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AUDIT COMMITTEE
23rd January 2018
AGENDA NO:

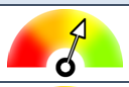
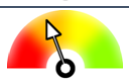
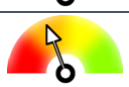
AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

1. PURPOSE

The purpose of this report is to advise the Audit Committee of the outcomes of finalised Internal Audit and Specialist Service Unit reports.

2. REPORTS ISSUED

Since the last meeting the following audit reports have been finalised:

Subject	Rating[1]
Internal Audit	
Primary Care Cluster Governance (ABM-1718-007)	
Third Sector Commissioning (ABM-1718-013)	
Financial Ledger (ABM-1718-015)	
Information Governance Framework (Follow Up) (ABM-1718-030)	
Community Dentistry (ABM-1718-038)	
Mental Health & Learning Disabilities Unit Governance (ABM-1718-039)	
Sickness Absence Management (Follow Up) (ABM-1718-103)	
Locum Medical Cover (ABM-1718-106)	
Specialist Services Unit (SSU)	
Renal Ward Refurbishment (ABM-1718-049)	

[1] Definitions of assurance ratings are included within Appendix A to this report

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

Audit report findings and conclusions are summarised below in Section 3. Full copies of the reports can be made available to Audit Committee members on request.

Actions have been agreed with Executive Directors in respect of audit recommendations made. Progress against agreed actions is input into an online database by lead officers and visible to Executive Officers for monitoring. The Associate Director of Finance analyses and summarises the status for Audit Committee meetings as a matter of routine.

In addition to the above listed audit reports, this paper includes the outcomes of two areas of SSu work issued to the Director of Strategy via briefing papers:

Specialist Services Unit (SSU)
Sustainability Reporting
Carbon Reduction Commitment

Audit & Assurance undertake follow-up reviews on key issues within areas deriving limited assurance ratings as part of its agreed plan of work for subsequent years. Additional follow up reviews may be undertaken at the request of the Audit Committee. The timing of follow up work is planned in liaison with Executive Officers.

3. INTERNAL AUDIT FINAL REPORT SUMMARY

3.1 PRIMARY CARE CLUSTER GOVERNANCE (ABM-1718-007)

Board Lead: Chief Operating Officer

3.1.1 Introduction, Scope and Objectives

In accordance with the 2017/18 Internal Audit Plan, a review has been undertaken of the Health Board's governance arrangements relating to primary care clusters.

Health Boards across Wales have created primary care clusters – 64 groups of neighbouring GP practices and partner organisations which provide services for their local populations of between 30,000 and 50,000 people. There are currently 11 Cluster Networks operating within the ABM locality.

The cluster design promotes joint working across practices and the integration of primary care services with key partners such as the

Ambulance Trust, Local Authority and Third Sector. Clusters also have a key role in supporting local health needs assessments, allocating appropriate resources and forecasting the potential future demand on primary care.

The Primary Care Annual Report 2015/16 presented to the Board in September 2016, included an appendix, developed by the NHS Wales' Directors of Primary Care, Community & Mental Health Services, setting out *Organisational and Governance Models for Clusters*. Whilst recognising that cluster development will evolve and differ within and between Health Boards, the report identified the importance of securing a number of basic requirements in respect of organisational and governance arrangements to support clusters.

At the pre-audit meeting with the Primary Care & Community Services Unit Directors on 2nd August 2017 the Unit confirmed that they had not followed the approach set out in the Appendix referred to above. The Head of Internal Audit confirmed that this would be taken into account during the audit and the audit review would evaluate the adequacy of governance arrangements in the approach evident from testing.

The overall objective of this audit was to review the Health Board organisational structure and information flows to support governance in respect of primary care clusters.

The audit focused on the aspects outlined in the basic requirements of the *Organisational & Governance Models for Clusters* framework outlined in the Primary Care Annual Report 2015/16. Consideration of Health Board arrangements to support good governance, and whether the clusters themselves were meeting expectations are set out in the report.

The audit scope considered the following:

- The agreement of cluster leadership teams, with roles & responsibilities as described in the *Organisational & Governance Models for Clusters* paper.
- The accountability framework in place for the regular reporting and monitoring of progress against cluster plans within the Unit, and Health Board.
- The documentation of discussions and decisions within minutes/notes of cluster meetings.
- The recording and consideration of declarations of interest when decisions are made within clusters.
- The evidence of action taken by the Health Board (typically demonstrated within cluster meeting notes) to respond to cluster requests for information or support.
- Documentation and agreement of the Health Board's understanding of the 'light touch' management approach to spending from indicative cluster budgets and its compliance with Standing Financial Instructions.
- The sharing of cluster investment plans with the Health Board and its agreement to them.

- Systems in place for ensuring value for money, corporate and clinical governance and improved patient services are established for service changes, and for ensuring periodic evaluation of cluster investment plans for cost effectiveness and patient focused outcomes.

The Cabinet Minister for Health & Social Care in his response letter of 27th November 2017 to the *Health, Social Care and Sport Committee Inquiry into Primary Care* stated that:

"I want each Health Board to review current practice to ensure these are evaluated systematically and proportionately. Unsuccessful initiatives must stop. Successful ones must be scaled up through the health boards' three year plans using discretionary funding."

In light of this recent direction, the above final audit objective was set aside and will be revisited at a future audit period.

Provision of routine information on quality and delivery measures has not been included within the scope of this audit – a separate audit has considered those arrangements. However, the flow of information to meet cluster requests at meetings has been considered, as has feedback on cluster plans and the provision of guidance on matters supportive of good governance.

3.1.2. Overall Opinion

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. Whilst this report recognises some of the positive arrangements in place to support cluster governance, we would note that there are a number of areas to be progressed nationally within NHS Wales which are aimed at improving arrangements and clarifying expectations further. The findings and recommendations of this internal audit report should be read alongside the additional national guidance and direction expected nationally.

Our review noted that the maturity and development of the clusters alongside the Health Board has resulted in defined cluster leadership teams being established which incorporates GP practices, Health Board and other stakeholders. Cluster Development Plans spanning a three-year period have been created as part of the Quality Outcomes Framework (QOF) requirement with the aim of supporting local health needs through the allocation of appropriate resources and forecasts of future demands.

Support is given to the Primary Care Clusters through the Heads of Primary Care and their supporting teams. We noted numerous examples of

information presented and Health Board support given at the Bay Health and Bridgend North cluster meetings during 2017.

There were no fundamental key findings raised by our work. However, as noted above there are areas for further development, some of which are reflected in the Cabinet Minister's directions issued in his letter to Health Board Chairs of 27th November 2017.

Action has been agreed by the Unit Service Director to address recommendations made in the Internal Audit report with a completion target of the end of January 2018.

3.2 COMMUNITY DENTISTRY (ABM-1718-038)

Board Lead: Chief Operating Officer

3.2.1 Introduction, Scope and Objectives

In accordance with the 2017/18 Internal Audit Plan, a review was undertaken of the Community Dental Service within the Health Board.

Community Dental Services (CDS) provide treatment for people who may not otherwise seek or receive dental care, such as people with learning disabilities, elderly housebound people, and those with mental or physical health problems or other disabling conditions which prevent them from visiting a dentist.

The CDS performs an essential role and aims to deliver comprehensive services by:

- Providing a full range of treatment for those who have experienced difficulty in getting treatment through general dental services
- Supporting oral health promotion programmes and initiatives such as Designed to Smile
- Undertaking national and local dental health surveys to monitor the oral health of all age groups
- Participating in the oral health screening of school children and other priority groups

The CDS provides clinical services at Central Clinic (Swansea) and Port Talbot Resource Centre, satellite clinics in the community, mobile dental units and via domiciliary dental care.

The overall objective of this audit was to review the processes adopted to manage the CDS.

The audit reviewed arrangements in place to ensure that:

- There is a clear management structure, staff establishment and budget for the service[2], and responsibilities are clearly defined;
- Systems are in place to address issues & risks associated with the collection and reporting of accurate data required by Welsh Government;
- There is a group(s): at which CDS are considered alongside GDS and HDS; at which CDS is clinically represented; and which has a reporting line that leads to the Unit Management Board;
- Clinical audit and/or peer review processes are used to provide assurance regarding the quality of services and outcomes are reported within the Unit;
- The Unit monitors:
    - Quality & safety information relating to the service (eg incidents, complaints, patient experience);
    - Participation and progress in oral health promotional programmes such as Designed to Smile (D2S), Healthy Schools;
    - Waiting lists for vulnerable people awaiting treatment under General Anaesthetic (GA);
    - Participation in a programme of work to support improvements to oral hygiene within care homes (and the Health Board has a policy on mouth care within care homes);
    - Participation in and activities of the regional Managed Clinical Network.

3.2.2 Overall Opinion

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 reviewed the service management arrangements immediately following a review of the group governance structure. We have considered the first meeting of the new Oral Health Quality & Safety Group within our work and the platform the new group offers for coordinating the management of dental services in primary care, hospital and the community, though we have not been able to assess its effectiveness over time owing to the limited period within which it has been operating. The above assurance level assumes its ongoing, effective operation.

[2] Reflecting the breadth of services identified provided across ABMU Health Board area.

There was one key finding identified during this review:

- The Welsh Government publishes statistics annually on community dental services across NHS Wales. In its November 2016 release, which reported activity for 2015/16, it noted that Abertawe Bro Morgannwg CDS was unable to provide accurate data for that data collection year and therefore had been excluded from all analyses. The data collection tool used for collating information for submission to the Welsh Government, has in-built validation checks. In the 2016/17 submission, these checks highlighted some entries which were non-compliant with data validation rules. This was raised by the auditor during fieldwork and the CDS Service Improvement and Operations Manager sought clarification from Welsh Government whether data submitted was acceptable for reporting purposes. The response received highlighted that whilst reasons have been entered on the form for the issues above, in the same situation in the previous year, the decision had been taken to exclude ABM data from the analysis.

Additionally, we noted:

- Whilst CDS had undertaken clinical audit work in previous years, there was little completed, and so reported, in the last year;
- Information reported to the Welsh Government on progress against the Local Oral Health Plan has not been reported directly to the Board or Quality & Safety Committee.

Action has been agreed by the Unit Service Director to address the majority of recommendations made by the end of January 2018, with one further remaining for completion by the end of March 2018.

3.3 THIRD SECTOR COMMISSIONING (ABM-1718-013)

Board Lead: Director of Strategy

3.3.1 Introduction, Scope and Objectives

This assignment originated from the 2017/18 internal audit plan.

The Welsh Government Third Sector Scheme describes the third sector organisations as "*a very diverse range of organisations that share a set of values and characteristics. It is widely accepted that Third Sector organisations are:*

- *Independent, non-governmental bodies;*
- *Established voluntarily by people who choose to organize themselves;*
- *'Value-driven' and motivated by social, cultural or environmental objectives, rather than simply to make a profit;*
- *Committed to reinvesting their surpluses to further their social aims; and for the benefit of people and communities in Wales*."

The overall objective of this audit was to review the arrangements adopted for the management of services provided to the Health Board by the third sector.

The audit was undertaken shortly following the approval by the Board in March 2017 of its *Strategic Framework: Working Together with the Voluntary Sector 2017-2020*. The audit has considered the content of the Strategy itself; systems for monitoring its delivery; arrangements in place for engaging with the third sector; and current performance management arrangements.

3.3.2 Overall Opinion

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. Whilst reasonable assurance was reported overall, there was a need to improve and coordinate the third sector performance management arrangements. The performance management of third sector SLAs has been dispersed amongst many staff historically and the responsible officers had not been documented centrally at the point of audit. The lack of clarity regarding performance management responsibilities could lead to inadequate performance assessment for some contracts. The Health Board had developed a service assessment document, but this had not yet been implemented.

Reports to the Board did not present much information in respect of services engaged and the outcomes evident from performance management arrangements. This should be addressed as part of the ongoing development of governance arrangements.

A number of additional minor issues have been raised where recommendations have been made to enhance control or more clearly document evidence of controls in operation.

Action has been agreed by the Director of Strategy to address issues raised with target completion date of the end of February 2018.

3.4 FINANCIAL LEDGER (ABM-1718-015)

Board Lead: Director of Finance

3.4.1 Introduction, Scope and Objectives

This assignment originated from the 2017/18 internal audit plan.

The financial ledger records all financial transactions of the organisation and provides the basic information for the preparation of management accounts, final accounts and financial returns. In order to maintain proper financial control it is essential that adequate accounting routines operate to protect the integrity of the ledger and that those routines are implemented in practice.

The overall objective of this audit was to give assurance that the Health Board maintains records of all financial transactions and ensures their completeness and integrity, with the aim of providing the basic data from which management accounts, final accounts and statutory returns can be prepared.

The financial ledger relies upon data from a number of feeder systems. This review has reviewed the interface with those systems but has not included controls within the individual feeder systems.

The following control objectives were reviewed:

- All transactions of the Health Board are recorded;
- All input to the financial ledger is complete, accurate, timely and valid;
- All journals within the financial ledger are authorised and adequately documented;
- Output from the ledger is controlled, secure, timely and appropriate to the need of the Health Board;
- Data within the financial ledger is secure and free from risks of loss or corruption.

3.4.2 Overall Opinion

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

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

There were no key findings were identified during the audit and no recommendations made for management action.

3.5 INFORMATION GOVERNANCE FRAMEWORK: INFORMATION ASSURANCE (FOLLOW UP) (ABM-1718-030)

Board Lead: Executive Medical Director

3.5.1 Introduction, Scope and Objectives

This assignment originates from the 2017/18 internal audit plan.

In 2015/16, an Internal Audit review of the Health Board's Information Governance Framework derived a "limited" level of assurance (ABM-1516-023 refers). The report considered arrangements in place against the *Information Governance Standards Framework* and *Information Governance Toolkit* (the "Toolkit") adopted in NHS England. Following the audit, the Health Board agreed action to introduce an information governance framework reflecting the principles of the Toolkit.

The overall objective of this audit was to confirm progress in implementing appropriate structures, responsibilities & accountability arrangements to support the effective management and use of information.

The audit provides an interim review of evidence supporting action completed to date following the last review of this area. For those actions remaining, it has sought to confirm that progress towards revised target dates is being monitored by management.

3.5.2 Overall Opinion

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.

The previous audit made 12 recommendations of which:

- 8 were addressed / compliant; and
- 1 was partially addressed / partially compliant;
- 3 remained to be addressed.

Following the original internal audit review, the Information Commissioner (ICO) conducted an external audit of information governance arrangements within the organisation. The scope & approach were different (confidentiality of personal data did not feature within the internal audit, but was a significant component of the external one) but both audits

considered the information governance framework and identified the need to develop an information asset register.

Following the last audit, improvement work has been coordinated by management within an information governance work plan incorporating good practice requirements and the recommendations of the internal audit and ICO audits. Significant steps have been taken in the implementation of a new, comprehensive *Information Governance Strategic Direction & Framework* (the "*Strategy*"). The scope has widened from the clinical information supported by the Informatics Directorate to wider business information used across most of the Health Board (and consideration is being given to expanding this further at the next review). The former Informatics Governance Committee has been replaced with an Executive led-Information Governance Board (IGB), chaired by a Senior Information Risk Officer (SIRO), and supported by a new Information Governance Lead. The IGB's scope has expanded similarly and the membership broadened to include leads from operational and corporate service areas. The IGB has embarked on a programme of work to identify and record its information assets in a structured, consistent way within an information asset register, and to assign ownership of those assets and the responsibility for managing the associated risks to individuals.

Progress made by the Health Board has been reported by the ICO Auditor too, her report recognizing the production of the Strategy and that the development of the information asset register was well underway.

There are a number of actions remaining to be completed and some additional recommendations have been raised to enhance the effectiveness of arrangements implemented to date. Action has been agreed by the Executive Medical Director (SIRO) to address issues raised.

Of the issues identified this audit, the completion of the information assets register with high priority assets identified across all operational and corporate areas, and the assignment and training of information asset owners (IAO) is key. This action is ongoing, tracked and reported through the information governance work plan presented regularly at IGB meetings and is currently targeted for completion by April 2018.

There will remain a significant body of work to progress after this point, but this will form a sound basis from which to take forward the further actions agreed within the Health Board's work plan.

3.6 MENTAL HEALTH & LEARNING DISABILITIES UNIT GOVERNANCE (ABM-1718-039)

Board Lead: Chief Operating Officer

3.6.1 Introduction, Scope and Objectives

In accordance with the 2017/18 Internal Audit Plan a review was undertaken of governance structures and arrangements within the Mental Health & Learning Disabilities Service Delivery Unit.
The Health Board went through a period of transition to a new organisational structure in 2015. New Service Delivery Units became operational from October 2015, with work planned to implement a strengthened governance framework to address quality, performance, risk and assurance between October 2015 and March 2016. The Service Director reviewed and revised his Unit governance structure in the last quarter of 2016/17.

The overall objective of this audit was to confirm that the Unit governance structure is designed and operates in accordance with the principles set out in the Health Board's system of assurance, and supports the management of key risks and the achievement of the Unit's objectives.

The approach taken was a desktop review of the terms of reference, work plans, agendas, minutes and action notes for key Unit management groups with the aim of confirming a clear framework had been put in place within which to manage the Unit's business.

We have also reviewed the Unit's use of its risk register for the assessment and management of recorded risks, in accordance with the Risk Management Strategy.

Findings of the previous Unit governance review have been considered but we have not reported against specific, previously agreed actions, noting the new Delivery Unit structure.

3.6.2 Overall Opinion

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

There were no key findings to report. A number of improvement recommendations were made (one medium priority and five low priority) and action has been agreed with the Service Director with target completion date of the end of January 2018.

3.7 SICKNESS ABSENCE MANAGEMENT (FOLLOW UP) (ABM-1718-103)

Board Lead: Acting Director of Human Resources

3.7.1 Introduction, Scope and Objectives

An audit of Sickness Absence Management, undertaken in July 2016 (ref 004/2016) derived a Limited assurance rating and identified a number of high priority issues for management action. This follow up audit has been undertaken at the request of the Audit Committee.

The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the 2016/17 audit review of Sickness Absence Management.

As a follow up audit, the audit scope has focused on progress made in those areas highlighted previously as requiring management action alone.

3.7.2 Overall Opinion

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.

Progress has been noted following the last audit in respect of management audit of sickness policy compliance. The previous audit made ten recommendations, of which three were low priority. We have followed up progress on the seven high and medium priority recommendations:

- Two have been addressed;
- Five have been partially addressed.

Additionally (and separately), there were actions tasked to the Occupational Health service as part of the Recovery & Sustainability Programme to support management in addressing sickness absence. This work is Executive led and reports to a Programme Board chaired by the Health Board Chair.

Last audit, we reported that there was a need to enhance the Occupational Health Transformational Change Project governance. The project was prompted by an external review of the service (by *Wellbeing4Business*) undertaken in February & March 2015, which reported that the service needed urgent transformation. It made a number of recommendations and suggested a phased approach to progression delivering the change in three stages and within 12 months. We can see that the project team has met more regularly and work stream leads report on activities. However, the

project continues to lack a project plan with clear timescales against which to report meaningfully on progress. The project does not have dedicated project management resource and since its inception there has been significant change within the Health Board including targeted intervention and the instigation of new initiatives and priorities (eg the Recovery & Sustainability programme) which make additional calls on resources available.

We have therefore recommended that the Director of Human Resources review the position of the project against the recommendations raised in the original external report. Remaining recommendations should be considered alongside other priorities to determine which aspects of this Project continue to be priorities, what resources are available and to agree revised objectives and timescales so that key benefits are delivered.

The following key findings were noted:

- HR audit of compliance has been progressed and reported within Mental Health; Whilst corporate HR audits have included three hotspot areas within Primary Care & Community Services, the outcomes and actions taken or required have not been reported to the Unit's Management Board;
- Whilst some actions have been progressed with respect to the Occupational Health Transformational Change Project, some remain to be addressed fully. In particular, there are many actions within the project plan without target completion dates. Until these are agreed, clarity regarding progress and assurance reporting to the Workforce & OD Committee will continue to be limited. As noted above, there are other priorities for the Occupational Health Service now incorporated within the Recovery & Sustainability Programme Workforce Work stream. We have recommended that a stocktake be performed of the current position of the Transformational Change Project against the original external review recommendations. What remains should be considered alongside other Health Board priorities and if the project continues to be supported in full or revised form within resources available, then a revised project PID and plan be produced that can be delivered.

Action has been agreed with the Acting Director of Human Resources with target completion date of the end of January 2018, though it is recognised that one of these actions is the reconsideration of the scope of Occupational Health transformational work, following which action will remain ongoing to implement improvements prioritised as part of any revised project arrangements.

3.8 LOCUM MEDICAL COVER (ABM-1718-106)

Board Lead: Director of Finance (audit sponsor)
Supported by Executive Medical Director and Acting Director of Human Resources

3.8.1 Introduction, Scope and Objectives

This audit was undertaken at the request of the Director of Finance and approval of the Audit Committee.

Whilst the Health Board reported an underspend against its pay budget at the end of June 2017, the Director of Finance highlighted that a significant reduction in pay costs was required to meet savings targets – Medical & Dental staff being a key area for attention. Variable pay is one area of cost pressure. The cumulative spend attributed to medical agency and irregular internal shifts, reported to the Performance & Finance Committee in October, was £4.5m and £3.5m respectively.

The overall objective of this audit was to review systems in place to control expenditure arising from the engagement of locum medical cover.

The audit considered controls over expenditure arising from both external agency locums, and internal locum cover paid via *Additional Duty Hour (ADH)* payroll submissions.

The following control objectives were considered:

- All agency locums are engaged via the Medacs managed service and the associated Health Board process;
- Payments for agency cover and additional duty hours are approved in accordance with Standing Financial Instructions and the scheme of financial delegation agreed within Units;
- Payments are made promptly and only once for hours worked;
- Rest breaks are deducted in accordance with WTD from agency shifts;
- Hourly rates for agency are paid in accordance with rates agreed and within any limits imposed by the Health Board;
- Payments made at rates in excess of those agreed are approved in accordance with predetermined escalation arrangements.

Originally the audit had intended to review whether relevant, timely and accurate management information on locum costs is produced and monitored also. However, noting the issues arising in respect of other objectives and in light of impending Welsh Government directions with respect to locum controls, the work was curtailed in order to report on related issues promptly.

3.8.2 Overall Opinion

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.

The Medacs *Envoy* system enables the electronic authorisation of individual weekly timesheets by assigned officers. However, review of bookings indicates that the commitment of expenditure within Units is for longer periods and values. Currently systems and records available do not demonstrate compliance with delegated financial limits effectively.

The audit was undertaken during the period immediately preceding the publication of directions from Welsh Government aimed at enhancing control over locum medical expenditure across NHS Wales. Management were developing improved processes and documentation for the prospective approval of internal and external locums and the control over rates agreed. Early discussion and sight of documentation indicated that it would provide a platform for improving control over some of the issues highlighted within this report. Comments were provided ahead of publication of this report to assist.

The following key findings were identified:

- There is no documented policy or procedure describing the process for generating additions, changes and removals to the approved user list administered by Medacs for their *Envoy* system (the electronic system used for recording times worked by locums), or the authority on which those changes can be actioned. Our review of the *Envoy* users on the Medacs list indicated there were 25 staff with no delegated financial authority recorded on Unit lists of authorised signatories for non-stock goods and services. Four users had approved timesheets but were not recorded on the Medacs user list either, indicating it was not a reliable record. These staff certified a total of 2,077 timesheet shifts for 19,286 hours from April to August 2017.

  We have recommended that the expected controls over users allocated timesheet approval functionality within *Envoy* be documented within formal Health Board procedures.

- The commitment of expenditure is made at the outset when the request for cover and details of the shifts required are communicated to Medacs. In light of the absence of assurance of compliance with the unit authorised signatory lists indicated above, we reviewed a sample of locums that had a high frequency of sessions and high expenditure, to test whether records of approval of the hours and expenditure were available in their specialties. Limited evidence was available to enable independent confirmation of appropriate approvals, and bookings were not specific about the total hours or expected cost of periods for which locums were to be engaged.

  Using hours actually worked and the rates agreed when booked, we calculated indicative costs for the periods of engagement sampled. Had

the hours worked been known at the time of booking, the total cost of engagement periods would have exceeded the Unit's signatory lists for 9 out of 10 bookings sampled. In addition, applying the Standing Orders Scheme of Delegation limits to the Health Board's published Unit management structures, suggests that these limits too would have been exceeded on 6 of 10 occasions.

We have recommended that the process, authorisation and record-keeping required for the prospective approval of agency locum cover be clarified within formal procedures. Lists of authorisers' names, approved by Units and compliant with Standing Orders Scheme of Delegation, should be maintained, reviewed & revised periodically and published so accessible to staff and to Medacs personnel.

- We reviewed timesheets across Medacs, ADH and Non-Framework agencies and identified 55, 12 and 24 instances respectively where breaks had been paid. Additionally, we reviewed the actual hours worked in three specialties over a five month period and identified 373 instances where the shift patterns booked and/or worked by the Locums were longer than the normal rota patterns. The extensions for the three areas considered totalled 253 hours.
- As noted above, there are no procedures describing expectation for the prospective approval of locum cover. In addition to addressing that we have also recommended that any additional controls in respect of review and approval of breaks and extended hours worked be documented formally within procedures.

Following the audit, procedures were implemented in response to Welsh Government's requirements and timescales, though it was recognised and accepted that within the timescales they would not address all the issues identified in this audit report. It was noted by management that the new procedures implemented would be reviewed in a short timescale and revisions made to address learning points following implementation and issues raised in the audit. An action plan has been agreed via the Director of Finance, Executive Medical Director and Head of Human Resources (Delivery Units & Medical Staffing) to address issues raised by the end of March 2018, though it is recognized that cost-effective mechanisms to control payment relating to shift extensions may require more time to achieve and require improved electronic systems.

3.9 RENAL WARD REFURBISHMENT [ABM-1718-049]

Board Lead: Director Of Strategy

3.9.1 Introduction, Scope and Objectives

The objective of the audit was to evaluate the associated processes and procedures supporting the delivery of the Renal Ward Refurbishment project.

The project was approved by the Welsh Government in February 2016 in the sum of £5.880m and it was anticipated to take circa 12 months to complete. The project seeks to ensure compliance with building regulations and provide a much safer clinical environment for patients. The completed refurbishment will incorporate an integrated out-patients and day case department as well as on-call facilities for staff.

The focus of the audit was directed to the following areas:

- An evaluation of the project governance arrangements, including the allocation of defined roles and responsibilities for individuals and working groups, and appropriate reporting, monitoring and approval processes;
- Assurance that adequate budgetary and cost management arrangements were in place to monitor and review the financial performance and progress of project delivery;
- Assurance that appropriate contract documentation was executed by both parties;
- An evaluation of the processes and procedures established to ensure that the contractor was correctly reimbursed in accordance with the contract;
- Assurance that appropriate change management arrangements were applied and changes were processed / authorised in accordance with the contract and local internal control procedures.

3.9.2 Overall Opinion

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 **moderate impact on residual risk** exposure until resolved.

The primary reasons for the level of assurance applied were:

- The current forecast project overspend of circa £498k; noting on-going management arrangements to mitigate the issues; and
- The reported programme delays; noting the delay in the original procurement programme [FBC forecast completion July 2017 but now June 2018]. This has primarily been attributed to the earlier progression of other schemes on site and the 'knock on' effect of available space (due to the pressures of unscheduled care experienced throughout Wales) required to progress the decant works. It is however recognised that the works contract is currently on site and progressing in accordance with the contract programme.

Whilst noting the delays in the progression of the project and the impact on project costs, it was acknowledged that the UHB project management team had been transparent throughout the process: addressing the issue of cost and timing with appropriate officers at both Executive and Welsh Government level.

Noting the above, the audit raised 4 recommendations (3 medium and 1 low priority). The following key findings were identified which required management attention:

- The appropriateness of the Project Director appointment needed to be reviewed for this (and future) projects to ensure appointed officers have adequate time and knowledge available to strive towards the successful delivery of the project objectives;
- The project value engineering exercise needed to be finalised and reflect the outcome in the projected outturn; whilst continuing to ensure transparency of the situation at both Executive and Welsh Government level;

  (Note: both of the above items had been addressed by management at the time of the issue of the final report)
- A financial plan for the funding of the overspend associated with the project required finalisation and approval.

Action has been agreed by management to address the remaining outstanding issues arising from the review.

4 BRIEFING PAPERS

4.1 BRIEFING PAPER: SUSTAINABILITY REPORTING

Board Lead: Director Of Strategy

4.1.1 Introduction, Scope and Objectives

In May 2012 the Welsh Government launched the 'Achieving Excellence: The Quality Delivery Plan for the NHS in Wales 2012-2016'. The plan sets out the Governments' ambition to achieve a quality driven NHS, focused on providing high quality care and excellent patient experience.

The plan includes the requirement that every NHS organisation from 2012 will publish an annual report. From 2012/13 public bodies in Wales that report under the Government Financial Reporting Manual (FReM) and meet the FReM de-minimis are required to produce a FReM sustainability report.

The format within the International Financial Reporting Standards (IFRS) NHS Wales Manual for Accounts 2016-17 provides a recommended structure for NHS Wales's bodies' Sustainability Reports, including minimum requirements.

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

- Whether the form and content of the statement complied with the requirements of guidance published by the Welsh Government;
- Whether the information published within the report provided an

accurate and representative picture of the quality of services it provided and the improvements it has committed to undertake.

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

- Follow up of prior years' recommendations;
- Arrangements for the preparation, approval and publication of the Sustainability Report including ensuring compliance with relevant guidance;
- Management arrangements for securing data quality in reporting of non-financial performance information;
- Internal controls over the collection and reporting of the data included within the sustainability report, and confirmation that these controls were working effectively in practice;
- Testing of selected indicators to ensure the underpinning data was robust and reliable, conformed to specified data quality standards and prescribed definitions, and was subject to appropriate scrutiny and review.

4.1.2 Conclusion

We sought assurance that appropriate action was taken to address the previously agreed recommendations. Of the 16 recommendations raised at prior briefing papers, 13 have been closed or superseded (1), 1 partially implemented and 2 remain outstanding. Over the past two years, the University Health Board has significantly reduced the waste destined for landfill with the majority of waste collected now being 'incinerated with energy recovery'.

The UHB operate a system of regular 'self-reads' for energy and water consumption data with monthly and annual contractor invoices utilised for waste collections.

This has resulted in a robust system allowing the Environment team responsible for the collation of data to gain a good level of accuracy.

Accurate data was presented for the EFPMS report with only minor discrepancies when reported in the UHB's Sustainability report. This was primarily attributed to the Welsh Government reducing the timetable for submission of the same.

Additional recommendations have been provided to strengthen or enhance the current data collection systems currently employed by the Environment Team.

4.2 CARBON REDUCTION COMMITMENT

Board Lead: Director Of Strategy

4.2.1 Introduction, Scope and Objectives

This review sought to provide the Health Board with assurance that the operational procedures utilised were compliant with the Carbon Reduction Commitment (CRC) Scheme guidelines, including mandatory and best practice elements.

The CRC Energy Efficiency Scheme (CRC) is a UK Government initiative to reduce carbon dioxide (CO2) emissions from large and medium-sized organisations, meeting certain qualification criteria. Participation for these organisations is mandatory.

The first phase of the scheme ran from April 2010 to the end March 2014.

The second phase, where health boards were required to participate, runs from 1 April 2014 to 31 March 2019.

Health Boards were required to submit their annual report before the 31st July 2017.

The CRC guidance requires participants to be subject to an annual review to ensure compliance with guidance.

As an aside, the UK Government announced in March 2016 that the Carbon Reduction Commitment (CRC) energy efficiency scheme will be abolished following the 2018-19 compliance year. Increases in the Climate Change Levy (CCL) are planned for 2019 to compensate for the lost revenue from this decision.

The overall objective of the review was to assess compliance with CRC requirements and guidance.

The scope of the assignment was therefore limited to the following aspects:

- Follow up: Assurance that the recommendations made in last year's review were appropriately addressed;
- A review of the 2016/17 annual report (submitted on the 31st July 2017), to assess:
    - Accuracy of reported figures/totals;
    - Correct treatment of data including actuals/estimates, inclusions/exclusions etc.; and
    - Audit trail to supporting evidence;
- Assessment of the management of the purchase of allowances; and
- Sufficiency of the Evidence Pack.

This review also acknowledged the findings of any relevant audit assignments undertaken within the reporting year to prevent any duplication.

4.2.2 Conclusion

We sought assurance that previously agreed management actions had been implemented. The UHB had implemented 3 of the previous 6 recommendations raised at prior briefing papers, with 3 recommendations superseded with those present in this report. All remaining recommendations are closed.

Due to the continued use of robust data collection systems, the employment of additional staff resources and implementation of recommendations at prior reviews, the UHB has been able to strengthen CRC principles.

The UHB continued to utilise robust data collection techniques through operating monthly 'self-read' meter readings. This method negated the reliance upon less accurate supplier invoices.

As raised at prior reviews, the change to the purchasing strategy and associated financial impact should be formally reported for executive consideration, along with the merit/risks of re-establishing the original strategy or continuing with the current approach.

Issues were experienced in processing the associated 'forecast sale' invoice which resulted in the UHB having to revert to the more expensive 'buy to comply' purchasing strategy. This arrangement has continued to date (incurring additional costs estimated at £216,544 for the duration of the CRC programme) but the formal approval and reporting of the consequential effect of reverting to the 'buy-to-comply' purchase strategy was not identified.

However, management advised that to revert to the 'forecast sale' purchase strategy would effectively require two compliance payments within one financial year (one buy-to-comply payment and one 'forecast sale' payment), which due to the high costs involved, severely limited the UHB's options.

Combined heat and power units integrate the production of usable heat and power (electricity) in one single, highly efficient process, generating electricity whilst also capturing usable heat that is produced in the process. CHP systems offer the capability to make more efficient and effective use of valuable primary energy resources.

It has been recommended that a report be submitted to the Executive Team on the benefits/risks and cost implications of re-commissioning the four non-operational Combined Heat and Power units installed throughout the UHB estate. However, it is acknowledged that the UHB are currently engaged in the process of planning a phased programme of energy conservation measures.

5. RECOMMENDATION

5.1 The Audit Committee is asked to note the summarised findings and conclusions presented by Audit & Assurance, and the exposure to risk pending completion of action by management.

5.2 The Audit Committee is asked to consider whether:

- **It requires full reports on any of the above subjects;**
- **It requires attendance from management to provide assurance on action being taken to manage risks in relation to any of the above;**
- **It wishes to direct any reports in summary or full form, to other Board Committees for further consideration.**

APPENDIX A

AUDIT ASSURANCE RATINGS

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