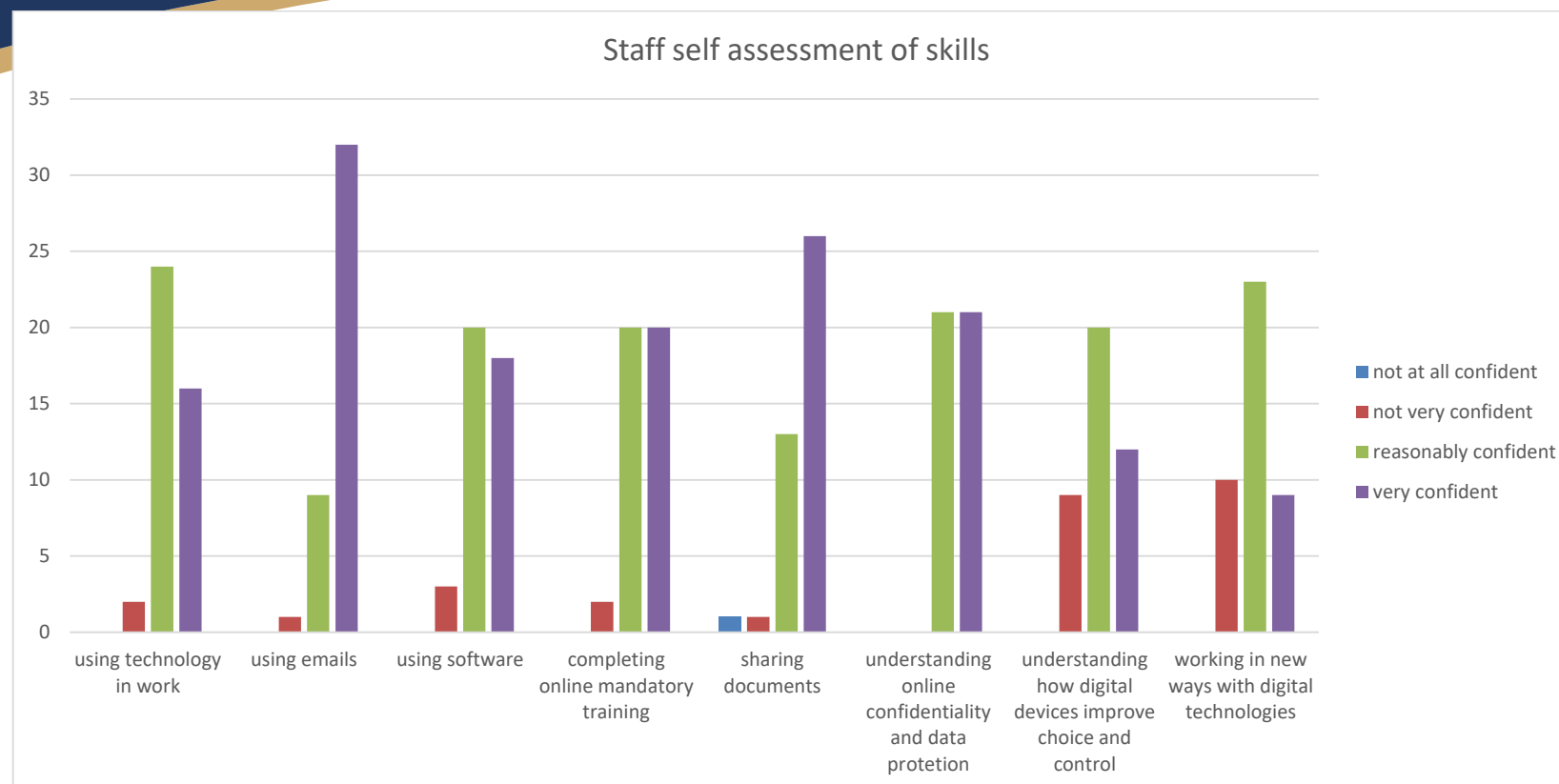
Summary of Recommendations

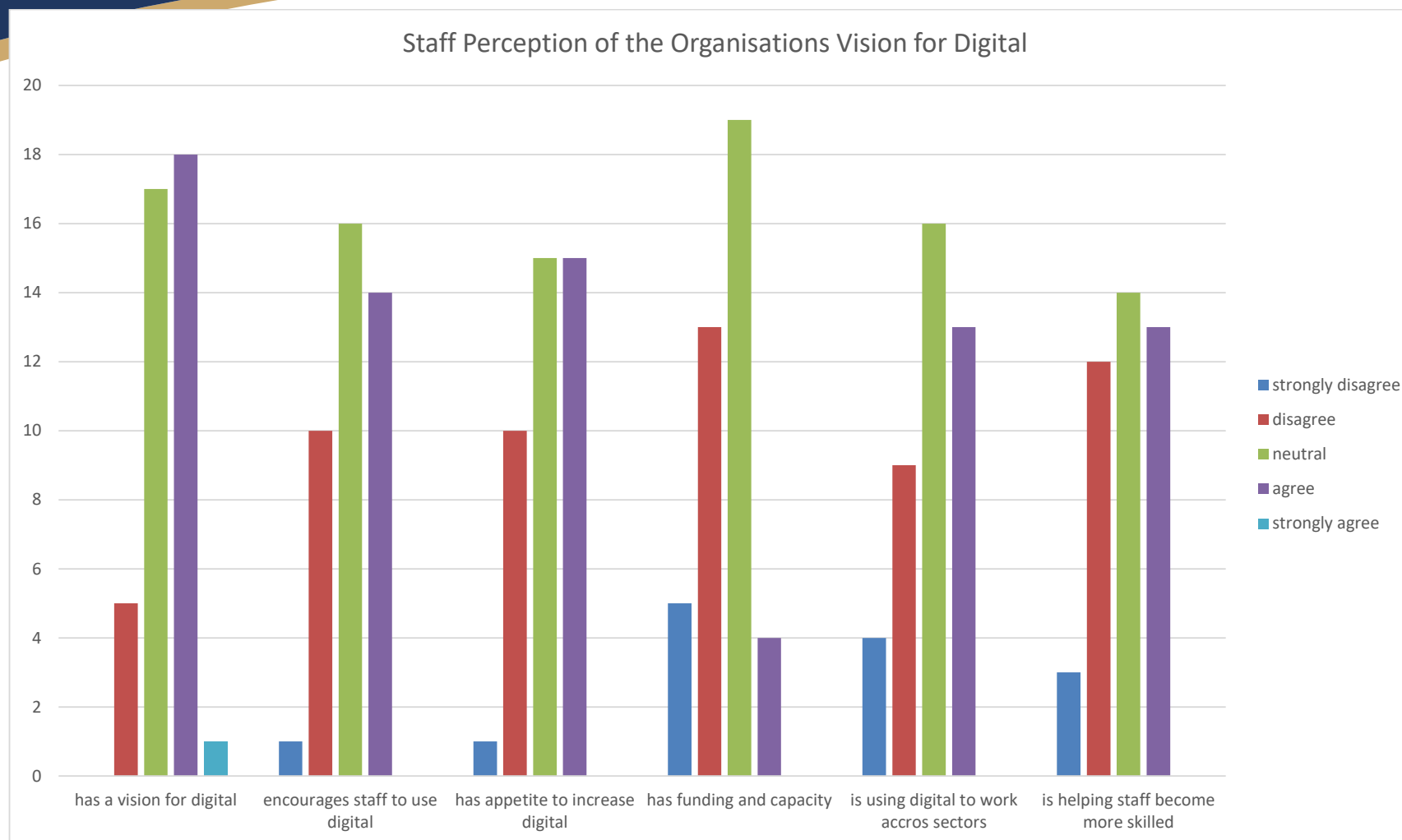
Recommendation 1	The Health Board should seek to increase the level of participation of technical staff, or business analysts in the service redesign work.
Recommendation 2	The Health Board should seek to encourage and facilitate participation at the Clinical Information Council by providing protect time for medical and nursing staff to attend.
Recommendation 3	The Health Board should seek to identify key “champions” within divisions and formalise this role. The champions should be a key conduit for identifying possible digital developments and leading on pilots and implementations.
Recommendation 4	The Health Board should improve its assessment of service user wants and needs for digital technology. The Stakeholder Reference Group should feed into this process and consult with service users.
Recommendation 5	The HEALTH BOARD should issue an Executive level directive that states that all purchases or commissioning of ICT services and equipment should be required to be notified to the ICT department. This will ensure that ICT can act as a gatekeeper or coordinator and ensure a consistent approach is taken.
Recommendation 6	The Health Board should continue to work with NWIS and ensure the dependencies are escalated and commitment to delivery is received.

Summary of Recommendations

Recommendation 7	The Health Board should undertake a full assessment of the future need for ICT staff, this should include the number of staff required for ongoing support and also the numbers and skill types needed to increased use of new technology and the development of this. Accordingly, a formal workforce plan should be developed for ICT to ensure that the establishment matches the aims of the Health Board. This should consider recruitment issues and the possibility of improving and enhancing current staff skills.
Recommendation 8	The Health Board should increase the communication of the benefits of digital technologies and how care can be improved without increased risk to confidentiality. Related to this work, a series of training sessions should be offered to staff to ensure they are comfortable in working with technology. As digital projects are rolled out, the Health Board should continue the use of change managers / agents to ensure all users are engaged.
Recommendation 9	The vision for digital technologies should be fully articulated within a strategy and/ or the IMTP and communicated to all staff across the HB.
Recommendation 10	Work should be undertaken with Board members to ensure they understand the possibilities of digital technologies and have the appropriate knowledge and skills to take their priority areas forward.
Recommendation 11	A process to get new ideas into frame should be established. This should engage divisional champions and seek user ideas.







References

Delivering the Benefits of Digital Health Care – Nuffield Trust / KPMG (Feb 16)

Building a Successful Digital Transformation Roadmap – Earley Information Science (Jan 16)

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Digital Transformation and Six Key Questions to Drive It – IT ProPortal (Jun 17)

Digital Transformation Survey (Report) – Centre for Creative Leadership (March 2018)

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Advisory report

The advisory review was undertaken using a risk-based methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.



A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

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

Aneurin Bevan University Health Board

Use of Digital Technology, Fit for the Future



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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Organisational Development and Training

Final Internal Audit Report

2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix B	Assurance opinion and action plan risk rating
Appendix C	Responsibility Statement

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Committee

Audit Committee
Finance and Performance
Committee

ACKNOWLEDGEMENT

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

Please note:

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

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1. Introduction and Background

The review of Organisational Development and Training has been completed in line with the 2018/19 Internal Audit Plan.

Aneurin Bevan University Health Board (the 'Health Board') has embarked on a significant transformational project – Clinical Futures. This seeks to bring care closer to home for patients and to provide specialised services and critical care from the new Grange University Hospital that is under construction.

Clinical Futures is a key strategy within the Health Board's Integrated Medium Term Plan (IMTP) and organisational development is central to the IMTP. In particular it focuses on:

- developing leadership and management potential;
- improving staff experience and engagement;
- bringing the organisational values to life;
- facilitating talent management and succession planning at all levels;
- supporting the delivery of the service change plans;
- creating a sustainable workforce through growing talent internally;
- developing the widening access agenda;
- enhancing and protecting the well-being and health of staff; and
- the delivery of the five ways of working.

2. Scope and Objectives

The objective of the review was to evaluate how the Organisational Developmental Strategy of the Health Board integrated with medium term planning and the opportunities available for the training and development of staff within the Health Board.

Any weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

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

Organisational Development

- to ensure that policies and procedures, including an Organisational Development Strategy, are in place to support the IMTP;

- to determine if the Health Board's programme of organisational development initiatives is aligned to the IMTP;
- to determine if a sample of organisational development initiatives are achieving desired outcomes;

Training

- to determine if the Health Board has a coherent strategic approach to training;
- to ensure that the process for identifying training needs and responding to them is operating effectively; and
- to ensure that training resources are being applied effectively to support the organisational development objectives.

3. Associated Risks

The risks considered in the review were as follows:

- the Health Board does not have sufficient, trained staff;
- staff are not supported to fulfil their maximum potential;
- training budgets are not utilised effectively;
- there is a lack of central oversight, resulting in the organisational development elements of the IMTP not being delivered; and
- failure to ensure that the Health Board is an employer of choice.

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 Organisational Development and Training 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.

Whilst a range of initiatives is currently in place to implement organisational development, this will remain a work in progress until the Clinical Futures workforce plan is finalised. Upon completion, the overall personnel requirements for the Health Board will be established, assisting the Health Board with adjusting the overall strategy. Therefore, whilst the current progress is laying the foundations for Clinical Futures, it will be a number of years before the full benefit is realised.

At this point, we expect organisation development to continue evolving, to match the priorities and objectives of the Health Board in the future, as described within the IMTP and required by the Clinical Futures transformation project.

5. Assurance Summary

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

Assurance Summary					
1	Policies and procedures, including an organisational development strategy, are in place to support the IMTP.			✓	
2	The Health Board's programme of organisational development initiatives is aligned to the IMTP.				✓
3	Organisational development initiatives are achieving desired outcomes.			✓	
4	The Health Board has a coherent strategic approach to training.			✓	
5	The process for identifying training needs and responding to them is operating effectively.			✓	
6	Training resources are being applied effectively to support the organisational development objectives.		✓		

* 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 **three** issues that are classified as weaknesses in the system control/design for Organisational Development and Training.

Operation of System/Controls

The findings from the review have highlighted **one** issue that is classified as a weakness in the operation of the designed system/control for Organisational Development and Training.

6. Summary of Audit Findings

We found that the Health Board has an Organisational Development Strategy

that is embedded into the IMTP and for setting corresponding goals within the IMTP. The Strategy is aligned to Clinical Futures and the opening of the Grange University Hospital. Through this process, the Health Board has refreshed its overall strategic direction and identified areas for further development. Further detail for each of the audit objectives is detailed below:

Organisational Development Strategy

Since 2015, the Health Board has maintained a three year Organisational Development Strategy to support the development of individuals, teams and the community that they serve. The three year plan was replaced during 2018 with the People Plan, which as an updated plan, aligns to the strategic objectives within the Integrated Medium Term Plan (IMTP) and in particular, the Clinical Futures transformation project.

The key priorities of the People Plan include:

- enabling everyone to work productively and efficiently;
- engaging everyone to support their well-being and developing our people; and
- sustaining our services now and for the future.

Each of the above include further sub-objectives to achieve the overall strategic direction. The Board approved the People Plan during January 2019.

In addition, we found that there is a strong partnership with the Clinical Futures Workforce & OD Committee in determining current and future workforce requirements.

Within the People Plan, appropriate success parameters are listed within the 'Measuring our Success' section, but each lack quantifiable targets. Therefore, it is not possible to determine which initiatives the Health Board would view as a success, as the output from each initiative is not set an appropriate target to achieve. For example, a reduction in staff sickness would be a positive result, but with a range of actions implemented to address this area, the expectation may be a higher reduction in staff sickness. This has been raised as a recommendation within Appendix A.

Alignment of the organisational objectives to the IMTP

The Health Board has established a list of 10 key organisation objectives, which are listed within the IMTP (table 1.1). In particular, number 7: an enhanced focus on efficiency, productivity and value based care and number 8: improving services based on feedback, align closely to the three key priorities of the People Plan listed above.

The core element of the IMTP is the Clinical Futures transformation project. Clinical Futures in particular has prompted a complete review of the workforce plan within the Health Board, by identifying skills required and those provided by the existing workforce. This work is still underway, as the clinical models within the Health Board are finalised for the implementation phase of the Clinical Futures project.

However, a Cultural Change Programme Plan, as part of Clinical Futures is currently within phase 2, with all actions identified as 'on track'. The overall aim is to bring about positive, visible and consistent changes to the culture across all levels of the organisation to harness the best of what the Health Board already achieve and integrate it with best practice and innovation. The output will assist with multiple objectives, both within the IMTP and the People Plan.

Organisational development initiatives are achieving the desired outcome

The Health Board monitor some workforce related targets which are linked to the priorities within the People Plan and the achievement of the objectives within the IMTP. For example, PADR compliance is tracked, to ensure that staff are working productively, efficiently and to support their development. In addition, sickness absence levels are also monitored, to assist with the management of the wellbeing of the workforce.

We examined the initiative for emergency nurse practitioners (ENPs), advanced nursing practitioners (ANPs) and first contact therapy practitioners (FCPs), to determine if it is achieving the desired outcomes. The ongoing performance of upskilling nurses is measured via the Clinical Futures Workforce & OD Committee, as part of wider workforce considerations. Success is determined via recruitment numbers, but as personnel rotate, further vacancies arise. There are no success criteria factors developed, but rather ongoing monitoring.

As stated within the first objective above, more specific measurements and milestones are required over the wider range of priorities, to ensure that the People Plan is successfully delivering what it intends to. For example, this includes setting out measurements for how technology will be used to achieve increased efficiency and the timeframe for this.

Overall, there is a wide range of measures already in place, which report on some priorities within the People Plan directly and indirectly. However, these can be extended further to capture all of the priorities listed.

Coherent strategic training approach

Clinical Futures requires delivering care closer to home and alongside the

building of the Grange University Hospital, the Health Board has determined a range of additional skills required to successfully achieve this. These include: ENPs, ANPs and FCPs.

The Health Board has funded cohorts of each of the above (amongst other skills) in collaboration with the training needs identified by the divisions.

Furthermore, the wider strategy of employing additional registered nurses to reduce agency nursing expenditure is funded corporately by the Health Board. The overall aim is to upskill and support healthcare support workers (HCSWs) to qualify as registered nurses. Where HCSWs lack the requisite qualifications, to embark on this route, the Health Board has been supporting the applicable staff to obtain the appropriate qualifications.

In addition, a training programme is established to upskill managers through a leadership programme and a Managing Transformation Programme to assist managers with preparing for Clinical Futures. The latter is currently at a pilot stage.

Within the overall strategy of the Health Board, work is underway to understand the succession planning requirements for personnel. However, the Health Board is currently waiting upon further details of the approach to take on an All-Wales basis, with guidance to be provided by Health, Education and Improvement Wales (HEIW). In the meantime, there is a risk that insufficient time is available to implement an appropriate strategy. We recommend that the Health Board start considering core elements of succession planning, in preparation for the HEIW's guidance. This has been raised as a recommendation within Appendix A.

Identifying training needs

Training is identified in accordance with the strategic direction of the Health Board (for example, registered and non-registered nurses and managers) and individually, as part of the PADR process.

Within a sample of individual training plans examined, we found that training needs are often identified, but are not always clearly linked into the current role or career aspirations of the individual. With the PADR completion rate at 78% (at the time of the audit) there is a risk that relevant training is not being identified for some staff. This has been raised as a finding within Appendix A.

The Health Board engages with the staff regularly, through pulse surveys and a Clinical Futures Engagement survey to understand key priorities for staff and to target areas for development.

Training resources

Funding is provided centrally within the Health Board for the large scale training programmes referred to above, including upskilling of nurses and managers. In addition, we were informed that individual training posts exist within the Health Board, to support training throughout.

Individual training is identified through the personal appraisal and development review (PADR) process, as part of the individual's training plan and is funded through a devolved budget within each division. However, a review of the costs incurred to date (£1.1m to the end of February 2019), demonstrated that spending levels varied throughout the Health Board and when financial pressure is experienced, this spending has been curtailed in the past. We have raised a recommendation within Appendix A, to protect the funds available for training, particularly as the Health Board continues through its period of transformation.

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	1	4

Finding 1: Individual Training Plans (Operation)**Risk**

The completion of individual training plans (as part of the Personal Appraisal and Development Review) is key to ensuring that individual training and development is focused within the correct areas and that funds allocated to each division are spent prudently, targeting the most effective areas of development.

To examine this further, we tested a sample of 12 training plans (6 from Unscheduled Care and 6 from Facilities), as part of the PADR process and identified the following:

Unscheduled Care

- Development aspirations were generally included.
- In most cases it was not clear how the training aspirations were linked to the staff members' current roles, or how they met the needs of the Health Board going forward.
- There was generally a lack of detail on how the Health Board would support the aspirations.

Facilities

- There was nothing significant to note.

Overall, the training needs and plans identified as part of the PADR process require further improvement, to link in training requirements to the role and career aspirations of the individual.

Staff do not receive the training required to meet the current and future needs of the Health Board.

There is a shortage of the required skills within the Health Board.

Action Plan

Recommendation 1	Priority level
Where the training plan quality or completeness is not to the required standard, action should be taken by the PADR Strategic Group to improve both aspects, i.e. training plans should be fully completed and aligned to the job description and / or career aspirations.	Medium
Management Response 1	Responsible Officer/ Deadline
Agreed. The quality assurance mechanisms put in place by the Strategic PADR Group were strengthened following the PADR Internal Audit in 2018. The PADR quality audit documentation will be adapted to ensure that it includes checking that training plans are fully completed and aligned to the job description and / or career aspirations. All results of these audits are reported back to the Divisions to ensure learning and changes required in practice are acted on.	Geraint Evans Director of Workforce & OD June 2019

Action Plan

Finding 2: Training Budgets (*Design*)

Over a 12 month period, approximately £1.2m is included in delegated budgets for spending on training within the Health Board, across a variety of teams.

As the Health Board continues to implement Clinical Futures and approach the opening of the Grange University Hospital, identifying key areas for upskilling staff becomes more important. The Clinical Futures Workforce & OD Committee continually reviews the current gaps and areas for development. Organisation led initiatives are embedded, but individual training initiatives require access to the training funds set aside within divisions.

However, when pressure on budgets increases, training expenditure is often curtailed. Whilst this level is typically capped (e.g. a 20% reduction), it can place additional barriers for staff to undertake further development.

Risk

Staff are insufficiently trained, increasing the risk of the Health Board not operating as effectively as it should.

Insufficient skills are in place for the successful introduction of Clinical Futures.

Recommendation 2

It is recommended that the Health Board consider ring-fencing a portion or all of the divisional training revenue available for staff development.

Priority level

Medium

Action Plan

Management Response 2**Responsible Officer/
Deadline**

This proposal will require further discussion and agreement between Executive Directors and senior management teams within the Divisions at Executive Board. Following discussion, if the decision taken is not to progress with the recommendation then the reasons will be documented accordingly and communicated to the Audit Committee, as part of the tracking of audit recommendations.

Geraint Evans
Director of Workforce & OD
September 2019

Finding 3: Success Factors (Design)

The Health Board has implemented a range of initiatives to help achieve the strategic objectives within the IMTP. However, the success or achievement of those initiatives is not actively being monitored against pre-determined success parameters. For example, we found that:

- the Health Board has not defined the success factors to use for determining if the upskilling of HCSWs initiative is achieving the required output. For example, the percentage of HCSWs to graduate through the scheme; and
- the section within the People Plan, 'Measuring our Success' has identified a number of indicators for assessing performance / level of improvement. However, there are no quantifiable targets to measure against.

Risk

The benefits of the People Plan have not been realised or assessed, due to insufficient success factors identified.

Recommendation 3

The Health Board should identify what the success factors are for all key components of the People Plan. Each of these should be monitored on a regular basis and further action taken where insufficient progress has been achieved.

Priority level

Medium

Action Plan

Management Response 3**Priority level**

Agreed.

Geraint Evans

The People Plan is currently being reviewed and this recommendation will be addressed as part of that review. This will ensure success factors for all key components of the People Plan are identified and monitored on a regular basis.

Director of Workforce & OD
September 2019

Action Plan

Finding 4: Succession Planning (Design)	Risk
The Health Board does not have a succession programme for senior managers established. Whilst one is being developed on an All-Wales basis by the Health Education and Improvement Wales (HEIW), no work has been completed by the Health Board towards establishing a succession programme.	The Health Board does not have a sustainable workforce, skills or knowledge base for future requirements.
Recommendation 4	Priority level
The Health Board should commence succession planning, particularly as the requirements of any method of succession planning are likely to be consistent with the HEIW.	Low
Management Response 4	Priority level
Agreed. The work to date on the comprehensive suite of leadership and management development programmes supports a succession planning approach. This approach is also included in clinical development opportunities such as Nursing and Midwifery Post Registration Education, Advanced Practice and HCSW development. The Health Board will ensure that these approaches are formalised to enable an effective pipeline into the HEIW succession programmes for tiers one, two and three and in the meantime develop a programme consistent with the HEIW approach.	Geraint Evans Director of Workforce & OD November 2019

Audit Assurance Ratings



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



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



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



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

Prioritisation of Recommendations

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

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

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

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

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NHS Wales Audit & Assurance Services

HSDU Project

Final Internal Audit Report

2018/19

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services



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Appendix A	Management action plan
Appendix B	Audit assurance ratings

Review reference:	SSU_ABU_1819_01

Report status:	Final

Fieldwork commencement:	7 February 2019

Fieldwork completion:	6 March 2019

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Auditor/s:	NWSSP: Audit & Assurance - Specialist Services Unit

Executive sign off:	Nicola Prygodzicz, Director of Planning & Performance

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Committee:	Audit Committee

ACKNOWLEDGEMENT

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

Please note:

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

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 Aneurin Bevan 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 audit was undertaken in order to evaluate the processes and procedures that support the delivery of the Hospital Sterilisation & Disinfection Unit (HSDU) project at the new Grange University Hospital (GUH) site. The HSDU has been identified as a priority for completion in time for the commissioning of the GUH.

An Outline Business Case (OBC) was developed to support the construction of the HSDU, with a capital cost of circa £15m. Support had been received in principle from the Welsh Government, in the context of emerging guidance around the need for on-site facilities to support acute surgery.

The OBC was presented to the Board in September 2018 with approval to proceed to Full Business Case (FBC) received from the Welsh Government in January 2019.

The audit forms a part of the approved 2018/19 internal audit plan; and is the first audit of the project.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of Aneurin Bevan University Health Board (the UHB), taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The audit evaluated the systems and controls in place within the UHB with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas covered were appropriately managed.

Accordingly, the scope and remit of the audit was directed to the following areas:

- **Project Governance:** appraisal of project governance arrangements; assurance that appropriate scrutiny and approval processes were defined and applied at the scheme and assurance that appropriate approvals (including funding) had been obtained.
- **Appointments and Contract:** assurance that parties contracted to the UHB had been appropriately appointed; and contract documentation had been completed in accordance with the current phase of the project.
- **Project Management:** assessment of progress to deliver the full business case; assessment of project management tools utilised; and assessment of performance monitoring.
- **Workstreams:** appraisal of the supporting structure of workstreams; robustness of supporting information; co-ordination, scrutiny and approval of outputs; and involvement of stakeholders and user sign-off of brief.

3. Associated Risks

The potential risks considered in the review were as follows:

- The project may not be properly controlled;
- Un-funded costs may be incurred;
- The business case may not be progressed in a timely fashion; and
- The business case may be poorly informed.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

General compliance was noted with the established control frameworks in each of the objective areas sampled.

The overall assurance determined is cognisant of the recommendations made to enhance the control environment and the current stage of the project (i.e. progress to FBC stage).

Accordingly, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the HSDU Project within the UHB at the time of the audit is assessed as **Reasonable Assurance**.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Project Governance			✓	
2	Appointments and contract			✓	
3	Project Management			✓	
4	Workstreams			✓	

* 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 were classified as weaknesses in the system control/design for the HSDU project.

Operation of System/Controls

The findings from the review have highlighted **two** issues that were classified as weaknesses in the operation of the designed system/control for the HSDU project.

6. Summary of Audit Findings

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

Project Governance



We appraised the project governance arrangements and sought assurance that appropriate scrutiny and approval processes were defined and applied at the scheme.

The project structure was formally developed and set out in the Outline Business Case (OBC) [(submitted to the Welsh Government in October 2018)].

The Project Owner and Project Director were defined in the OBC; however, confirmation of acceptance (such as an Acceptance Certificate) for these roles was not confirmed (**recommendation 1**).

Project Board functions were the responsibility of the Clinical Futures Strategic Capital & Estates (SCEW) workstream – both pre and post approval of OBC.

Project progress in the development of the OBC was regularly reported in standard highlight reports to the SCEW. The HSDU project was incorporated

with the Grange University Hospital (GUH) reporting. Post approval of the OBC, project specific reporting had been prepared.

A Project Team was established for the OBC stage and meetings were held monthly. The team was re-established post OBC approval and, at the date of reporting, had continued to hold monthly meetings. The terms of reference for the Project Team were reviewed in January 2019; however, not all expected content had been defined (**recommendation 2**).

Following approval of the OBC, Project Progress meetings were held with the appointed external advisors and the contractor. Commercial Team meetings were also held.

Funding (£597k) to support the development of the OBC was approved by the Welsh Government in 2017; with further approval to progress to FBC received January 2019.

As the above operated effectively, **reasonable assurance** has been determined in respect of governance arrangements applied at the project to date.



Appointments and contract

We sought assurance that parties contracted to the UHB had been appropriately appointed and contract documentation had been completed in accordance with the current phase of the project.

The procurement strategy was documented within the OBC and defined for both the contractor (SCP) and advisers.

The preferred procurement route, documented as being followed until completion of the OBC, was to instruct the works as a compensation event to the Grange University Hospital project [Designed for Life: Building for Wales Framework (NEC 3 Form of Contract)].

Subsequent to producing the completed design and input into the OBC, the SCP advised the UHB they did not wish to proceed to the FBC stage with the HSDU project.

A review of the contract options available to the UHB to continue with the project encountered delays in the finalisation of the OBC submission.

Post OBC approval, advisers and a new SCP were procured under the new All Wales Designed for Life 4 Building for Wales Framework and all contract documentation was appropriately issued in relation to the same.

Receipt of signed contract documentation was after work / commissions had commenced and, at the time of our review, had yet to be signed by the UHB (**recommendation 3**).

In the context of the stage the project had reached, a **reasonable assurance** has been determined.



Project Management:

We sought assurance that project management tools and risk control frameworks were employed to deliver the FBC.

A Project Execution Plan was prepared, by the cost advisors, confirming the structure to achieve the completion of the OBC and latterly updated for the FBC stage. In addition, a FBC Pre-Construction Programme Document was prepared by the SCP confirming the activities required for sign-off of the FBC.

A planned route of progression from OBC to FBC was defined within the approved OBC; anticipating submission of the FBC to the Welsh Government in June 2019.

The planned programme also noted the requirement for enabling works [May to August 2019]; commencement of construction [September 2019]; and completion of project [December 2020].

Prior to the submission of the OBC, cost reporting and scrutiny was presented to the Project Team meetings. As noted in the *Governance* section of the report, highlight reports were presented to the SCEW.

Management confirmed that as progress is made in the FBC phase, cost reports will be presented to the Commercial Team meetings. Noting the early stage of this phase, no cost reports had been provided at the date of reporting.

Welsh Government dashboard reports had not yet been requested for the project. Expenditure incurred to date was itemised separately on the overall UHB monthly monitoring return.

The OBC defined responsibility for risk management as resting with the Project Director; and a detailed risk register was included within the Estates Annex to the OBC submission. Total capital risk costs for the project were stated as £1.195m [UHB: £575k; SCP: £620k]. No further review of the register had been undertaken post OBC approval (**recommendation 4**).

Whilst in the early stages of contractual appointment, there were no defined performance monitoring systems in place for the SCP and advisers (**recommendation 5**).

However, in the context of the stage of the project to the point of our review, a **reasonable assurance** has been determined.



Workstreams:

We appraised the supporting structure of workstreams; robustness of supporting information; and co-ordination, scrutiny and approval of outputs.

The OBC identified the HSDU project as an integral part of the Clinical Futures Programme with specific workstreams named to oversee the management and implementation of the programme.

Further definition of workstreams [to include stakeholders and users] had been included in the PEP:

- Clinical Model Group;
- Workforce and OD Group;
- IT Group;
- Equipment Group; and
- Divisional / Directorate Project Teams / User Groups.

Whilst user interaction was evident, there was no visible documented evidence of user sign-off for the current stage of the project (**recommendation 6**).

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

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	-	6	-	6

Finding: Acceptance Certificate	Risk
The Project Owner and Project Director were defined in the OBC as the Chief Executive Officer and the Programme Director GUH & LGHs respectively (<i>title of the latter revised to 'Strategic Capital & Estates Programme Director'</i>). There was no evidence of completion of an Acceptance Certificate by these officers.	Lack of clarity and acceptance of delegated authority invested in the Project Director.
Recommendation 1	Priority level
Acceptance Certificates should be issued at projects to reflect the assignment of responsibilities (O)	Medium
Management Response	Responsible Officer/ Deadline
Agreed: acceptance of ownership for the project will be documented and authorised appropriately.	Strategic Capital & Estates Programme Director April 2019

Finding: Project Team Terms of Reference	Risk
The terms of reference for the Project Team were re-reviewed and approved in January 2019. Review of the document noted: • Reference is made to personnel, rather than roles / posts, restricting coverage of the duration of the project scheme; • Frequency of meetings is not specified; • Definition of quorate is not specified; and • Appointed Chairperson for the meetings is not defined. Whilst the terms of reference included identified personnel, it was not evident that a detailed resource (including skills) requirement plan had been undertaken in relation to the project.	Project governance is not effectively established.
Recommendation 2	Priority level
a) To enhance current arrangements, Project Team terms of reference should be updated (O). b) A mapping exercise [resources and skills] should be undertaken with remedial action taken to identify any gaps (O).	Medium
Management Response	Responsible Officer/ Deadline
Agreed: the terms of reference will be updated and approved at the next Project Team meeting.	Strategic Capital & Estates Programme Director April 2019

Finding: Contract Documentation	Risk
Post OBC approval, the SCP and advisers were procured under the new All Wales Designed for Life 4 Building for Wales Framework and all contract documentation was appropriately issued in relation to the same. However, receipt of signed contract documentation was after work / commissions had commenced and had yet to be signed by the UHB.	The longer-term liabilities are not fully confirmed until the contract is executed.
Recommendation 3	Priority level
At future stages of the project, contract documentation should be signed prior to the commencement of the respective commissions / works (O)	Medium
Management Response	Responsible Officer/ Deadline
Agreed: contract documentation [with the exception of that of the cost advisers] has been returned to the UHB. Arrangements have been made, with the Board Secretary for UHB, for the signing at the next Board meeting (scheduled end of March 2019).	Strategic Capital & Estates Programme Director April 2019

Finding: Risk Register	Risk
The risk management process for the project was outlined in the OBC and further defined in the PEP. A risk register was included in the Estates Annex of the OBC and defined total capital risk as £1.195m [UHB: 575k and SCP: £620k]. The register, and risk contingency, had not been reviewed post OBC approval. Whilst the content of the risk register was adequate, it was noted that not all risk had a defined countermeasure.	Inadequate risk management disciplines negatively impacting delivery of the project [including time, cost and quality].
Recommendation 4	Priority level
a) The risk register should be reviewed, and updated for the current phase of the project; and frequency of subsequent reviews suitably defined. (O) b) The detail of the risks, and their associated countermeasures, should be reviewed to ensure they are SMART. (O)	Medium
Management Response	Responsible Officer/ Deadline
Agreed: the planned approach is for the risk register to be reviewed on a quarterly basis. Post OBC approval, the first detailed review of the risk register is scheduled for April 2019.	Strategic Capital & Estates Programme Director April 2019

Finding: Performance Monitoring	Risk
As best practice, Health Boards should use the Key Performance Indicators (KPIs) that have been developed for the operative framework. Noting the current stage of the project [progress to the FBC stage], there are no defined performance monitoring systems in place for the SCP and the advisers. It is suggested that appropriate KPIs should be developed.	Proactive performance management cannot take place; poor performance goes unaddressed.
Recommendation 5	Priority level
A formal KPI process should be introduced at the current stage of the project, to monitor the performance of the SCP and advisers. (D)	Medium
Management Response	Responsible Officer/ Deadline
Agreed: discussions will be held with NWSSP:SES to confirm the KPI requirements to be implemented under the new framework.	Strategic Capital & Estates Programme Director May 2019

Finding: Stakeholder Involvement	Risk
Consultation of stakeholders / users is key in the development of a new building / facility. It was noted that stakeholders /users attended progress meetings as the OBC was being discussed / prepared and had input into the design and required facilities. However, there was no evidence of final sign-off prior to submission to Welsh Government.	Minimal stakeholder / user involvement leading to development of poorly informed business case.
Recommendation 6	Priority level
Key stakeholders and users should formally sign-off / approve the details to the included in the FBC; in addition to any changes that may be required to completion of the project (D)	Medium
Management Response	Responsible Officer/ Deadline
Agreed: future sign-offs required will be filed centrally to maintain the required audit trail.	Strategic Capital & Estates Programme Director On-going

Audit Assurance Ratings



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



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

Prioritisation of Recommendations

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

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

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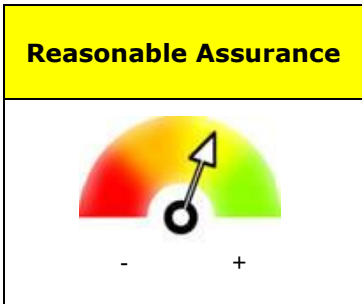
Capital Systems

**FINAL INTERNAL AUDIT REPORT
2018/19**

Aneurin Bevan University Health Board

Private and Confidential

**NHS Wales Shared Services Partnership
Audit and Assurance Services**



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Appendix A	Management Action Plan
Appendix B	Follow up of previously agreed management actions
Appendix C	Assurance opinion and action plan risk rating

Review reference:	SSU ABU 1819 02
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Auditor/s:	NWSSP: Audit & Assurance – Specialist Services Unit

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Committee	Audit Committee

ACKNOWLEDGEMENT

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1. Introduction and Background

This review has been completed in accordance with the agreed internal audit plan for 2018/19.

The objective of the audit was to evaluate the processes and procedures that support the management and control of capital projects within Works & Estates.

The audit sample was selected from the Discretionary Capital Programme as follows:

- Aseptic Pharmacy Unit, Royal Gwent Hospital;
- Combined Maternity & Children's Assessment Unit (CAU), Royal Gwent Hospital; and
- Ward Security Improvements, Nevill Hall Hospital & Royal Gwent Hospital.

The forecast outturn cost position of each project at the time of the audit was:

Project	Approved budget	Forecast Outturn (as at March 2019)	Variance
Aseptic Pharmacy Unit	£511,000	£511,000	£0
Maternity & CAU	£874,000 ¹	£912,268	+£38,268
Ward Security Improvements	£208,000	£157,860	-£50,140

¹Initial approved budget of £733k has been increased by £141k additional capital allocations to date.

2. Scope and Objectives

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

An objective of the audit was to evaluate the systems and controls in place within the Health Board, with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage are appropriately managed.

Accordingly, the focus of the audit included the following areas:

- **Follow Up** – An assessment of the status of recommendations made in the 2017/18 Capital Systems audit;

- **Monitoring & Reporting** – appropriate, adequate and accurate monitoring and reporting was evidenced in respect of time, cost, quality and risk factors;
- **Risk Management** – project risk registers were appropriately developed, maintained and reported;
- **Change management** - robust change management processes were defined and applied ensuring the impact of changes on time and cost were adequately controlled; and
- **Programme management** – appropriate arrangements were in place to monitor the construction programme, project programme and associated funding/ cashflow programme.

3. Associated Risks

The potential risks considered in the review were as follows:

- Previously agreed management actions had not been implemented, therefore acknowledged weaknesses in controls remain unaddressed;
- Projects were not effectively managed;
- Project over-runs on time and cost; and
- Failure to achieve the required quality or anticipated benefits.

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.

Positive arrangements were noted in the following areas:

- Five of the previously agreed recommendations, followed up at this review, had been closed. Four remain to be implemented (acknowledging that these have been delayed by the recent change in Head of Capital Planning);
- Appropriate external advisers had been appointed at each project to facilitate project and cost management;
- Progress meetings had been held regularly at each project, appropriate to the project size (i.e. fortnightly project progress

meetings at the smaller two projects, with a full project structure of Project Team and Project Board at the largest project);

- Monitoring arrangements were robust (in terms of, for example, the cost, time and risk position) at all three projects reviewed; with monthly cost reports submitted by the external cost adviser at the two larger projects, and relevant matters reviewed at the project meetings (as above); and
- Programmes were found to be well managed at each project, with extensions of time appropriately considered alongside instructed project changes.

However, certain recommended improvements have been raised:

- Internal monitoring at Project Manager level was sound, but there was no evidence of progress reporting to relevant Project Directors. Reporting and accountability requirements could be better defined at the Capital Procedures, to ensure that Project Directors are kept suitably informed of project performance, even at smaller schemes;
- The Project Director had not attended the Project Board meetings reviewed at the Maternity & CAU project. Further, a recent re-assignment of this role had not been formally documented;
- Risk registers applied had not utilised the standard best practice template required by the Capital Procedures. Further, one of the three registers had not been reviewed and updated since the project commenced;
- Project management control documents should be enhanced, to include the preparation of Project Execution Plans and the documentation of delegated authority arrangements; and
- The change control audit trail should be improved at the Maternity & CAU project, noting that significant changes. Whilst this was agreed by email, changes had not been formally documented using the required Variation Change Control Proforma.

In view of the generally positive arrangements in place at sampled projects, the overall level of assurance has been assessed as **Reasonable**.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Follow up			✓	
2	Monitoring & Reporting		✓		
3	Risk Management			✓	
4	Change Management			✓	
5	Programme Management			✓	

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

Design of Systems/Controls

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

Operation of System/Controls

The findings from the review have highlighted **6** issues that are classified as weakness 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**.

Follow Up



We sought assurance that previously agreed management actions had been implemented.

The status of these actions arising from the previous review (May 2018) is:

	High	Medium	Low	Total
Closed	-	5	-	5
Partially Implemented	-	1	-	1
Outstanding	-	1	2	3
Total	-	7	2	9

The detail in support of the above summary is included at **Appendix B**.

The two outstanding medium priority recommendations are:

- Whilst work has been undertaken to review and update the Capital Procedures, the updated Procedures require finalisation and approval; and
- Contracts at two of the three projects reviewed had not been executed until after works had commenced.

Noting the progress made, **reasonable assurance** has been determined.

Monitoring & Reporting



To ensure appropriate, adequate and accurate monitoring and reporting was evidenced in respect of time, cost, quality and risk factors.

Project structures at the projects reviewed varied in relation to the size of the projects.

A full structure of Project Board and Project Team operated at the Maternity & CAU project, with fortnightly progress team meetings operating at the two smaller projects.

Project Directors were assigned to each project; with support being provided by the Works & Estates Project Manager and the Service project lead, together with external project managers and cost advisers.

However, the appointed Project Directors were not in attendance at any of the project meetings reviewed. There was also a lack of reporting to the Project Directors from the project teams. The robustness of reporting and accountability arrangements at the projects should therefore be enhanced (**recommendation 1**).

There was a lack of visibility of Project Directors at each of the projects sampled. Additionally, at the Maternity & CAU project the Project Director role had recently been reassigned, but the change had not been formally documented (**recommendation 2**).

At the two larger projects (Maternity & CAU and Aseptic Pharmacy Unit), the role of the cost adviser included provision of monthly cost reports to the Works & Estates PM. This was not included in the arrangements at the smallest scheme, as this was minor work instructed via an order under the Measured Term Contract. The cost position at this project was seen to be appropriately monitored by the Project Manager in terms of invoices paid against the project budget.

The cost position, and wider project performance matters, including time and risk, were noted to be reviewed at project meetings, however reporting of such matters to the Project Director was not evident (see **recommendation 1**).

A Project Execution Plan (PEP) is an expected control set out in the Health Board's Capital Procedures, for projects over £500,000 in value. Such a document is beneficial to outline the project control framework, including the project scope and budget, project structure, risks and project management arrangements. However, a PEP was not in place at any of the projects reviewed (with two exceeding the £500k threshold for requiring this document) (**recommendation 3**).

It was also concluded that structures for project files and documentation should be standardised to enforce minimum control levels across projects (**recommendation 4**).

Noting the above, **limited assurance** has been determined.

Risk Management



To ensure that project risk registers were appropriately developed, maintained and reported.

Risks had been identified and documented in risk registers at each of the three projects reviewed. The registers were seen to have been regularly reviewed and updated at two of the three projects and, at the largest

project, the risk register was presented to the monthly Project Board meeting as a standing agenda item.

However, none of the registers had utilised the standard risk register template provided within the Capital Procedures.

Accordingly, there was a varying approach to risk scoring and the level of detail captured, with room for improvement based on best practice, at each register.

In particular, the Ward Security Improvements risk register did not comply with the traditional likelihood x impact (5x5) assessment, being the accepted basic principle for risk management. Further, the Aseptic Pharmacy Unit risk register had not been updated since project initiation (**recommendation 5**).

However, whilst noting this lack of consistency in approach to risk recording and assessment, we acknowledge that risks had been identified appropriately at all three projects, with the risk position being regularly reviewed and updated at two of the three projects.

Noting the arrangements were generally robust at two of the three projects, **reasonable assurance** has been determined.

Change Management



To confirm that robust change management processes were defined and applied ensuring the impact of changes on time and cost were adequately controlled.

As discussed at **finding 3**, Project Execution Plans were not in place at the projects reviewed. The formal documentation of the agreed delegated authorities in place at each project was also not evident (**recommendation 6**).

Change Management practices were therefore considered against the requirements of the Capital Procedures and contractual requirements.

At the Aseptic Pharmacy Unit and Ward Security Improvements projects, only one change had been agreed at each, managed within the project contingencies. Both had been appropriately documented and assessed, with authorisation given at an appropriate level noting the financial values involved (whilst recognising as above that the delegated approval limits had not been formally documented).

At the Maternity & CAU project, however, whilst email approvals of the changes to date and additional capital allocations were evident, the required Variation Change Control Proformas had not been utilised to formally document and approve the changes (**recommendation 7**).

Noting concerns were only evident at one of the projects sampled, **reasonable assurance** has been determined.

Programme Management



To confirm that appropriate arrangements were in place to monitor the construction programme, project programme and associated funding/ cashflow programme.

Construction programmes were in place, and seen to be regularly updated, at each of the three projects; with appropriate discussions taking place at the project meetings.

None of the projects had formally completed at the time of audit fieldwork (although the Ward Security Improvements project was substantially complete with no notable delays affecting cash flow (noting this project was let as an order against the Measured Term Contract, rather than a dedicated project contract)).

It was confirmed that extensions of time had been granted at the Aseptic Pharmacy Unit and Maternity & CAU projects, extending the agreed contract completion dates to accommodate contract variations instructed by the Health Board (as discussed above), as follows:

- Aseptic Pharmacy Unit: Contract completion date extended from 12th April 2019 to 1st May 2019 (2.5 weeks); and
- Maternity & CAU: Contract completion date extended from 18th March 2019 to 8th April 2019 (3 weeks).

The extensions of time had been appropriately assessed and were deemed to be required due to the additional work instructed by the Health Board.

Evidence was seen at each project that the implications of project delays on cash flow had been discussed with the Health Board's Finance team in relation to management of the Health Board's Capital Resource Limit (CRL).

Noting the programmes were found to be reasonably managed, **reasonable assurance** has been determined.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	0	6	1	7

Monitoring & Reporting

Finding 1: Reporting & Accountability	Risk
The Capital Procedures contain various references to reporting requirements at projects, including: <i>"All schemes, from a minor departmental upgrade to a procurement of a major item of medical equipment or major capital scheme to deliver a significant service change, are only successful if the following principles are reflected:...</i> <i>• There is regular reporting of progress and costs."</i> (3.1) and <i>"The project team reports on a regular basis using financial and non-financial Monitoring Forms included in the ABHB Capital Procedures."</i> (Annex 4). Reporting and accountability arrangements were found to vary at the three projects reviewed (which may be expected given the relative sizes of the projects). However, as addressed below (findings 3 & 6) project management arrangements and delegated authorities were not formally documented, e.g. via a Project Execution Plan (PEP). Therefore, control requirements could not be confirmed.	Projects may not be subject to appropriate oversight, scrutiny and control.

The Maternity & CAU project was found to have an appropriate monitoring and reporting structure, via the Project Team and Project Board (although note **finding 2** below in respect of Project Director attendance at Project Board).

However, at all schemes, noting the Project Directors did not attend project meetings, reporting to them on project progress from the Works & Estates (W&E) Project Managers (PM) was not otherwise evidenced.

We were advised that Service representatives attended Project Team meetings and would feedback relevant information accordingly, however we were not sufficiently assured that this would include key information such as the cost and time position, or other key risks as managed by the W&E PMs.

It is acknowledged that projects are additionally reported, on an exception basis, to the monthly Estates & Facilities Capital meetings. However, the Project Directors did not attend this forum.

In assessing the above, we note that in recent years the Health Board's capital programme contains a greater number of smaller projects (e.g. those under £1m), and that the Capital Procedures do not sufficiently define the control requirements for monitoring and accountability, at such smaller schemes.

Recommendation 1	Priority level
Capital Procedures should define appropriate reporting and accountability requirements specifically in relation to smaller schemes (D).	Medium
Management Response	Responsible Officer/ Deadline
Agreed. The majority of the smaller projects carried out in 2018/19 were delivered using a number of variable structures and reporting mechanisms. Whilst projects generally over £500K are managed through a consistent approach the smaller projects lacked the same consistency. It is recognised that smaller projects do not require labour intensive controls, however the Capital Procedures are to identify a 'standard' set of appropriate reporting documentation and structured delivery documentation to ensure a consistent approach.	Head of Capital Planning September 2019

Finding 2: Project Director	Risk
The Capital Procedures state that: <i>"The Chief Executive/Director of Planning has overall responsibility for any Capital project and shall ensure (normally through delegation to the Project Director) that: ...</i> <i>The Project is the responsibility of one named individual with clear duties and responsibilities."</i> (3.2) And that the Project Director will: <i>"Lead and direct (on behalf of the Project Owner) the Project Board and Project Team(s) towards the successful delivery of the project objectives as agreed with the Project Owner (Chief Executive) and ABHB Board."</i> (Annex 4) A project director, of appropriate seniority and role (in relation to the focus of the project) was appointed at each project. As outlined in finding 1, the limited visibility of reporting to the Project Director on project progress was noted. At the largest project, Maternity & CAU, a project board was in place, confirmed to meet regularly and discuss an appropriate agenda, supported by relevant papers. However, the named project director did not attend the Maternity & CAU project board meetings reviewed. The Estates Project Manager advised that a deputy	The project may not be appropriately directed and controlled.

attended in their place. We were also advised that the Project Director role had subsequently been reassigned (to the deputy seen to be in attendance at the above meetings), however this had not been formally documented.	
Recommendation 2	Priority level
a) The assignment of the Project Director role should be formally documented, and accepted. b) Project Directors should ensure appropriate visibility at projects (O).	Medium
Management Response	Responsible Officer/ Deadline
Agreed. To ensure that project responsibilities are carried out in accordance to Capital Procedures, Project Directors are appointed to monitor that controls and accountability are in place. It is the case that Project Directors have rarely attended project boards or progress meetings in the projects identified in this sample. How to improve the attendance of this key role will need to be reviewed.	Head of Capital Planning / Project Directors May 2019

Finding 3: Project Execution Plan	Risk
The NHS Capital Investment Manual, (which provides project management best practice guidance), defines a Project Execution Plan (PEP) as a: <i>"... core document for the management of a project. It is a statement of policies and procedures defined by the project director... It sets out in a structured format the project scope, objectives and relative priorities."</i> The Health Board's Capital Procedures state (at section 5.2.4) that: <i>"Subject to Capital Group agreement a PEP should also normally be developed for major schemes in excess of £500,000 (Annex 12)."</i> A Project Execution Plan (PEP) was not in place at any of the projects reviewed. Both the Maternity & CAU, and the Aseptic Pharmacy Project, were over the £500k threshold as defined in the Capital Procedures.	Lack of an up to date central reference point for project officers may reduce project control.
Recommendation 3	Priority level
A PEP should be prepared for major schemes in excess of £500,000, in accordance with the Capital Procedures (O).	Medium

Management Response	Responsible Officer/ Deadline
Agreed. We will reinforce the importance of this and consider how the requirement can be tailored to the size of the project. Head of Capital Planning response: The Project Execution Plan is a key document setting out typically roles, responsibilities, delegated authorities and general project management arrangements. To assist in 'good practice' and consistent approach in project delivery, the Head of Capital Planning will review the Capital Procedures with view to development of a less onerous PEP for minor projects below £500K whilst providing appropriate governance for Project Director/Project Delivery Team	Divisional Director of Facilities / Project Director oversight (with implementation by Works & Estates) May 2019

Finding 4: Project documentation	Risk
The Capital Procedures, in Section 3.2 Project Management, states: <i>"Appropriate project files and documentation are kept in such a way that will allow auditors to examine the project."</i> Whilst 2 of the 3 project files were well ordered and able to easily identify the required documentation during the audit, the Ward Security Improvements files, despite being the smallest project, spanned 4 full large lever arch files with no segregation into categories of documentation. Although all documentation was evident, its lack of categorisation diminished its purpose to enhance project control.	Project documents may not be appropriately stored for ease of reference.
Recommendation 4	Priority level
Structures for project files and documentation should be standardised to enforce minimum control levels across projects (O).	Low
Management Response	Responsible Officer/ Deadline
Agreed. We will implement a standard filing approach for all projects.	Divisional Director of Facilities June 2019

Risk Management

Finding 5: Risk Registers	Risk
The Capital Procedures provide a risk register template at Annex 11A, aligned to best practice requirements for risk assessment and documentation. It was confirmed that risk registers were in place at all each of the projects reviewed. However, none of the risk registers utilised the template provided at the Capital Procedures. Accordingly, each register contained varying degrees of detail: • Only the Ward Security risk register was costed (although the Aseptic Pharmacy Unit register did include a weighting for cost impact on a scale of 1-5); • The Ward Security register did not use the typical risk scoring methodology of likelihood x impact (instead focusing only on cost impact to generate the risk score, which may mean risks with high impacts on matters such as e.g. patient safety, may not receive sufficient weighting); • The Ward Security register did not assign risk owners; and • The Ward Security and Maternity & CAU registers had been updated regularly throughout the projects. However, the Aseptic Pharmacy Unit register had not been updated since the early stage of the project.	Project risks may not be appropriately identified and managed.

Accordingly, there is room for improvement in the standardisation in risk management practice across projects.	
Recommendation 5	Priority level
a) Projects should utilise the standard risk register template included at Annex 11 of the Capital Procedures. b) Risk registers should be regularly reviewed and updated throughout the project life cycle (O).	Medium
Management Response	Responsible Officer/ Deadline
Agreed. We will ensure projects apply a standardised, best practice approach to risk recording and assessment.	Divisional Director of Facilities May 2019

Change Management

Finding 6: Delegated Authority arrangements	Risk
The Health Board's Standing Orders & Delegation of Powers define the delegated authority process for the UHB. Further clarity in respect of projects is provided at the Capital Procedures. The Capital Procedures state: <i>"Successful Capital Programme and Project Management can only be achieved if named individuals have a clear role and responsibility as well as delegated authority."</i> (1.4) And further clarifies that the Project Director's role includes, to ensure: <i>"There is a clear scheme of delegation that supports each individual's levels of responsibility."</i> (Annex 4). The overall project budget was confirmed to be assigned within the Health Board's financial system to the nominated Project Director at each project. Therefore, any project expenditure would have to be appropriately authorised by the budget holder / Project Director before being released. However, prior to releasing expenditure, financial commitments can be enacted at contractual changes (see also finding 7). Delegated authorities to authorise the approval of the funding of project changes should be appropriately documented at project commencement. Project managers advised that arrangements had been verbally agreed, but not	Potential insufficient control over project budget. Financial commitments may be authorised outside approved delegated limits.

recorded. This links with finding 3 above in respect of a Project Execution Plan, in which delegated authority arrangements should typically be defined.	
Recommendation 6	Priority level
Delegated authorities should be defined (O).	Medium
Management Response	Responsible Officer/ Deadline
Agreed. Without the regular attendance of the Project Director and early development of a Project Execution Plan (PEP), delegated authority limits could be unclear to the project delivery team. It is imperative that clear roles and responsibilities and delegated limits are clearly understood from the inception of the project. In line with recommendation no:3 above a Project Execution Plan template is to be produced and included in the Capital Procedures Document for schemes below £500K. Project Execution Plans for above and below £500K are to be implemented for each project accordingly.	Head of Capital Planning (oversight role) Project Directors (at individual projects) May 2019

Finding 7: Change Control	Risk
The Capital Procedures state, in respect of change control: <i>"Any material change to the intended works is to be advised to the Project Director by the Project Manager in the form of a proforma [Annex 20]. The proforma to indicate the reason for design change, cost implications and programme implications...</i> <i>Change control forms must be completed although there may be no cost implications as the Project Director has to agree any design changes."</i> Each project was reviewed to ensure changes agreed to date had been documented and approved appropriately in accordance with the Capital Procedures and contractual management requirements. As noted approval of changes within specific delegation arrangements could not be confirmed, however, approvals were deemed appropriate noting: • Aseptic Pharmacy Unit: One change had been agreed to date, to the value of £51,035, which was managed within the project contingency. The change had been appropriately documented using the Variation Change Control Proforma and was approved by the Project Director; and • Ward Security Improvements: There was one minor change of £1,955.90, approved by the Works & Estates Project Manager via PMI (Project Manager Instruction). At the Maternity & CAU project, significant changes had been agreed to the original approved scope of works, requiring additional discretionary funding to be	Project changes may not be appropriately considered and approved. Potential overspend and additional pressure on the discretionary fund.

allocated to the project to cover the increased costs. Details were noted as follows:

- The latest cost report reported a forecast outturn of £912,268, against the original approved budget of £733k. Additional discretionary funding had been approved in the sum of £141k to date to fund the increased scope of works;
- 16 Contract Administrator's Instructions had been issued to date, signed by the Contract Administrator (external PM). However, a number of these had not been costed, as the contractor had not yet provided quotations to substantiate the costs; and
- There was email communication within the UHB approving the increased scope and additional funding, but the formal Variation Change Control Proforma, as required by the Capital Procedures, had not been utilised. Accordingly, the audit trail of changes and approvals lacked clarity.

Recommendation 7

The Variation Change Control Proforma included at Annex 20 of the Capital Procedures should be appropriately utilised (O).

Management Response

Agreed. We will reinforce to project managers and project directors the importance of using appropriate change control documentation and authorisation.

Priority level

Medium

Responsible Officer/ Deadline

Divisional Director of Facilities
May 2019

Follow Up of Previously Agreed Management Actions

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Current status as at February 2019	Updated Responsibility & Timescale
1	Management should review, update and arrange for the approval of: a) Standing Orders; Standing Financial Instructions and the Scheme of Delegation; and b) Capital procedures; in accordance with their review and expiry dates.	Head of Capital Planning September 2018	Medium	Outstanding: Partially Implemented a) The Standing Orders (including Delegation of Powers) and Standing Financial Instructions available on the internet were last updated in 2014. b) Work has progressed on the updating of the Capital Procedures, with evidence provided of the updates made to the documents. However, due to the recent change in Head of Capital Planning, the revised Procedures had not yet been formally approved.	Head of Capital Planning September 2019
2	Approved lists of suppliers should be reviewed and updated in accordance with capital procedures.	Divisional Director of Facilities June 2018	Medium	Closed: Superseded Management confirmed that the Works & Estates department no longer utilise the approved list. If at a point in the future a decision is made to re-introduce this, management confirmed that a full	N/A

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Current status as at February 2019	Updated Responsibility & Timescale
				review would be undertaken to ensure the list was updated and fit for purpose. It was also confirmed, during audit testing, for the three schemes sampled, that none had been selected from the existing Approved List.	
3	Operational procedures for approved lists should appropriately supplement capital procedures e.g. criteria for addition to and selection from the list.	Divisional Director of Facilities June 2018	Medium	Closed: Superseded As above.	N/A
4	Selection of contractors from approved lists should be made in accordance with capital procedures.	Divisional Director of Facilities June 2018	Medium	Closed: Superseded As above.	N/A
5	Management should undertake financial and insurance vetting of parties invited to tender in accordance with capital procedures.	Divisional Director of Facilities June 2018	Medium	Closed: Implemented It was confirmed that, for the three schemes reviewed during the audit, two had undertaken financial vetting of all parties.	N/A

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Current status as at February 2019	Updated Responsibility & Timescale
				At the third, attempts had been made to obtain a financial report, but difficulties with the department's account prevented this from taking place in a timely manner. In order not to delay the project any further, work commenced without a financial check. Insurance checks were appropriately evidenced. As the omission above was demonstrated as an exception, this recommendation has been recognised as closed.	
6	Capital procedures should be updated to specifically require commentary on variance to the pre-tender estimate at the tender evaluation report.	Head of Capital Planning September 2018	Low	Outstanding Accepting that the review and approval of the Capital Procedures has yet to be completed; this element was not addressed in the revised draft document.	Head of Capital Planning September 2019
7	Version control should be applied to business cases, with final (approved) versions	Head of Capital Planning	Low	Outstanding The Head of Capital Planning confirmed he would review this and	Head of Capital Planning May 2019

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Current status as at February 2019	Updated Responsibility & Timescale
	appropriately referenced and filed.	June 2018		ensure version control is applied to business cases.	
8	Appropriate contractual cover should be put in place in accordance with capital procedures.	Head of Capital Planning June 2018	Medium	Outstanding Of the three schemes reviewed, one was identified as being let under the Measured Term Contract, with central contractual arrangements in place. At the other two schemes, neither contract had been dated. It was confirmed that both contracts had been executed circa three months after work had commenced on site.	Divisional Director of Facilities April 2019
9	Contract schedules should demonstrate an appropriate arithmetic check.	Head of Capital Planning June 2018	Medium	Closed: Implemented External Cost Advisers were appointed at each of the three schemes reviewed, with responsibility for administering the tender and contract processes. Evidence was noted in the tender reports that tender / contract	N/A

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Current status as at February 2019	Updated Responsibility & Timescale
				schedules had been checked and were confirmed as correct. (Note, the accuracy of the schedules has not been verified by Audit).	

Audit Assurance Ratings



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



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



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



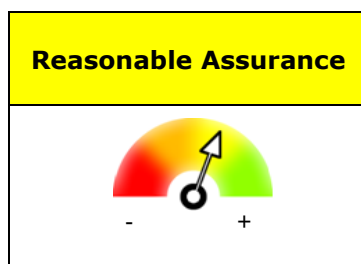
No Assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual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

Prioritisation of Recommendations

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

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

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



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Appendix A	Management action plan
Appendix B	Audit assurance ratings
Appendix C	Audit Test Findings

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Executive sign off:	Nick Wood, Executive Director
Distribution:	Gareth Hughes, Divisional Director of Facilities Neil Pearce, Head of Estates (Maintenance & Operations) Wayne Hicks, Statutory Compliance Manager
Committee:	Audit Committee

ACKNOWLEDGEMENT

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

Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan 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 Water Safety audit was commissioned in order to evaluate the associated processes and procedures that support its management and control. The audit will assess compliance with the requirements of Welsh Health Technical Memorandum (WHTM) 04-01, Safe Water in Healthcare Premises.

The audit forms a part of the approved 2018/19 internal audit plan.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the UHB, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The audit evaluated the systems and controls in place within the UHB with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas covered were appropriately managed.

Accordingly, the scope and remit of the audit was directed to the following areas:

- **Governance** - The Health Board had adequate arrangements in place to support the implementation of the approved code of practice. Also, that an appropriate policy is in place to address water safety issues, there are defined allocation of responsibilities, clear lines of communication and reporting and approval processes.
- **Risk Management** - Assurance that the Health Board had performed a suitable and sufficient assessment of risks. Risks are appropriately managed.
- **Monitoring and Reporting** - To ensure that the estate was appropriately monitored. To ensure that the Health Board had effective monitoring procedures in place e.g. the establishment of appropriate Water Safety Groups (WSGs) Assurance that there was appropriate record retention and dissemination of information through to the Executive team and Board.
- **Procedures** - To ensure that management were implementing applicable procedures – both internal and external requirements.
- **Management** - Assurance that relevant staff had received appropriate training, and appropriate resources are allocated. Assurance that an appropriate inspection / detection regime was operated.

3. Associated Risks

The potential risks considered in the review are as follows:

- Patient Safety;
- Prosecution / criminal negligence;
- Adverse publicity;
- Breach of regulations / Approved Code of Practice;
- Fines and defence costs;
- Ineffective / inappropriate governance arrangements;
- Ineffective / ill-informed management; and
- Ineffective risk control.

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 following issues were noted at the review:

- The Health Board's Water Safety Policy and Water Safety Plans were well defined and up to date;
- We evidenced a clear reporting line for water safety issues, from the sub-Water Safety Group, to the Water Safety Group, and upwards to the Health & Safety Committee and Executive Board;
- Training was up to date for all relevant staff with water safety responsibilities; and
- The sample of planned preventative maintenance (PPM) tasks reviewed during the audit had all been completed as required by the Water Safety Plan.

Whilst noting that the above, the audit identified some issues in the practical application of the required procedures. Key issues included:

- Improved attendance at the Water Safety Group was required;
- Flushing records were not found to be in place on the majority of wards visited during the audit;
- We noted some room for improvement in the audit trail and review process at the log books utilised to record the completion of scheduled maintenance tasks; and

- A large number of high priority actions were outstanding from the last Royal Gwent Hospital risk assessment.

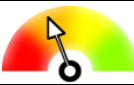
Accordingly, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with water management within the UHB at the time of the audit is assessed as **Reasonable Assurance**.

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

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

5. Assurance Summary

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

Assurance Summary					
1	Governance				✓
2	Monitoring and Reporting			✓	
3	Procedures				✓
4	Management		✓		
5	Risk Management		✓		

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

Design of Systems/Controls

The findings from the review have highlighted **no** issues that were classified as weaknesses in the system control/design for water safety.

Operation of System/Controls

The findings from the review have highlighted **four** issues that were classified as weaknesses in the operation of the designed system/control for water safety.

6. Summary of Audit Findings

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

Governance

To ensure there is an appropriate policy in place to address water safety issues, there is defined allocation of responsibilities, clear lines of communication and reporting and approval processes.



The Health Board has a well-defined Water Safety Policy in place. The current Policy was last updated and approved in October 2018, with the next review scheduled for 2021.

We evidenced a clear reporting line for water safety issues. The Water Safety Group reports into Health and Safety Committee, Infection Prevention Committee and Quality and Patient Safety Committee, with line of sight into the Executive Board.

The Health Board had appointed an external adviser (NWSSP: SES) to provide guidance and assurance on safe water management activities. Regular audit reviews at the UHB's key sites were undertaken, and an annual report issued summarising key compliance matters requiring attention.

The Health Board had formally appointed a Responsible Person (RP), who has the responsibility for routinely monitoring and testing compliance for water safety. Within the structure, there is additionally a central Deputy Responsible Person (DRP) and additional DRPs at each main site. Whilst noting the DRP role at Neville Hall Hospital was vacant at the time of the audit, we were assured that the central DRP role provided sufficient cover.

All roles within the structure had been formally assigned, with job descriptions and appointment letters all evidenced during the review.

Noting the positive governance arrangements operating, we therefore determine **Substantial assurance** in this area.

Monitoring & Reporting

To ensure that the Health Board has effective monitoring procedures in place e.g. the establishment of appropriate Water Safety Groups (WSGs). Assurance that there is appropriate record retention and dissemination of information through to the Executive team and Board.



The internal monitoring and reporting of water safety was the responsibility of the Statutory Compliance Manager within Works and Estates. Key Performance Indicators (KPIs) were utilised to monitor compliance, based

on the requirements of the Water Safety Plan. However, we did not find evidence that Works and Estates were monitoring flushing practices, as required in the Water Safety Plan (see **recommendation 3**).

The UHB had established a Water Safety Group (WSG), in line with Welsh Health Technical Memorandum (WHTM) 04-01 (Part B), which is centrally responsible for monitoring the management of water safety within the Health Board. However, we note that the terms of reference did not define a quorum for the Group.

Whilst the WSG was found to be meeting regularly, with appropriate information reported and discussed, there were certain issues with attendance. Absences included representatives from Clinical Boards/Wards, Infection Prevention nurses, nursing staff and Facilities (**recommendation 1**).

In addition, there is a sub-Water Safety Group comprising of RPs and DRPs, where more specific, technical issues are discussed. Minutes from the sub-Water Safety Group were reported as a standing agenda item at the main Water Safety Group.

We found that water safety records were retained within the Estates department for the required 5-year period as a minimum, and all records requested during the audit (i.e. legionella/pseudomonas sampling and temperature checking) were available for review. There were issues with retention of water flushing logs, and this is discussed further in the **Management** section below.

Noting, however, that arrangements were generally robust in this area, **Reasonable assurance** has therefore been determined.

Procedures

To ensure that management were implementing applicable procedures.

The Water Safety Plan has been robustly prepared in accordance with latest guidance. Local site arrangements had also been defined.

This was last formally reviewed and approved in October 2018, management confirming that the Plan was a "live" document and was updated as required, in accordance with best practice.

The Plan was readily available to Estates staff to assist with the day-to-day undertaking of their duties.

Substantial assurance is therefore determined in respect of procedural arrangements. Note that the application of the Plan is discussed and assessed in the **Management** section below.



Management



Assurance that relevant staff have received appropriate training, and appropriate resources are allocated. Assurance that an appropriate inspection / detection regime is operated.

It was confirmed that formal training for the appointed RPs and DRPs was in date, having been renewed in February 2019 ahead of the expiry date. Wider water hygiene training had also been delivered in 2017, for Estates staff with involvement in water management.

To ensure that the Health Board had appropriate monitoring and testing arrangements in place to enable effective water safety management, a sample of 10 PPM (planned preventative maintenance) log books held at Ysbyty Ystrad Fawr (YYF) and Royal Gwent Hospital (RGH) were reviewed during the audit.

We found generally robust practices in operation at YYF; there were no issues noted with regards backlog of re-testing, checking or remedial works.

However, at RGH, the following issues were noted:

- Shower cleaning log books had not been updated appropriately to demonstrate when the quarterly activities had been completed. However, management confirmed that the PPM activities had been completed as required, therefore; this is noted as a record keeping issue as opposed to a compliance issue; and
- Log books were only being signed off on an annual basis, which would be insufficient to detect any missed PPMs.

(Recommendation 2).

Flushing of infrequently used outlets is the responsibility of wards at RGH, and Hotel Services at YYF. We found a general lack of the required flushing records at both sites visited, with staff seemingly unaware, in a number of cases, of what the requirements were for their area. We additionally did not find evidence that Works and Estates were monitoring flushing practices, as required in the Water Safety Plan.

We therefore could not gain assurance that flushing was being undertaken as required (**recommendation 3**).

Audit testing is further detailed at **Appendix C**.

Noting in particular the high risk associated with the potential lack of sufficient flushing practices, **limited assurance** has been determined in this area.



Risk Management

Assurance that the Health Board has performed a suitable and sufficient assessment of risks, and that risks are appropriately managed.

The legionella risk was captured at the Health & Safety Risk Register, with the register reviewed at each Health & Safety Committee register as a standing agenda item.

Legionella was rated as an "extreme" risk at the register reviewed, with a target recorded to reduce this to "high." Mitigating actions were appropriately recorded, with additional required controls highlighted that would contribute to a reduced risk rating, if implemented.

The risk was similarly captured at the Estates & Facilities Operational risk register.

In accordance with the HSE Approved Code of Practice (ACoP), it was confirmed that site risk assessments had been undertaken in December 2017, and reported to the Health Board, along with associated action plans, identifying the required remedial works to address the risks identified.

The assessments for the two sampled sites were reviewed during the audit. It was noted that, whilst YYF had completed all remedial actions by March 2018, there were a significant number of outstanding actions at RGH, including 47 "Priority One" issues (to be addressed "asap").

Whilst we evidenced reporting to the Water Safety Group of this position, noting the length of time these have been outstanding it is recommended that the position be reviewed and considered in terms of the outstanding risk to the Health Board (**recommendation 4**).

Limited assurance was therefore determined in respect of Risk Management.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	2	2	0	4

Monitoring & Reporting

Finding 1: Water Safety Group	Risk
The Welsh Health Technical Memorandum (WHTM) 04.01 "Safe Water in Healthcare Premises" (Bart B), states in respect of the Water Safety Group (WSG): <i>"The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation and review of the WSP [Water Safety Plan]. The aim of the WSG is to ensure the safety of all water used by patients/residents, staff and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring it identifies water-related hazards, assesses risks, identifies and monitors control measures and develops incident protocols."</i> (6.3). The UHB has implemented a Water Safety Group, as required above, which was found to meet with the required frequency. Section 6.6 additionally states that representation is required from: <i>"...estates (operations and projects), infection control, medical microbiology, nursing, augmented care, housekeeping/support services, an Authorising Engineer/independent adviser, medical technical officers, specialist users of water (such as renal units and departments offering aquatic therapy), and sterile services departments (SSDs)."</i>	Governance arrangements may not be sufficient to facilitate effective oversight and control of legionella.

From a review of WSG meetings taken place in the last year, it was noted that not all required staff were attending the Group regularly. Absences included Clinical Boards, infection control nurses, nursing staff and Facilities. This reduces the opportunity for sharing of information and best practice, with wards potentially uninformed of their responsibilities. We noted that a quorum for attendance had not been documented in the terms of reference. <i>Note this links with finding 7 respect of flushing practices operating at the sites reviewed.</i>	
Recommendation 1	Priority level
a) A quorate attendance should be determined for the Water Safety Group, with "decision makers" and others "in attendance" clarified. b) Attendances of the Water Safety Group should be reviewed, with staff reminded of their responsibilities to attend; to ensure key groups are appropriately represented (O).	Medium
Management Response	Responsible Officer/ Deadline
Agreed. Poor attendance at the WSG is agreed, and has already been identified by management. Work to improve attendance commenced in early 2019, with commitment secured from senior management to improve attendances.	Head of Estates (Maintenance & Operations) April 2019

The meeting held on 21st January 2019 was well attended by all disciplines.

Management

Finding 2 : Water Safety PPMs	Risk
It was confirmed that both the WHTM 04-01 and the Health Board's Water Safety Plan (WSP) require that legionella sampling should be undertaken quarterly and pseudomonas sampling semi-annually. In addition, the Works and Estates department are required to carry out monthly temperature monitoring, shower checks, calorifier monthly checks, water tank inspections and thermostatic mixing valve (TMV) testing. An external contractor had been appointed to carry out chlorine tank checks and tank cleans. This audit included site visits to Ysbyty Ystrad Fawr (YYF) and Royal Gwent Hospital (RGH), to review the documentation available in respect of routine Estates checks in relation to water management (managed via PPMs; planned preventative maintenance schedules). A sample of 10 PPMs was reviewed at each site to ensure compliance with the requirements of the WHTM 04-01 and the WSP (testing details are included at Appendix C). At YYF, the sample was compliant and no issues were identified. However, certain issues were noted in respect of the testing at RGH, in respect of maintenance of log books: In respect of the required quarterly shower cleans, a number of log books had not been completed. These had often been missed on two consecutive quarters. These findings were reviewed by management, who confirmed that, whilst the log books had not been completed correctly, the Planet FM electronic system confirmed that the PPMs had been undertaken	Required water safety tasks may not be undertaken as set out in the Water Safety Plan, increasing the risk to patient / staff health. Identified risks may not be effectively prioritised and addressed, risking non-compliance with legislative requirements.

appropriately. This is therefore a record keeping issue, as opposed to a compliance issue; and Logbooks for all checks had been signed off annually, rather than when the jobs were completed. As a result, any tasks which had not been done (as above) might not be identified until the end of the year.	
Recommendation 2	Priority level
Logbooks should be accurately maintained, and reviewed and signed off in line with PPM frequency, in order to confirm that all checks have been undertaken as required (O).	Medium
Management Response	Responsible Officer/ Deadline
Agreed. We have confirmed that all the shower cleans were completed as required, with the jobs recorded in the electronic Planet FM system. However, the manual recording sheets are not in the log book and we acknowledge this is a local log book management defect. We also agree there should be more frequent Supervisor sign off within the log book. The quarterly shower PPM sheets have already been amended to enable quarterly sign-off as recommended.	Head of Estates (Maintenance & Operations) April 2019

Finding 3: Flushing	Risk
In respect of flushing requirements, WHTM 04.01 (6.42) states: <i>"HSG274 Part 2 recommends that generally, for infrequently used outlets, flushing is carried out once a week but that in healthcare facilities the risk assessment, as agreed by the WSG, may indicate a higher frequency, and water draw-off should form part of the daily cleaning process. The procedure for such practice should be fully documented and covered by written instructions."</i> The Water Safety Plan further clarifies that, on augmented wards, flushing should be undertaken daily and records retained on the Infection Prevention Nurses' Cleaning Schedule (WSP section 3.8), for annual inspection by Works and Estates. In order to manage the flushing requirements in the Health Board, Works and Estates have issued wards with worksheets, to record and sign-off when flushing has been undertaken. The audit sampled 10 wards at YYF and RGH to review the flushing records in place. Findings were as follows (full testing details are included at Appendix C): • Only one ward at RGH held the required documentation completed in compliance with flushing procedures (Critical Care). High risk wards such as Maternity, Neonatal and Haematology could not supply current flushing records. • At YYF, Hotel Services have delegated responsibility for flushing as part of the cleaning regime. The audit found that no records could be provided to	Required procedures may be undertaken incorrectly / may not be undertaken at all. Risk to patient / staff health. Potential non-compliance with ACOP / WHTM 04-01.

demonstrate that flushing was being completed (However, we were separately advised that Maternity Services flushed the birthing pool).

Whilst the Water Safety Plan requires annual reviews by Works & Estates of flushing practices, we did not identify any such reviews having taken place.

It is acknowledged that the above lack of completed flushing records may in part be due to the fact that there were no infrequently used outlets on the wards visited. However, staff when questioned were generally unclear as to what constituted "infrequently" used, and did not have the WSP-approved documentation to hand (which provides written guidance on this). There was also a risk that, whilst an outlet may have been unused for one day (e.g. a shower), staff would not recall by day 2 whether it had been used the previous day. Therefore, local control over identifying "infrequently used" outlets appeared weak.

This issue may be compounded by **finding 1**, where it was noted that required staff were not regularly attending the Water Safety Group in order for flushing requirements to be reviewed.

We therefore concluded that, in addition to improved compliance with the WSP, and central monitoring by Works and Estates, that training should be arranged for staff with flushing responsibilities.

Noting it was unable to be confirmed that outlets were being flushed appropriately, these issues have been rated as High priority.

Recommendation 3	Priority level
a) Flushing should be undertaken, and documented, in accordance with the requirements of the Water Safety Plan. b) Flushing records held on wards / by Hotel Services should be checked periodically (frequency to be defined by the WSG) by Works and Estates to ensure that flushing is being undertaken in accordance with the WSP. c) Training should be arranged for staff with flushing responsibilities (O).	High
Management Response	Responsible Officer/ Deadline
Agreed. We accept this finding and are currently working to resolve. Management recognise that buy-in is required from the top to drive this issue, being Health Board-wide. This will be raised again with Infection Control, and a service lead will be identified to take this forward. Flushing monitoring is a weakness because it is carried out by different persons depending on circumstances. This is something we accept needs improving. However, the priority will be identifying the infrequently used outlets to identify if there is a need for flushing.	Head of Estates (Maintenance & Operations) April 2019

Risk Management

Finding 4: Risk Management	Risk
The current risk assessments and action plans (dated December 2017) for the sampled sites (YYF and YGH) were reviewed. It was confirmed that all required actions in relation to YYF had been completed. However, at the time of the audit, a large number of outstanding actions were noted at the RGH action plan. These most notably included 47 Priority One (i.e. to be completed asap), and 50 Priority Two (to be completed within 2-3 months) actions. The on-site DRP advised that difficulties in completing actions related mainly to insufficient resource available to carry out the remedial jobs identified. It is acknowledged that not all recommended actions may need to be completed, providing alternative mitigating controls had been put in place. It is also acknowledged that certain actions may not be feasible to complete (e.g. due to cost). However, where this is the case, this should have been clearly recorded on the action plans (which was not evidenced during the audit).	Identified risks may not be effectively prioritised and addressed, risking non-compliance with legislative requirements.
Recommendation 4	Priority level
a) A review should be undertaken of all outstanding high priority actions arising from the latest risk assessments, including assessment of the risk to the Health Board of those not being completed. b) A plan should be put in place to address the outstanding actions, where appropriate.	High

c) The results of this exercise should be reported to the Water Safety Group (O).	
Management Response	Responsible Officer/ Deadline
Agreed. We accept this recommendation and intend to remedy this unacceptable delay in RGH addressing actions arising from the most recent risk assessments. We have already liaised with the responsible officer to review the action plan and ensure it is brought up to date asap.	Head of Estates (Maintenance & Operations) April 2019

Audit Assurance Ratings



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



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



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



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

Prioritisation of Recommendations

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

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

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

Flushing at Royal Gwent Hospital (see recommendation 3).

Ward	Flushing records held	Flushing undertaken	Comments
Pathology	Y	Y	No - most recent from 07/18
Delivery Suite	N	Y	No - no documents for bath in room 5 - want it removed
Maternity Ward	N	Yes shown cleaning schedule	No - no proof of specific flushing and not correct forms
Neonatal B5	N	All used	No - Wanted an office sink removed
Neonatal	N	Y	Unused shower for parents-no form showing flushing being done
Haematology B6	N	Everything used	No - Had a bath removed
Gynaecology theatre	N	Y	Unused shower in store room said it was flushed everyday no evidence
ante-natal	N	N	Unused sinks in offices not flushed
Foetal maternal medicine	N	N	No - all used
Critical care	Y	Y	Up to date

Flushing at Ysbyty Ystrad Fawr

We were advised that no flushing was undertaken. (see **recommendation 3**).

Water Safety

Final Internal Audit Report

Aneurin Bevan University Health Board

Quarterly Shower Cleans at Royal Gwent Hospital

Boxes which are blank are where shower cleans have not logged as having been undertaken. In addition, the logbook was signed by the DRP in December 2018 as a whole rather than in individual quarters which might have identified where cleans had not been done (see **recommendation 2**).

Water Treatment Services Logbook
Quarterly Shower Cleans

Aneurin Bevan Health Board

Site: Royal Gwent Hospital

Date: 2018

Sheet 1/7

POINT REF.	ASSET NO:	Q	1st Quarter. Date.....				2nd Quarter. Date.....				3rd Quarter. Date.....				4th Quarter. Date.....			
			Hot	Cold	Mix	Cnd	Hot	Cold	Mix	Cnd	Hot	Cold	Mix	Cnd	Hot	Cold	Mix	Cnd
MAU Ward Toilet/Shower (MAU28)	04172	U	MC	11	11		S4	17	40	✓					S6	18	44	✓
MAU Ward Toilet/Shower (MAU29)	04173	A	MC	"	"		SS	18	41	✓					S6	18	44	✓
D2E Ward Toilet/Shower (D2045)	04030	R	MC	"	"	"									SS	18	44	✓
D2E Ward Toilet/Shower (D2036)	04039	T	MC	"	"	"									SS	18	43	✓
D2W Ward Toilet/Shower (D2010)	03993	E					MC	"	"	"					SS	18	44	✓
D2W Ward Bathroom/Toilet (D2019)	04006	R					MC	"	"	11					SS	18	44	✓
D3E Ward Bathroom/Toilet (D3050)	03886	L									S0	19	35	✓				
D3E Ward Bathroom/Toilet (D3050)	03883	Y									S0	19	37	✓				
D3E Ward Shower/Toilet (D3045)	03897										S1	19	41	✓				
D3W Ward Shower/Toilet (D3010)	03926										S1	19	41	✓	S6	18	44	✓
C4W Ward Male Toilet/Shower (C4118)	03771		MC	MC	"	"									SS	44	18	N
C4W Ward Female Toilet /Store room (C4122)	03777		MC	MC	"	"												
C4W Ward End Cubicle 4 (C4131)	03789		MC	MC	"	"												
C4E Ward Shower (C4E459)	03692		S4	13	40	✓									S7	18	43	✓
C4E Ward Toilet/Shower (C4E447)	03720		S4	13	40	✓												
D4E Ward Bathroom (D4058)	03831		MC	"	"	"	"								S6	17	44	✓
D4E Ward Bathroom (D4058)	03828		MC	"	"	"	"								S6	18	43	✓
D4E Ward Shower/Toilet (D4036)	03852		MC	"	"	"	"								SS	18	43	N
D4E Ward Shower/Toilet (D4058)	03838		MC	"	"	"	"											
D4W Ward Female Toilet/Shower	N/A (Maynell V8/3)						MC	"	"	"								
D4W Ward Male Shower	03804						MC	"	"	"								

Signed:

Position:

Supervisor

Date:

Dec 2018

Monthly Temperature Checks on Calorifiers at Royal Gwent Hospital

As above, the logbook was signed by the DRP in December 2018 as a whole rather than on a more regular basis (see **recommendation 2**).

Water Treatment Services Logbook HOT & COLD WATER SERVICES - TEMPERATURE CHECKS

Royal Gwent Hospital

Site: Main Building Calorifiers

Date: 2018

POINT REF.	NOTES	M	JAN.	FEB.	MAR.	APR.	MAY.	JUN.	JUL.	AUG.	SEPT.	OCT.	NOV.	DEC.
Calorifier 1 Flow	Central Plant Room	O	63	63	63	62	62	63	63	64	63	62	62	63
Calorifier 1 Return	Central Plant Room	N												
Calorifier 2 Flow	Central Plant Room	T	62	62	63	62	62	63	63	64	63	64	62	62
Calorifier 2 Return	Central Plant Room	H												
Calorifier 3 Flow	Central Plant Room	L	REMOVED											
Calorifier 3 Return	Central Plant Room	Y												
Calorifier 4 Flow	Central Plant Room		REMOVED											
Calorifier 4 Return	Central Plant Room													
Plate Ex 1 Flow	Main Plant Room feeding Mortuary													
Plate Ex 1 Return	Main Plant Room feeding Mortuary													
Calorifier 1 Flow	Main Kitchen feeding MDU		58	56	58	58	58	58	56	58	58	59	59	59
Calorifier 1 Return	Main Kitchen feeding MDU		54	53	55	54	55	56	56	58	58	58	58	58
Calorifier 1 Flow	Opthamology Plant Room		67	68	69	67	68	68	67	66	67	67	67	67
Calorifier 1 Return	Opthamology Plant Room													
Calorifier 2 Flow	Opthamology Plant Room		66	67	69	66	66	69	66	66	68	68	68	68
Calorifier 2 Return	Opthamology Plant Room													

Signed:

Position:

Supervisor

Date:

Dec 2018



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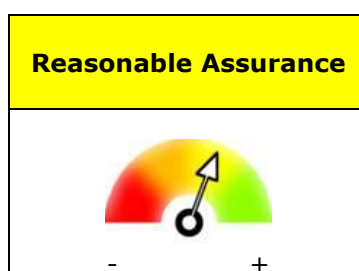
Final Internal Audit Report 2018/19

Aneurin Bevan University Health Board

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Audit and Assurance Services



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Opinion and key findings

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Appendix A	Management Action Plan
Appendix B	Assurance opinion and action plan risk rating
Appendix C	Levy calculations
Appendix D	Detailed coverage (Brief)

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Executive sign off	Nicola Prygodzicz, Director of Planning and Performance – Senior Responsible Officer

Distribution	➤ Nicola Prygodzicz, Director of Planning and Performance – Senior Responsible Officer ➤ Richard Bevan, Board Secretary ➤ Corrina Casey, Clinical Futures Programme Lead ➤ Hannah Capel, Senior Programme Manager

Committee	Audit Committee

Please note:

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

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1. Introduction and Background

This audit was commissioned by Aneurin Bevan UHB in accordance with its 2018/19 audit plan.

The Designed for Life Building for Wales framework agreement provides that auditors representing the Welsh Government, or their agents (e.g. Aneurin Bevan UHB), “*will visit contractor’s offices to establish defined costs incurred... and may return on an annual basis as required*”.

This audit sought to review the lead contractor (Supply Chain Partner - SCP) costs which could not be routinely checked by the Cost Adviser e.g. central overhead allocations.

Cost Adviser assurances

Assurance was obtained that work is performed (vetting / checks applied) by the Cost Adviser (CA) in relation to:

- Contractual arrangements and fee;
- directly invoiced sums / contractor charges;
- Wages and labour costs checked to ledger (would include on-costs / overhead);
- An executive assumed the role of SCP project lead on closure of the South Wales regional SCP office at additional cost as notified by the Cost Adviser to the project team.
- Holiday & sickness deductions - amended following CA challenge;
- Items of c.£54k disallowed costs (primarily training and agency fees) have been deducted from valuations to date by agreement with the Cost Adviser;
- Accruals;
- Directly charged ineligible training (and associated substance);
- Inflation; and
- Vesting (of title) agreements – re: off-site manufacture.

Cost Adviser issues raised

The Cost Adviser raised the following issues for investigation by the Open Book auditor:

- he was aware that the SCP (executive) project lead was being charged out at a rate and not at actual (defined) cost as per the contract;
- he had challenged and obtained adjustment for holiday and sick pay; and
- he had recently found certain redundancy costs being wholly charged at another project by the same contractor.

2. Scope and Objectives

Accordingly, the focus of the audit was on the various elements of charge, notably the following areas:

- the control framework;
- the fee - off-site overheads and profit margin;
- staff costs;
- volume rebates;
- sub-contractors, Materials and Purchased Services;
- other direct costs; and
- expenses.

(fuller details of coverage at **Appendix D**).

3. Associated Risks

The key risk is considered to be that:

- costs are artificially inflated, duplicated or disallowable under the terms of the contract.

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.

Overall, the control framework was reasonably assured, with expenses found to be appropriately charged.

Certain issues have been raised in respect of two items included - within the assessment of staff levies and the need to deduct volume rebates, that has produced an overpayment to date. The quantum of these issues is noted in relation to the construction costs.

It is recognised that these issues naturally derive from the financial systems operated by the SCP and the need for local adjustments at works valuations (to accord to allowable costs under this contract). The SCP has agreed to all recommendations made at this report and arrangements have been implemented for the recovery of appropriate sums from the March 2019 application for payment.

However, noting both the relative quantum of issues raised, assurances obtained and recovery arrangements enacted, the level of assurance given as to the effectiveness of the system of internal control in place to manage the associated risks is assessed as **Reasonable** Assurance.

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

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

Assurance Summary

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

Assurance Summary					
1	Control framework			✓	
2	Staff costs				✓
3	Fee - off-site overheads and profit margin		✓		
4	Volume rebates		✓		
5	Sub-contractors, Materials and Purchased Services				✓
6	Other direct costs				✓
7	Expenses				✓

* 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 weaknesses in the system design.

Operation of System/Controls

The findings from the review have highlighted **3** issues that are classified as a weakness in the operation of the designed system/control.

5. Summary of Audit Findings

Key findings are reported below against the areas outlined at the Scope and Objectives, with further details at the attached Management Action Plan:

Control framework



The audit sought to determine whether there were appropriate systems and sufficient contractual documentation to support the Open Book approach adopted.

Assurance was additionally sought that key contract clauses relating to the collaborative / Open Book approach, and associated value for money assurance had not been amended.

The agreed brief (additionally agreed with the SCP) included provision for a Systems Costing Statement to inform the audit testing, as to the nature of data systems.

This was not provided. Similarly protocols of applying SCP costs to the project / determining disallowable costs at the valuation were not provided. These had previously operated at the framework to clarify, for example, allowable travel and subsistence.

Accordingly, systems in use were established by both site and head office visits, with the methodology of testing confirmed. The audit was additionally informed by knowledge gained from prior Framework audits.

Systems in operation were confirmed as including:

- the ledger;
- personnel system;
- time booking / project allocation system;
- signing in / site access, time and attendance system;
- time booking / project allocation system;
- overhead allocation systems;
- staff benefit schemes; and
- the payroll system.

It was additionally confirmed that:

- at stage 2 & 3 (pre-construction) agreed framework rates had been applied (as additionally assured by the Cost Adviser);
- concrete and steel contracts were lump sum agreements;
- the Mechanical & Electrical contract was at defined (actual) cost, with this sub-contract mirroring the main client contract, in terms of its operation (and therefore similar allowable / disallowable costs);
- there was substantial in-house provision of preliminary items (noting this may risk inflated inter-company charges, that may not be reflective of costs incurred by the SCP);
- value for money of the contractual arrangements had been appropriately vetted prior to contractual recommendation of the Target Cost by the Cost Adviser;
- the appropriate fee had been applied (as additionally assured by the CA); and
- no amendments to the recommended standard form of contract were found.

Key conclusions were that:

- appropriate contractual arrangements were in operation;
- no rebates were due from concrete or steel sub-contracts; and
- Open Book findings may equally apply to the Mechanical, Electrical and/or in-house preliminary costs / contracts.

In view of above, together with the quantum of issues raised in the audit, and the substantial access to systems provided by the SCP to inform as to systems operation and charging systems, we conclude that a **reasonable** level of assurance is appropriate in relation to the Control Framework.

Staff costs



To ensure that staff costs charged can be substantiated and are reflective of the direct cost to the Supply Chain Partner, additionally avoiding duplication with allowances within the fee.

Staff costs totalled c.£14.3m of the £211m project costs.

On-site work performed included:

- vetting of support personnel charged to the project, to evidence their valid inclusion as a direct charge within the working area overhead (including confirmatory checks to the personnel system);

- a sample (8.5%) of staff ledger charges were reconciled to time sheets;
- time sheets were in turn reconciled to the Aurora signing in system, including overtime vetting; and
- there was a broad reconciliation of office staff numbers on site to those charged.

On-site testing determined that:

- appropriate time allocation systems were operated;
- ledger charges were appropriately supported by contractually defined (actual) cost incurred;
- staff directly charged were appropriately within the working area; and
- staff directly charged did not duplicate overhead support allowances within the fee.

That were no adverse issues arising as a result of the above testing.

Work performed at head office included:

- a vet of both salaries and wages to payroll costs incurred; and
- a sample of both wages and salaries for appropriate inclusion of:
 - holiday (chargeable at set framework allowance);
 - sickness (charges not allowable); and
 - redundancy (charges not allowable).

Key conclusions were that wage and salary costs were appropriately charged, though noting that one executive was charged at a median band rate (charge out rate). However, this was found to reasonably approximate to actual cost.

Assurance was therefore obtained that robust systems were operated in respect of both the SCP and advisers to record staff time allocated to projects, including completion of time sheets and appropriate authorisation.

The above also provided assurance that staff costs did not include elements of duplication with the fee.

Noting the above, **substantial assurance** has been determined for this area.



Fee, off-site overheads, and profit margin

To ensure that that costs recoverable through the general fee are not additionally recovered separately as a direct cost.

As noted above, the fee was vetted by the Cost Adviser, and therefore further review was outside the scope of this audit.

Staff overheads (levies) total 7.72% = c. £1m of project costs

The charges seen by the Cost Adviser were total ledger staff charges. These did not equate directly to payroll costs as they included various additional expenses, for example, employee health benefits forming part of pay packages.

Accordingly, there was a need to understand such additions, to ensure that these costs were necessarily incurred i.e. by employing an additional employee at the site.

The audit therefore sought to:

- determine the individual elements within the charge;
- affirm overhead allocation calculations to tested wages & salaries, including testing of worker and salaried staff numbers;
- review over / under recoveries;
- test and verify relevant elements to actual cost e.g. payments of the compulsory Construction Industry Training Board (CITB) levy;
- private health insurances; and
- determine and agree any ineligible sums, accruals or apportionments.

Individual elements within the charge were identified to be:

- employee benefits – forming part of the employee contract (e.g. including childcare vouchers, life assurance, company doctor, and reward schemes); including
- wage administration costs related to the same
- CITB apprentice levy;
- healthcare
- training; and
- IT.

Overhead calculations / allocations were reconciled to ledger costs and staff numbers. Recovery calculations did not show over-recovery. However:

- Wage administration overhead was included within levies (which is a central overhead and therefore disallowable).
- Central training was charged within the overhead. It is noted that while site specific training is allowable, central training is not.

Accordingly, deductions were assessed (valued to the end of the project)

- Wage overhead - c. £44,000 (**Recommendation 1**)
- Central Training - c. £111,000 (**Recommendation 2**)

(Note, however, as outlined in the detail of the report, the potential operation of the pain/gain mechanism may reduce such sums).

It is concluded that most staff overhead included was legitimate and reconcilable to actual allowable costs, however, **limited assurance** has been determined for this area in view of above incorrect inclusions.



Volume rebates

To establish that the project benefits from its contribution to achieving any volume rebates.

The audit sought a statement of rebates, to compare with information previously discovered / declared at prior Open Book audits of the SCP.

The SCP had declared to the prior Open Book D4L:B4W framework audit that they no longer utilised any rebate arrangements/agreements.

No rebate deductions were found within SCP applications for payment.

However, rebates of c. £23k were declared during the audit, which reflected equivalent values found at prior Open Book audits (as noted, the potential operation of the pain/gain mechanism may reduce such sums). While these remain to be declared to the Cost Adviser, their relative materiality in relation to the project is noted (**Recommendation 3**).

We were advised that such low values are largely a result of the high value items of concrete and steel being subject to fixed price contracts between the SCP and its group supply companies. These arrangements were part of

the value proposition by the SCP in bidding for the contract and in agreement of their target cost.

However, noting no declarations prior to the audit, coupled with lack of a Systems Costing statement to declare the current operation of volume discounts, and prior statements that rebates were no longer received, we have determined **limited** assurance in this area.

Sub-contractors, Materials and Purchased Services



To establish that progression of off-site assembly is appropriately assured and that payments are not made at risk ahead of progress/ completion/ ownership.

Off-site assembly has been separately reported within the project audit.

General assurances as to invoiced sums were obtained by the Cost Adviser, excepting timeliness of payments. Accordingly, payments were tested to establish whether monies were appropriately paid to the supply chain or unreasonably delayed / withheld by the Supply Chain Partner.

Excluding group subsidiaries, the payment dates of 20% of transactions were selected and checked to supporting invoices and transaction dates.

No undue payment delays were observed, and payments were made within contractual terms.

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

Other direct costs



To ensure that costs are appropriately charged and supported, and do not duplicate allowances within the fee.

Other Direct costs were c.£11m to project completion (excluding sub- Sub-contractor costs and purchased services that were inspected by the Cost Adviser; excepting insurances and preliminary costs).

Insurance charges were reviewed and found to be site related only.

Similarly, the audit sought to determine that plant, equipment costs were appropriately charged and supported, including:

- assurance that enhancement expenditure was not charged for plant while on site (e.g. addition of kitchens / toilets to accommodation); and that
- assets removed from site were appropriately deducted (e.g. fencing, and IT).

6% of preliminary costs were sampled (including on-site plant, canteen and fencing) with no issues of enhancement or duplication with the fee being noted, and the potential value of assets, which could be removed from site, being assessed as de-minimis.

Noting this, **substantial assurance** has been determined for this area.

Expenses



To ensure that expenses are charged in accordance with the contract.

The audit sought assurance that expenses are charged in accordance with the contract, and to sample expenses, car and fuel charges for reasonableness of work related mileage apportionments, exclusion of hospitality etc.

Of 10 sampled staff, 6 had expenses claimed within the sampled valuation (combined values totalling c.£537).

A defined expenses policy was found, including appropriate claim limits and excluded non-business related expenditure. The policy accorded with HMRC temporary workplace travel rules and expenses claimed were found to relate to business expenses / journeys in accordance with the policy and HMRC rules.

It was concluded, therefore, that expenses were appropriately charged to the project.

Noting the issues outlined above, we have determined **substantial assurance** in this area.

6. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	-	3	-	3
Number implemented	-	3	-	3
Number outstanding	-	0	-	0

That is all recommendations raised in this report have been implemented since audit fieldwork, that is, from the March 2019 application for payment.

Finding 1: Staff Overhead – Wage administration	Risk
Wage administration overhead was included within staff levies (which is a central overhead and disallowable). This may be assessed to the end of the project in the sum of c. £44,696 (Appendix C) (note: this sum may be reduced by 50% by the operation of the pain/ gain mechanism at the contract).	Central overhead charged within the fee is duplicated within direct charges.
Recommendation 1	Priority level
Wage administration overhead should be deducted from valuations. (O)	Medium
Management Response 1	Responsible Officer/ Deadline
Implemented since audit fieldwork. These deductions are now being made at the valuations and vetted by the Cost Adviser, informed by calculations supplied by audit. <u>SCP response</u> We agree that the admin. levy applied to hourly paid employees should be excluded from the Defined Costs, and agree that this should therefore be discounted from the salaried staff costs.	Cost Adviser to affirm with SCP Framework Manager May 2019

Finding 2: Staff Overhead – Training	Risk
Central training was included within staff levies (which is central overhead and disallowable). Note – as all training was included within staff levies, <u>any</u> training charged directly would duplicate the charge for site specific training. However, no such training has been agreed to date by the Cost Adviser. Therefore, noting the above, all training presently charged within levies should be deducted. This may be assessed to the end of the project in the sum of c. £111,496 (Appendix C) (note: this sum may be reduced by 50% by the operation of the pain/ gain mechanism at the contract).	Central overhead charged within the fee is duplicated within direct charges.
Recommendation 2	Priority level
Central training should be deducted from valuations. (0)	Medium

Management Response 2	Responsible Officer/ Deadline
Implemented since audit fieldwork. These deductions are now being made at the valuations and vetted by the Cost Adviser, informed by calculations supplied by audit. <u>SCP response</u> There are no charges in the valuation for direct training, these have been discounted by our Commercial Manager prior to application. However, on review, a proportion of these costs are for safety training specific to the project. These costs will be presented in future applications to the Cost Adviser. As is evidenced above all cost components are under constant review and as a consequence any identified disallowable costs are discounted by the LOR Commercial Manager at each application. We agree, this cost is ineligible and will be discounted from all future applications for payment. We will continue to raise awareness of any recurrent issues going forward and ensure that the project costs and any disallowable costs identified by the LOR Commercial Manager, the Cost Adviser or through audit will be discounted from the Defined Costs. All of the adjustments identified in the audit will be made in the forthcoming (March 2019) application for payment. We are therefore confident that the	Cost Adviser to affirm with SCP Framework Manager May 2019

stated costs at the year-end will be compliant with the requirement of the contract.

Finding 3: Volume rebates	Risk								
The project is charged costs throughout its life cycle. However, rebates may subsequently be received by the SCP, meaning that the project may be over-charged cost, if unadjusted. The SCP has previously operated several rebate schemes both with suppliers and sub-contractors. These have included agreements with suppliers to provide rebate, including volumes purchased by sub-contractors directed by the SCP to utilise a particular supplier. The SCP had declared to the prior Open Book D4L:B4W Framework audit that they no longer utilised any rebate agreements. Rebates due were declared to this audit as: <table data-bbox="369 845 1041 997"> <tbody> <tr> <td>2017/18</td><td>£1,539.19</td></tr> <tr> <td>2018/19</td><td>£4,697.38</td></tr> <tr> <td>Future to scheme completion</td><td>£4,671.10</td></tr> <tr> <td>Catering £500 per month¹</td><td>c. £12,500.00</td></tr> </tbody> </table> TOTAL <u>£23,407.67</u> (note: sums may be reduced by 50% by the operation of the pain/ gain mechanism at the contract). It was noted that steel and concrete were procured through lump sum contracts; the project does not have scaffolding (a potential large rebate item); and fuel cards were stated to have discount, rather than rebate. The Supply Chain Partner commented that:	2017/18	£1,539.19	2018/19	£4,697.38	Future to scheme completion	£4,671.10	Catering £500 per month ¹	c. £12,500.00	Key governance arrangements are not clearly communicated/ understood.
2017/18	£1,539.19								
2018/19	£4,697.38								
Future to scheme completion	£4,671.10								
Catering £500 per month ¹	c. £12,500.00								

<i>"We will declare these rebates within our interim applications for payment and update the Cost Adviser as and when these agreements are revised / renewed."</i> At the time of this audit no rebates had been declared. However, their limited materiality in relation to the project value was noted. In view of the above observations (and making appropriate adjustments to sums due), these sums match equivalent values found at prior Open Book audit of this SCP. ¹ Based on advised commencement of the catering contract in May 2018 & concluding in June 2020.	
Recommendation 3	Priority level
Rebates should be declared at the monthly valuations. (O)	Medium
Management Response 3	Responsible Officer/ Deadline
Implemented since audit fieldwork. These deductions are now being made at the valuations and vetted by the Cost Adviser. <u>SCP response</u> Volume rebates are of a significantly reduced importance to our business, but certain companies do continue to offer rebates based on the turnover that the LOR Group places with them. These rebates have been, and will continue to be declared, and discounted from the defined costs by the LOR Commercial Manager.	Cost Adviser to affirm with SCP Framework Manager May 2019

Audit Assurance Ratings



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



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



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



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

Prioritisation of Recommendations

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

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

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

Appendix C - Levy repayment calculations

Payroll Admin Costs

People costs to end Oct 2018 £4,328,659

Payroll admin levy as a
proportion of people costs 0.218784%

£ 9,470

Plus 42% Crown House = **£13,447** = Payroll Admin costs within staff levies to end October valuation.

Training costs

People costs to end Oct 2018 £4,328,659

Training levy as a proportion of
people costs 0.5457559%

£ 23,623

Plus 42% Crown House = **£33,545** = Training costs within staff levies levy to end October valuation]

All costs here are projected to the end of project below (which is when mechanical and electrical costs will be at c. 42% - being currently only 12% - see valuation - generally being fitted towards the end of a project)

Payroll Admin Costs

People costs to end project £14,387,191 = 4,328,659 (211,005,027 / 63,484,858) i.e. * (Target / October valuation)

Payroll admin levy as a
proportion of people costs 0.218784%

=

£ 31,476

Plus 42% Crown House **£44,696**

Training costs

People costs to end project £ 14,387,191 (as above)

Training levy as a proportion of
people costs 0.5457559%

=

£ 78,519

Plus 42% Crown House **£111,496**

Combined total **£ 156,192**

* Note – There will additionally be some levy costs within the internal charges for preliminary items. However, these are substantially the equipment cost. Any further deduction would be to a small staff administration cost which is unknown at the time of audit, and therefore not further adjusted in this calculation.

Appendix D - Detailed coverage

Area	Risk	Assurance sought	Responsibility
Control framework	Inadequate systems and contractual documentation are evidenced to support the open book approach adopted.	Systems costing statement to inform of the mechanisms and legitimacy of cost allocations to the project.	SCP ¹
		Assurance that key contract clauses relating to the collaborative / Open Book approach, and associated value for money assurance have not been amended.	CA ²
		Review contractual control framework operated.	CA ²
Fee - off-site overheads and profit margin	Costs recoverable through the general fee are also recovered separately as a direct cost - effectively recovered twice.	Assurance that sums included in off-site overheads are not also included in direct charges - as per cost elements below.	CA ² / SCP ¹
Staff Costs	Staff costs charged are not substantiated and/or not reflective of the direct cost to the Supply Chain Partner.	Assurance that robust systems are operated in respect of both SCP and advisers to record staff time allocated to projects including completion of time sheets and appropriate authorisation.	CA ² / SCP ¹
		Charging systems are operated in accordance with the Systems Costing Statement and the contract.	SCP ¹
		Assurance that staff costs do not include elements of duplication with the fee.	SCP ¹

Area	Risk	Assurance sought	Responsibility
Volume Rebates	The project does not benefit from its contribution to achieving volume rebates.	Assurance that appropriate systems are operated by advisers.	CA ²
		Assessment of an SCP self-declaration of volume rebates & their apportionment to the project.	SCP ¹
		Validation of source data provided e.g. ledger extracts.	SCP ¹
		Assurance that volume rebates received by SCP are in accordance with declared sums and have been properly credited back to the project.	SCP ¹
Sub-contractors, Materials and Purchased Services	Payments are made at risk ahead of progress/ completion/ ownership.	Mechanism by which management / advisers are assured that payments are not at risk.	PM ³ / CA ²
	Progression of off-site assembly is not appropriately assured.	Materials and sub-contractor charges are appropriately supported.	CA ²
Other Direct costs	Duplication with fee Costs not appropriately charged and supported.	Assurance that plant, vehicle and equipment costs are appropriately charged and supported.	CA ² / SCP ¹
		Assurance that other direct costs are appropriately charged and supported and do not include elements that duplicate central overhead (as charged by the fee).	CA ² / SCP ¹
Expenses	Expenses are charged in accordance with the contract.	Assurance that expenses are charged in accordance with the Systems Costing Statement and the contract.	SCP ¹

- 1 SCP – Supply Chain Partner
- 2 CA – Cost Adviser
- 3 PM – Project Manager

Grange University Hospital: Project Audit

Final Internal Audit Report

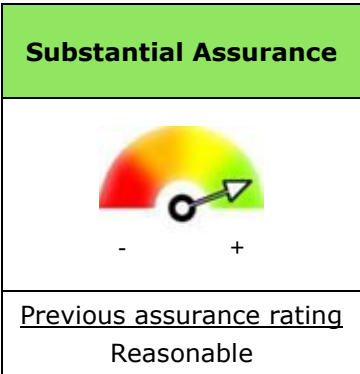
2018/19

Aneurin Bevan University Health Board

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NHS Wales Shared Services Partnership

Audit and Assurance Services



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Appendix G	Grange University Hospital Audit Plan 2019/20

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Distribution	Nicola Prygodzicz, Director of Planning & Performance Richard Bevan, Board Secretary Corrina Casey, Programme Director Richard Morgan-Evans, Assistant Programme Director
Committee	Audit Committee

ACKNOWLEDGEMENT

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

Please note:

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 Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

This audit was commissioned in accordance with the agreed Grange University Hospital (hereafter referred to as GUH) audit plan.

The focus for the current year of the audit plan was the performance of external parties in the technical application of the contract and framework conditions.

The forecast cost position as summarised at the latest cost report (January 2019) is summarised as:

	Approved (£)	Forecast (£)
Stage 4 contract sum	206,457,498	206,457,498
Additional fire cladding funding	3,147,714	
Agreed compensation events		6,234,479
Adjusted contract sum	209,605,212	212,691,977
Enabling and advance works	27,285,325	27,188,601
SCP Total Cost	236,890,537	239,880,578
Health Board fees	11,774,210	11,779,636
Non works costs	10,743,801	10,534,688
Equipment	25,750,959	25,682,845
Contingency	4,412,112	3,112,258
VAT	46,159,120	46,204,335
Less Works Inflation CEs		-2,114,931
PROJECT TOTAL £	335,730,739	335,079,409

The contract start date was confirmed as 30 October 2017; contract completion date 11/09/2020; and one compensation event issued affecting a change to the completion date for adverse weather [ref 029A: award of 4 days to the 15/09/2020]. Management advise that the Supply Chain Partner is currently anticipating that completion will be ahead of programme.

2. Scope and Objectives

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

The objective of the audit was to evaluate the systems and controls in place within the UHB, with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage were appropriately managed.

Accordingly, the scope and remit of the audit included the following:

- **Follow up provision:** a review of progress made to address previously agreed recommendations arising from prior project audits.

- **Performance of UHB, Advisers and the Supply Chain:** to ensure that appropriate arrangements were in place to define the respective duties and responsibilities of parties; and ensure that appropriate performance measures were in place.
- **Valuations / Fees:** noting the value of monthly throughput (£) at the project, the review evaluated the processes applied by the Project Manager / Cost Adviser to enable them to recommend SCP and adviser payments. This included, for example, an evaluation of the sampling / testing methodology applied, the quantum / adequacy of supporting information sought from the SCP and any deductions / adjustments made. The review included the evaluation and verification of non-works costs elements.
- **Payments:** to obtain assurance that appropriate mechanisms were in place to ensure that payments were authorised in accordance with established UHB and project defined delegated limits. Additionally, to confirm that those mechanisms did not impinge on the UHB's ability to comply with the payment terms as specified within the contract. The audit also considered the arrangements for the vesting and payment of materials utilised during off-site manufacturing.
- **Change Management:** the review sought assurance that client requirements were clearly established / frozen; and that there was evidence of subsequent changes being managed in accordance with contractual Project Managers Instruction and Compensation Event processes. The review also considered the UHB internal change management arrangements, compliance with delegated authority and management of SCP and client contingency.
- **Discharge of Supervisor role:** to ensure that the role of the supervisor was discharged in accordance with the appointment, was sufficient to meet contractual requirements and contributed to the informed client role.

3. Associated Risks

The potential risks considered in the review were as follows:

- The UHB fails to address known issues risks raised at prior audits.
- Valuations / fees paid not adequately challenged / scrutinised resulting in potential overpayments.
- Payments not processed in accordance with contractual requirements, putting the UHB at risk of potential recourse.
- Changes not managed in a controlled manner leading to potential additional time and cost implications.
- Parties fail to meet the expected performance standards established, affecting the overall objectives of the project.

- Impact on quality as key aspects of the supervisor role were not adequately defined or poorly complied with.

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 on the effectiveness of the system of internal control in place was assessed as providing **Substantial Assurance**, noting:

- The level of assurance is confined to the specific technical areas of coverage outlined at **section 2** of this report.
- The Programme/ Project Leadership was going through significant change at the time of this review, and whilst preparatory arrangements were acknowledged, failure to successfully implement the same could have a significant impact on the programme.
- The report should be read in conjunction with the Open Book audit report (issued March 2019). This sought to review the lead contractor (Supply Chain Partner - SCP) costs (i.e. those that could not be routinely verified by the Cost Adviser e.g. central overhead allocations).

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

The GUH internal audit plan for 2019/2020, as agreed with management, is also set out in **Appendix G**. The plan includes a shift in focus to the internal processes and control arrangements. Additionally, further Open Book work is proposed.

5. Summary of Audit Findings

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

Assurance Summary					
1	Follow Up			✓	
2	Performance of UHB, Advisors, HB Staff and Supply Chain			✓	
3	Valuations / Fees			✓	
4	Payments				✓
5	Change Management				✓
6	Discharge of Supervisor Role				✓

Design of Systems/Controls

The findings from the review have highlighted **1** issue that is classified as a weakness in the system control/ design at the project.

Operation of Systems/Controls

The findings from the review have highlighted **2** issues that are classified as weaknesses in the operation of the designed system/control at the project.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan (**Appendix A**) together with the management action plan and implementation timetable.

6.1: Follow Up Provision



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

Report	Outstanding	Closed	Total
2014/15	-	2	2
2015/16	1	3	4
2016/17	2	10	12
	3	15	18

In summary, the three outstanding recommendations are all medium priority:

1. The UHB awaits approval from Welsh Government to allow the finalisation of the section 278 agreement. This has been pursued by management on a regular basis;
2. SCP contingency monitoring is to be introduced shortly, upon conclusion of the remaining sub-contractor packages; and
3. A Design for Manufacture and Assembly benchmarking exercise is to be programmed post completion of the main works.

The detail in support of the above summary is included at **Appendix B**. Accordingly, **reasonable assurance** has been determined in respect of the action taken to address previously agreed audit recommendations.

6.2: Performance of UHB, Advisers and the Supply Chain



We sought assurance that appropriate arrangements were in place to define the respective duties and responsibilities of all parties; and that appropriate performance measures were in place.

The duties and responsibilities of all parties were defined within the Project Execution Plan, contraction and framework requirements.

Appropriate steps had been taken to adopt performance measures to monitor the performance of parties; with the agreement for performance measures to be completed on a six-monthly basis throughout stage 4 construction in line with Designed for Life framework (DfL) requirements.

The DfL template was used for all parties with the output being reported into the Quarterly Strategic review process. Areas of consideration included: fulfilment of their project role; quality of service; ability to deliver to programme; collaboration; and contributions to safety.

We were made aware that the Clinical Futures Programme Director would be leaving the post in April 2019, creating a vacancy for both the Clinical Futures Programme Director and GUH Project Director roles. At the time of

the current review both Job Descriptions had been finalised and were in the process of being matched ready for advert.

It is acknowledged that preparatory and contingency arrangements have been determined to address this matter. It is important that both are prioritised so as not to significantly impact the Programme/ Project. **(recommendation 1).**

It is important that the UHB is able to challenge/ scrutinise external parties, however it was noted that there was limited major construction project experience at the Project Board. Management had recognised this deficiency and was actively seeking opportunities to address the same **(recommendation 2).**

In addition to the D4L KPIs returns, the SCP was also subject to fortnightly Dunn & Bradstreet financial vetting (an assessment of the financial risk) – coordinated by NWSSP: SES. Management confirmed that the Director of Finance has taken a lead on these matters and routinely reports to the Project Board in respect of the same.

Noting the above, we have determined **reasonable assurance** in this area.

6.3: Valuations / Fees



We sought assurance on the processes applied by the Project Manager / Cost Adviser to enable the recommendation of SCP and adviser payments. We also sought assurance on the evaluation and verification of non-works costs elements.

A defined process was observed at the Cost Advisers which complemented the requirements as defined within the contractual documentation. The audit confirmed compliance in respect of the review and receipt of the contractor's valuation to culminate in authorisation for payment (issued by the Project Manager).

For the sampled valuation (no. 11), the Cost Adviser requested a reasonable sample of information to support the valuation received from the SCP. The content of information was confirmed as adequate and sufficient to allow the Cost Adviser to provide an assessment of reasonableness.

Further to this, a 'walk around' of the site was undertaken by the SCP and the Cost Adviser prior to the end of the respective monthly payment period. This enabled an assessment of the progression of work and a review of materials held on site.

Completion of the above ensured the percentage of completion defined in the valuation was in line with expectations.

The Cost Adviser challenge to valuation 11 resulted in a reduction of £66.3k [total of 14 challenges made] arising from incorrect coding or inaccurate

percentage of completion logged compared to observations during the site walk around process.

Sampled testing as outlined above, resulted in no additional issues being identified:

	Category		
	People	Equipment	Subcontractors
Amount per valuation 11	£702, 688	£486,345	£44,968,072 (gross application amount)
% reviewed	4% (invoiced amounts)	26%	99%

Off-site manufacturing

One of the identified roles of the Supervisor is to periodically visit the sites where off-site manufacturing is undertaken and ensure the materials are complete and clearly identified as UHB property. An agreed protocol defining contract requirements (developed by the cost adviser) identified requirements as:

- Precast concrete frame, upper floor and façade panels
 - The precast concrete frame and upper floor members must be fully manufactured and cured;
 - The façade panels must be fully manufactured, cured and suitable for installation;
 - Noting that windows [mastic sealed and water tested] will be installed at a later date than the completion of the panels, the SCP must demonstrate that they have title to the windows as well as the façade panels.
- Bathroom pods
 - The pods must be complete, fully assembled and fitted out. The SCP must demonstrate that they have title to the sanitary goods as well as the pod construction.
- M&E services modules
 - The modules must be complete and fully assembled. The SCP must demonstrate that they have title to the plant and equipment within the module.

To confirm compliance with the above, we undertook a visit to the Workstop site in October 2018. Issues were noted with regard to record keeping and identification of stock this project **(recommendation 3)**.

Payments for materials held off site were included in the main invoices that were received for the project. Confirmation received from the supervisor, following off site visits, fed into the Project Manager's information for validation of the invoice. Upon satisfactory review, approval for payment would follow the standard process [as detailed above].

Whilst there are defined procedures for payments, noting the minor record keeping weaknesses identified for off-site materials, we have determined **reasonable assurance** in this area.

6.4: Payments



We sought assurance that appropriate mechanisms were in place to ensure payments were authorised in accordance with established Health Board and project defined delegated limits; and in accordance with the contract payment terms.

Payments

An appropriate process had been established to ensure the timely authorisation and transaction of payments. The Project Execution Plan set out the agreed invoicing procedure as follows:

- Payment assessment date is the 28th day of each calendar month;
- The SCP submits their application for payment to the Cost Adviser [cc Project Manager] either on or before each assessment date;
- A payment certificate is issued within 7 days of the above; which serves as payment notice;
- Once the payment certificate is issued, the SCP is required to raise a VAT invoice by immediate return;
- Invoice to be received by the UHB no later than 7 days of issue of the payment certificate;
- Payment to be made by the UHB within 21 days of the assessment date.

The UHB's Scheme of Delegation was updated in March 2018 with specific changes made in relation to GUH and signing of invoices. It covered the roles of the Director of Planning; External Cost Adviser; Project Director [based on the advice of the External Cost Adviser]; and the Capital Group. The Capital Group formally reviews project payments against the approved budget and outturn forecast with any variance noted requiring additional approvals in line with the normal scheme of delegation.

We reviewed 49% of the cumulative payments (£27,044,356) and confirmed all details reconciled to invoices received, had been authorised for payment appropriately and had been made within the required timescales (see **Appendix C** for detail).

Noting the above **substantial assurance** has been determined in this area.

6.5: Change Management



We sought assurance that changes were managed in accordance with contractual Project Managers Instruction and Compensation Event processes. The review also considered the UHB's internal change management arrangements, compliance with delegated authority and management of SCP and client contingency.

The defined change control process to manage requests for change [as defined at **Appendix D**] was in accordance with the requirements of the contract operated at the project. This facilitated internal acceptance/approval of the proposed changes in accordance with delegated limits, prior to issue to the external advisers to action.

Demonstration of value for money was sought by the Cost Adviser. Upon the receipt of a request for change, a review was undertaken against known bills of quantities / prices from other invoices received / detailed from other projects to ascertain the reasonableness of the costs. Once the prices quoted for the change were deemed reasonable, the change request was approved and forwarded to the Project Manager to advise the SCP to proceed.

A sample of changes requested to date were reviewed to confirm appropriate management and adherence with the contractual requirements). Further details of the changes reviewed are set out in **Appendix E**.

Noting the above, we have determined **substantial assurance** in this area.

6.6: Discharge of the Supervisor Role



We sought assurance that the role of the supervisor was discharged in accordance with the appointment, was sufficient to meet contractual requirements and contributed to the informed client role.

A supervisor was appointed in November 2017 for the commencement of the construction phase of the project.

Supervisor reports were prepared on a weekly basis for the client, with monthly reports being presented to the site progress meetings.

The content of the reporting was in accordance with expected requirements as defined in their contracts and suitably informed the reader of the issues that have been noted and the actions taken/ required.

Accordingly, **substantial assurance** has been determined in relation to the discharge of the supervisor role.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	-	2	1	3

Finding: Programme Director / Project Director	Risk
We were made aware that the Clinical Futures Programme Director would be leaving the post in April 2019, creating a vacancy for both the Clinical Futures Programme Director and GUH Project Director roles. At the time of review both Job Descriptions had been finalised and were in the process of being matched ready for advert. It is acknowledged that there are preparatory and contingency arrangements in place in the event that there is a delay in appointments, with internal staff providing interim cover for the Programme Director role and the current post-holder willing to provide cover for the Project Director role until resolved. Nonetheless, it is important that roles are assigned as swiftly as possible so and not to adversely impact the project as it enters the commissioning and equipping phase.	Inadequate project governance results in a loss of control of project objectives.
Recommendation 1	Priority level
Noting the significant monthly progress and cash flow at this stage of the project, both appointments should be resolved as a matter of urgency (0)	Medium
Management Response	Responsible Officer/ Deadline
Agreed.	Director of Planning May 2019

Finding: Duties and responsibilities	Risk
The duties and responsibilities of all parties are defined within the PEP (updated August 2018), contract documentation and framework requirements. However, whilst the role of the Project Board is appropriate and in accordance with expectations, a review of its membership noted potential issues regarding Estates representation with a major construction background. Noting the current stage of the project, and the impending changes of the Programme Director, the requirement for construction/estates experience is more prevalent.	Project governance is not appropriate.
Recommendation 2	Priority level
Management should seek assurance that Estates / Construction representation is appropriate to ensure the project facilitates the Clinical Futures agenda. (D)	Low
Management Response	Responsible Officer/ Deadline
Agreed.	Programme Director May 2019

Finding: Valuation of materials off site	Risk
A standard methodology to check 100% of materials off-site had been developed by the cost advisor and was evidenced during fieldwork. However, more recently, inspections of lattices were based on a much reduced sample check (5 of circa 50). During the course of our off site visit to the Worksop site, not all lattices from the sample could be located (1 of 5); noting a large amount of the UHB lattices were recessed within piles of stock of other clients.	Materials specific to the GUH project are not maintained or accounted for appropriately.
Recommendation 3	Priority level
A full verification of stock should be undertaken as per the Cost Advisor's methodology; or approval for an alternative approach be applied [i.e. percentage of total stock] noting the forthcoming vesting programme [doors: circa £600k] (O)	Medium
Management Response	Responsible Officer/ Deadline
Agreed.	Programme Director May 2019

Interim Report No. 2 – Reasonable Assurance - 2017/18

Prior Ref	Recommendation	Current Status	Updated responsibility and timescale	Current year priority rating
Medium				
1	The Quorum for Project Board will be agreed (D) .	Closed The terms of reference were updated at the June 2018 Project Board meeting. As confirmed in the Project Board minutes, quorate is: Chair; Vice Chair plus at least 3 other Executive Directors or their nominated deputies. Review of the minutes of subsequent Project Board minutes confirmed adherence to this quorum.	N/A	N/A
2	The Project Board will receive a short summary independently from both the SCP and the professional advisers on their confidence in respect of programme and cost certainty. (D) .	Closed Review of the project board minutes noted inclusion of the summaries as recommended.	N/A	N/A

Prior Ref	Recommendation	Current Status	Updated responsibility and timescale	Current year priority rating
3	The roles and responsibilities of the Director of Planning in respect of the GUH will be further defined (D)	Closed Review of the Project Manager Progress Report [September 2018] noted a future action being the sign off of the updated Stage 4 PEP. The document has been prepared to summarise accountabilities of the Clinical Futures Senior Responsible Officer and the Executive Work stream lead for the GUH project. The document sets out the responsibilities of the SRO [Chief Executive Officer] and Sponsor Lead [Executive Director of Planning & Performance]; and acceptance of accountabilities was evident.	N/A	N/A
4	Noting the limited contingency available, the existing focus on risk management at the Project Board should be extended to include the balance of contingency (O)	Closed A 'contingency tracker' and supporting Capital Finance report is presented to each Project Board meeting. At the date of review, contingency usage was less than expected (circa 9%) with a predicted	N/A	N/A

Prior Ref	Recommendation	Current Status	Updated responsibility and timescale	Current year priority rating
		£4.3m contingency available to the end of the financial year.		
5	The performance of the SCP contingency should also be reviewed against available contingency provisions made within the Target Cost and FBC (O)	Outstanding Upon conclusion of the significant element of subcontractor packages in the Autumn of 2018, the cost adviser will be in a better position to report on the status of the SCP contingency. The contingency position, including any implications on pain/gain, will be monitored thereafter.	Programme Director May 2019	Medium
6	Appropriate risk management arrangements will be determined for significant cash flow changes (O)	Closed Regular cash flow reporting is provided to the Project Board; noting that the HB is working closely with the SCP to monitor expected spend to assist manage the CRL position with the WG.	N/A	N/A
9	Responsibilities for monitoring and achieving the revenue cost funding / savings detailed at the FBC will be affirmed (D)	Closed Confirmed that responsibility for monitoring and achieving the revenue cost funding / savings detailed at FBC is undertaken by the Clinical	N/A	N/A

Prior Ref	Recommendation	Current Status	Updated responsibility and timescale	Current year priority rating
		Futures Delivery Board; taking account of the while system revenue costs and savings.		
10	Regular information will be obtained in relation to contractor financial performance and reported to WG (e.g. via the Capital Review meetings and/or Dashboard reports). The risk register will be updated accordingly (O)	Closed NWSSP: SES provide regular updates on the financial standing of the SCP; with any issues of concern reported to the Project Board and WG. Review of Project Board minutes noted no concerns have been raised. Furthermore, the risk register (which is regularly reviewed) includes a low-rated risk for SCP bankruptcy; noting that the SCP had been selected from the All Wales DfL Framework [there subjected to a robust selection process]. In the unlikely event of SCP insolvency, the correct Framework and NEC Contract procedures will be followed [parent company guarantee / bonds are in place for Stage 4 works].	N/A	N/A

Prior Ref	Recommendation	Current Status	Updated responsibility and timescale	Current year priority rating
11	<i>Future Assurance</i> Post completion, the DfMA approach should be benchmarked versus traditional construction methods to ensure the proposed advantages have been achieved (O)	Outstanding This is a recommendation for post completion therefore no work is expected to have been undertaken to address at this stage.	Programme Director Post completion	Medium
12	An open book audit will be commissioned to ensure that the costs recovered at the project reflect the reasonable cost due to the Supply Chain Partner and sub-contract (O)	Closed An Open Book audit was scheduled within the 2018/19 GUH IA plan. The output of the open book audit will be reported separately.	N/A	N/A
Low				
7	The cost report will include graphical presentation of performance against the anticipated CRL / cash flow (D)	Closed CRL monitoring had been included in the April 2018 cost report onwards. Review of the latest cost report available noted the inclusion of two graphical presentations. One is the comparative monthly chart - predicted v actual; and one is the comparative cumulative chart - predicted v actual.	N/A	N/A

Prior Ref	Recommendation	Current Status	Updated responsibility and timescale	Current year priority rating
8	The Welsh Government Dashboard will be completed to highlight the key project risks (O)	Closed Whilst the UHB continues to not document the top 5 risks on the face of the dashboard report, supporting the submission of the dashboard is a 'combined risk register' which reflects all the risks facing the GUH project and the actions being taken to mitigate them. The Senior Programme Manager [Clinical Futures] confirmed that the WG has full visibility of the risks and has not raised any questions regarding this approach to submission.	N/A	N/A

Interim Report No. 1 – Reasonable Assurance – 2015/16

Prior Ref	Recommendation	Status @ December 2017	Current status	Updated responsibility & timescale
Medium				
3	Further consideration should be given to the operation of delegated authority during the construction stage of the contract so as not to adversely impact the project objectives (D)	Partially implemented Whilst the scheme of delegation for Stage 3A was the same as that for Stage 3, it is considered no longer feasible to replicate this scheme for Stage 4. The lines of approval currently required are too constrained and will impede the effective processing.	Closed Following issue of the December 2017 report, there was a change in the named Programme Director. Whilst due process was followed to action a mandate form, it was noted that the delegated limit was £50k [noting the Programme Director had been appointed as a contractor]. Most requests for payment remained outside of the delegated limit. The Director of Planning & Performance authorised the payment; and testing undertaken confirmed that	N/A

Prior Ref	Recommendation	Status @ December 2017	Current status	Updated responsibility & timescale
			this did not the timely processing of payments.	
7	Clarification will be sought from the Cost Adviser on the CDM costs, and the target cost amended as required.	Partially implemented Whilst CDM costs (£136,767) have been included in the target cost submitted within the FBC addendum, there was no evidence to confirm that the £47,080 from Stage 3 had been removed as recommended.	Closed Subsequent to the issue of the December 2017 report, the Cost Adviser provided confirmation that the FBC submission and approval did not include the forecast sum from Stage 3, only actual costs incurred.	N/A
9	Satisfactory sign-off will be obtained to the section 278 agreement (O)	Partially implemented The section 278 agreement with Torfaen County Borough Council [new roundabout and Caerleon Road works] was finalised and signed in advance of commencement of works. It is noted the UHB does not have a signed copy of the agreement; this needs to be obtained from the solicitor.	Outstanding Whilst the section 278 agreement relating to the roundabout and Caerleon roadworks has been obtained, a signed copy of the agreement with the Welsh Government has yet to be received. The agreement is in relation to the fire hydrant covers in the carriageway. Meetings held with the UHB, WG and Welsh Water have agreed actions to take [move the	Programme Director / Programme Board Upon completion of agreed works

Prior Ref	Recommendation	Status @ December 2017	Current status	Updated responsibility & timescale
			hydrants]. Upon satisfactory completion of the agreed works, the HB will obtain, and retain, the signed section 278 agreement.	
10	The UHB will seek clarification from NWSSP:SES that the key performance indicators to be applied at the project remain unchanged and confirmation on the recourse/consequence of failing to meet defined performance requirements (O)	Partially implemented The key performance indicators for the conclusion of Stage 3A were completed by the UHB, in consultation with the cost advisers. It was noted that confirmation of the process to follow for Stage 4 has yet to be determined. Consideration should be given for completion, as a minimum, every six months in light of the project pace.	Closed Post issue of the December 2017 'Follow Up' report, two KPI exercises have been undertaken. The latest exercise [for submission to Welsh Government in October 2018] was reviewed; concluding satisfied / very good performance for all parties.	N/A

Interim Report 2014/15 – Reasonable Assurance – February 2015

Prior Ref	Recommendation	Status @ December 2017	Current status	Updated responsibility & timescale
High				
3	The programme for delivery of the project will continue to be reviewed and up-dated to take account of emerging issues and latest projections. Risks of non-delivery to timescale will be identified and included (together with other key risks), at both project and corporate risk registers (O)	Partially implemented An updated programme of delivery was determined, and agreed with the associated advisers. The programme was incorporated into the FBC addendum which was submitted to Welsh Government for approval in October 2017. However, a corresponding project specific risk has not been recorded at the corporate risk register.	Closed The following risk was added to the corporate risk register in March 2018 [risk score of 16]: The Grange University Hospital is not delivered as per programme and within approved capital cost / cost profile.	N/A
Medium				
8	Health Board committees and the Clinical Futures Programme Board will be provided with copies of the template 'Dashboard reports' produced for the Welsh Government (to ensure openness and enable	Not implemented Whilst the dashboards are submitted to the Welsh Government on a monthly basis, they are not provided to	Closed The dashboard report is standing agenda item for the GUH Project Board agenda	N/A

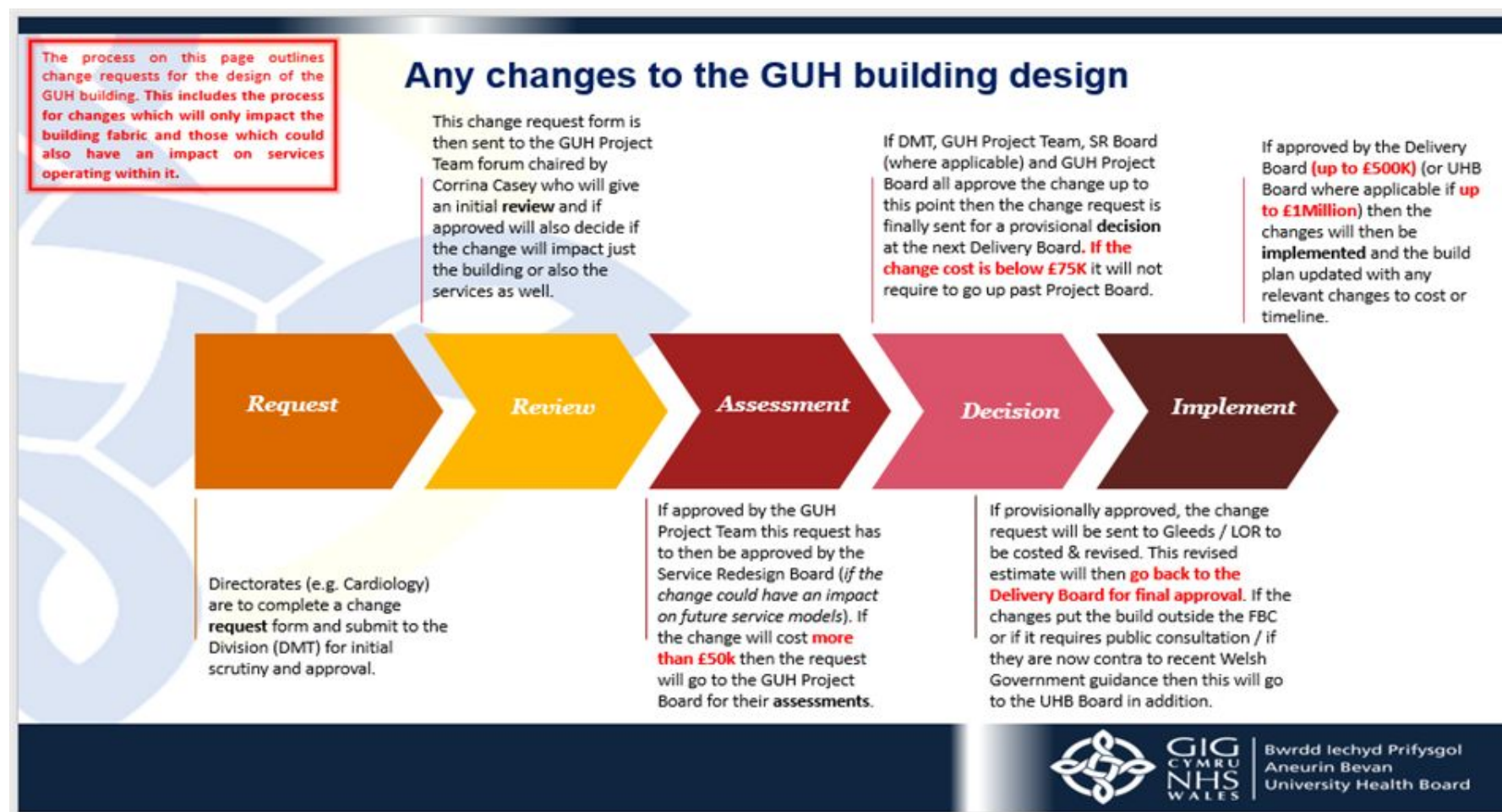
Prior Ref	Recommendation	Status @ December 2017	Current status	Updated responsibility & timescale
	appropriate scrutiny and challenge (O)	any of the committee structures relating to the project.		

Appendix C: Cumulative value of payments [and testing performed]

Valuation ref	Valuation date	Payment date	Predicted payment	Actual payment	Actual cumulative	Testing performed
1	28/11/2017	19/12/2017	£2,585,614	£2,583,414	£2,583,414	✓
2	28/12/2017	18/01/2018	£3,251,879	£3,251,879	£5,835,293	
3	28/01/2018	18/02/2018	£3,192,879	£3,192,474	£9,027,767	
4	28/02/2018	21/03/2018	£4,175,176	£4,231,676	£13,259,443	
5	28/03/2018	18/04/2018	£3,623,149	£4,122,003	£17,381,446	✓
6	28/04/2018	19/05/2018	£6,048,189	£5,869,837	£23,251,283	
7	28/05/2018	18/06/2018	£5,399,747	£5,668,819	£28,920,102	
8	28/06/2018	19/07/2018	£5,983,946	£6,057,190	£34,977,292	✓
9	28/07/2018	18/08/2018	£6,240,502	£5,973,449	£40,950,741	
10	28/08/2018	18/09/2018	£6,309,201	£6,776,202	£47,726,943	✓
11	28/09/2018	19/10/2018	£7,093,551	£7,505,547	£55,232,489	✓

✓	Payments selected for testing – total amount £27,044,356 [49% of cumulative payments]. Confirmed all details reconciled to invoice received; had been authorised for payment appropriately and had been made within the required timescales. With regard to the scheme of delegation, the standard for a Programme Director would be £75k; but in the instance of the GUH project this has been increased to £100k. Noting there had been changes in the responsible Director, the Director of Planning has continued to certify the invoices as the current appointed Programme Director has a delegated limit of £50k and there have been no discussions, to date, regarding amendment.

Appendix D: Change control process



Appendix E –Change Management Sample

Ref	PMI	PMN	CEN	Detail	Value of change	Approval in line with procedure?
1	-	21	31	Studio Response: acceptance of appointment of role of Artist Project Manager	£36,283	✓
2	-	29 Rev 2	29 Rev 2	Lying snowfall in March	£87,723	✓
3	68	40	47	Duct connections to future HSDU	£16,009	✓
4	-	45	27B	Emergency lighting changes	£70,608	✓
5	97	56	59	Endoscopy lead lining specification change	£29,293	✓
6	-	58	26B	Additional S278 road signs required by TCBC	£10,274	✓
7	88	53	57B	Resin floor specification change	£92,262	✓
8	113	64	71	Omission of lift shaft painting to all lifts	(£28,182)	✓

Appendix F - Assurance Opinion and Action Plan Risk Rating



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



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



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



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

Prioritisation of Recommendations

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

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

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

Appendix G: Grange University Hospital Audit Plan 2019/2020

Assurance/Approval	Outline Scope	2019/20 Financial Year (show expected start date)											
		A	M	J	J	A	S	O	N	D	J	F	M
Programme/Project Milestones													
	Completion Anticipated - 15/09/2020	Construction Period											
General Assurance													
Validation of Management Action													
Governance													
Risk & Contingency Management													
Functional Assurance													
Financial	CRL/ Cashflow Management Capital Cost Monitoring												
Technical	Progress Monitoring & Reporting Open Book - potentially including the supply chain Commissioning Arrangements												
Quality	Construction Management												
Information	No coverage proposed												
Stakeholder Engagement	Equipping & IM&T												
Non- Opinion Assurance													
Attendance of Key Meetings													
Project Director Support													
General Advisory Support													
Audit Committee Prep & Attendance													

The is in line with the overall audit plan and associated annual budget previously agreed with management.
The financial implications of the above has been adjusted to account for inflation.



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University Health Board

Annual Quality Statement

Final Internal Audit Report

2019/20

Aneurin Bevan University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix A	Management Action Plan
Appendix B	Matters arising from Source Documents
Appendix C	Prioritisation of Recommendations
Appendix D	Responsibility Statement

Review reference:	AB1920-18
Report status:	Final
Fieldwork commencement:	10 April 2019
Fieldwork completion:	21 May 2019
Draft report issued:	22 May 2019
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Final report issued:	31 May 2019
Auditor/s:	James Quance, Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Rhian Gard, Principal Auditor

Executive sign off Paul Buss, Medical Director

Distribution Kate Hooton, Assistant
Director, Quality & Safety

Committee Audit Committee
Quality & Patient Safety
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 Aneurin Bevan 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 Annual Quality Statement (AQS) has been completed in line with the 2019/20 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that the AQS is compliant with the requirements of the Welsh Health Circular: Annual Quality Statement 2018/19 Guidance.

The Health Board is required to publish an Annual Quality Statement (AQS) by 31st May 2019 reporting on the 2018/19 year. The AQS is a statement from the Health Board to the public and represents a key step forward in meeting the commitment set out in 'Together for Health' for absolute transparency on performance and specifically, action 10 of the 'Quality Delivery Plan' for the NHS in Wales.

The AQS is an opportunity for the public to be informed, in an open and honest way, about what and how the Health Board is doing in making the best use of resources to provide and deliver safe, effective and user / patient-centred services and ensuring that care is dignified and compassionate.

2. Scope and Objectives

The overall objective was to provide assurance that the AQS is complete and consistent with information reported to the Board and other committees and meets the requirements of Welsh Government. As we tested a limited sample of the AQS, the intention is not to provide a high level of assurance against the full content.

The scope was limited to ensuring:

- that the AQS is complete and consistent with information reported to the Board and other committees over the period;
- compliance with the Welsh Health Circular: Annual Quality Statement 2018/19 Guidance (WHC/2019/007); and
- the previous recommendation that was raised during the 2018/19 audit of the AQS has been implemented.

The areas that we considered during our review included:

- Board papers for the financial year and an up to date production of the AQS;
- Quality and Patient Safety Committee papers for the financial year;

- Information Governance Committee papers for the financial year;
- any other relevant papers;
- performance reports over the period covered by the AQS;
- other relevant performance information / data demonstrating 2018/19 achievements and challenges;
- papers relating to relevant participation in national clinical audits and clinical outcome reviews and resulting actions;
- response to staff feedback;
- evidence to demonstrate the quality of services commissioned by the Health Board;
- evidence to demonstrate improving patient experience;
- the Health Board's concerns, including incidents and claims, Public Services Ombudsman Wales reports, Coroner rule reports and actions followed;
- compliance with patient safety alerts;
- details of any 'Never Events' and actions taken;
- evidence of quality priorities identified for 2019/20; and
- feedback from other stakeholders, such as Community Health Council, when agreeing the statement.

3. Associated Risks

The risks considered in the review were as follows:

- the information detailed in the AQS is incomplete and / or incorrect;
- the public is not clearly informed of any improvements and challenges experienced in the range of services being provided as well as improvement priorities for the coming year; and
- failure to adhere to Welsh Government guidance, including the 'Wales for Africa' disclosure and other international health partnership initiatives.

CONCLUSION AND KEY FINDINGS

4. Overall Assurance Conclusion

Based on the results of our procedures we noted that:

- the AQS is presented in a user friendly way which can be understood by those who use the services and recognised by staff, primary care and other providers;
- the sample of information tested is consistent with supporting documentation and sources;
- the AQS is aligned to the Health Board's Integrated Medium Term Plan (IMTP), with referencing to each of the required themes of the Health and Care Standards; and

- the Welsh Health Circular: The Annual Quality Statement 2018/19 is complied with, where applicable.

No issues have come to our attention that lead us to believe that the AQS has not been prepared in accordance with the Welsh Government Guidance, or that information in the AQS is not materially consistent with source documents.

5. Summary of Audit Findings

We have reviewed various iterations of the AQS and identified issues arising from our content review to management.

Management has been informed of changes required as a result of our review. Appendix B provides information on the matters arising from our review of the source documents and the consistency of that information when compared to the AQS. Management has addressed all required changes.

Last year's audit identified a low priority recommendation for improving the control for retaining supporting evidence to each of the facts provided within the AQS. This year, the recommendation priority has been increased to medium, as the control has still not been fully implemented. Whilst we obtained all supporting information required within our sample testing of the AQS, we had difficulty obtaining some of this information.

Finding 1 Supporting Evidence	Risk
During the 2017/18 AQS audit we identified a low priority finding regarding supporting documentary evidence. This year, we found that the documentation was not readily available and we had to request some information directly from Health Board staff, to verify the statements within the AQS. A log is utilised by the Health Board for tracking outstanding deliverables for the AQS. However, this is not used to ensure that sufficient evidence is available to verify each figure and statement within the AQS. It is important that each statement, fact and figure included within the AQS is supported by appropriate evidence.	There is a risk of inaccurate / invalid information being disclosed within the AQS.
Recommendation 1	Priority level
- When requesting information / evidence from staff, the accompanying email / communication should remind staff of the importance of retaining documented, corroboratory evidence to support facts and figures reported. In particular, the importance of using information that has been formally reported within the Health Board should be emphasised. - Once received each piece of information supplied for the AQS should be reviewed against the supporting documentation and centrally logged, tracked and referenced to the supporting evidence. - Reliance should not be placed on narrative supplied within emails from members of staff.	Medium

Management Response 1

For the 2019-20 AQS, the issues covered will largely be taken from Board and QPSC papers to minimise the issues of staff needing to provide corroboratory evidence for facts and figures.

A log is kept detailing which member of staff has provided information. They will in future be asked for the corroborating evidence, and without this the story will not be included in the AQS.

Responsible Officer/ Deadline

Kate Hooton, Assistant Director of QPS/ April 2020, during the preparation of the next AQS.

Appendix B: Matters arising from our source document review of the Health Board's 2018/19 Annual Quality Statement that have been addressed.

	Findings
1	Our verification of the data/information did not identify any significant findings with regard to the accuracy and completeness of data/information that fed into the AQS. However, some minor inconsistencies were identified, which are detailed below: • Page 4 – “We have not achieved the target set for us by the Welsh Government of 25 C difficile infections per 100,000 population, although we have reduced the rate to 26.37 per 1000 population, compared to the rate in 2017-18 of 36.81 per 100,000.” – following the review of Healthcare acquired infections data this should read we have reduced the rate to 26.37 per 100,000 not 1000 as stated, this was fed back and amended in the AQS. • Page 7 – “In Gwent, nearly a fifth (18%) of the adults smoke. Despite the encouraging fall in smoking rates overall, differences can be seen across Gwent local authority areas, where in 2017-18, the percentage of people that smoked ranged from 13% in Monmouthshire to 22% in Blaenau Gwent.” – following the review of the Public Health Annual report and other Public Health data this should read 19% not 18% as stated, this was fed back and amended in the AQS. • Page 12 – “Falls have now reduced from 139 in 11 months in 2016 to 31 in the same period in 2018.” – following a review of supporting Datix information this should read 140 in 11 months in 2016 not 139 as stated, this was fed back and amended in the AQS. • Page 32 – “The Primary Care Academy has now assessed and approved 16 GP Practices across Gwent: 10 to support training of nurses new to primary care and 6 to support training of pharmacists new to primary care.” – following the review of the January 2019 Sustainability Board minutes this should read 18 practices and 12 to support nurses and 6 to support training of pharmacists, this was fed back and amended in the AQS.

Prioritisation of Recommendations

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

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

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

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

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

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