Concerns: Serious Incidents

Final Internal Audit Report

2020/21

Swansea Bay University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditors: Helen Higgs, Head of Internal Audit
Neil Thomas, Deputy Head of Internal Audit
Johanna Butt, Principal Auditor

Executive sign off: Pam Wenger, Director of Corporate Governance

Distribution: Christine Williams, Interim Director of Nursing & Patient Experience
Hazel Lloyd, Head of Patient Experience, Risk & Legal Services
Nigel Downes, Head of Quality & Safety

Committee: Audit Committee
Quality and Safety Committee

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

1 EXECUTIVE SUMMARY

1.1 Introduction and Background

This review originated from the 2020/21 internal audit plan.

The Welsh Government legislation the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011), sets out the arrangements that NHS trusts and health boards must have in place for the handling and investigation of concerns. Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible Body in Wales. 'Putting Things Right' is the integrated process for the raising, investigation of and learning from concerns. These regulations are supported by Welsh Government guidance on the reporting and handling of serious incidents (SIs) and other patient related concerns.

The health board's systems and processes for the management of serious incidents were reviewed by the Welsh Government Delivery Unit in 2017/18 and its report published in February 2018 made a number of recommendations for improvement in respect of serious incident management and wider quality & safety governance. From this, the health board developed a detailed action plan, against which, progress with delivery was reported to the Audit Committee as part of the health board's governance work programme. The action plan was reported as complete at the March 2020 meeting of the Audit Committee.

1.2 Scope and Objectives

The overall objective of the audit was to review corporate arrangements in place to ensure serious incidents are managed in accordance with Welsh Government requirements and health board policies and procedures.

This scope considered the following:

- The framework for managing Serious Incidents sets out roles, responsibilities and accountability clearly, and promotes consistent approaches to investigation;
- Training is provided to staff to support effective incident investigation and response;
- Serious incident investigations and corrective actions are quality assured and approved by appropriate officers;
- Clear pathways have been established for the sharing of learning from serious incidents;
- The Quality and Safety Governance Group operates effectively and provides oversight of the health board's serious incident management processes;

- The Welsh Government is alerted to the occurrence of serious incidents where required[1]; and
- The Quality & Safety Committee receives information on serious incidents for assurance on action taken and organisational learning.

Consideration was given to actions taken in response to the 2017/18 Welsh Government Delivery Unit recommendations when undertaking the review. However, the audit is not a follow up / verification of progress reported against that action plan.

It is acknowledged that the Covid-19 pandemic has had a significant effect on health board operation this year. This has been considered when assessing the above and recognised when reporting.

1.3 Associated Risks

The potential risks considered in the review were as follows:

- A lack of a clear framework of roles, responsibilities and ownership of serious incidents may undermine the timely and effective response by the health board;
- The provision of training on investigation and action planning may promote more effective responses to serious incidents;
- Without effective quality assurance and approval of investigations & action plans, the health board responses to serious incidents may be ineffective;
- Lack of a system and pathway for learning from serious incidents could lead to inconsistency of approach and effectiveness;
- Weaknesses in corporate oversight and coordination of the health board response to serious incidents could lead to variation in approach and quality and timeliness of investigation, action and learning;
- Poor communication with Welsh Government could undermine working relationships and reputational damage; and
- The Quality & Safety Committee may not receive adequate information to undertake its assurance role effectively on behalf of the Board.

2 CONCLUSION

2.1 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.

[1] We did not substantively test the classification of incidents, but reviewed the reporting to Welsh Government of incidents classified as serious following management review & approval.

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 area reviewed 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.

2.2 Assurance Summary

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

					
1	Serious incidents framework				✓
2	Incident training		✓		
3	Quality assurance and approval of response			✓	
4	Sharing of lessons learned			✓	
5	Oversight by Quality and Safety Governance Group				✓
6	Alerts to Welsh Government				✓
7	Quality & Safety Committee reporting			✓	

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

2.3 Design of Systems/Controls

The findings from the review have highlighted **one** issue that is classified as a weakness in the system control / design.

2.4 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.

3 FINDINGS & RECOMMENDATIONS

3.1 Summary of Audit Findings

The health board has an overarching policy in place for concerns, including Serious Incidents (SIs), which is available to all staff on its intranet, and which clearly sets out roles, responsibilities and accountability. Additionally, the SI team has produced a SI toolkit that sets out the five phases of an investigation which promotes a consistent approach and details responsibilities further in respect of SIs in particular.

The SI Team provided training to the Mental Health and Learning Disabilities (MHLD) directorate in June 2019. The training slides were appropriately aligned to the SI Toolkit. Attendance records were not available, but invitations to delegates were provided. The SI team had planned to roll out further training in 2020 but this was cancelled due to COVID-19. However, at the time of our review a plan was in place to roll out training in 2021. The health board has not undertaken a training needs analysis to identify who should receive training - noting the revised timeline for delivery the opportunity exists to do this to ensure it is delivered to all those who require it.

SIs are recorded on Datix and walkthrough of five SIs confirmed that Datix included, where appropriate, evidence of initial meeting, witness statements, report of investigation (or a completed falls or pressure ulcer checklist) and documentation demonstrating review throughout the process. Walkthrough of SIs confirmed that all were subject to review by either the unit/service group Nurse Director/Medical Director or, for one incident that had occurred within the Maternity service, the Head of Midwifery. All Welsh Government (WG) forms had been subject to review by the SI Team prior to sign off by an Executive Director for submission to the WG.

The Welsh Government decided to remove the formal 60 day target for SI closure reporting from the NHS Wales Delivery Framework from 1 April

2020, but while it would no longer monitor against the target, it indicated that NHS organisations would still be required to work towards the 60 days as a guide. As is clear from reports at the Quality and Safety Governance Group (QSGG) and Quality & Safety Committee (QSC), the level of achievement of the 60 day target has been low – we understand this is largely due to a change in the reporting requirements for MHLD investigations. Reports indicate a high number of SIs outstanding for investigation and closure within Mental Health & Learning Disabilities. The service group's Nurse Director has allocated resources and developed a plan to clear the backlog over the course of the coming year against which progress can be monitored. Unit/service group Nurse Directors are provided with regular reports which include information on open SIs.

The SI Team lead on all Never Events and SIs that result in death or long-term harm and learning from these are issued via Datix safety alerts. Learning briefs are also produced and included in the patient experience reports presented at the Quality and Safety Committee (QSC).

The QSGG has met monthly throughout the pandemic and meetings were generally quorate, with the one exception of the July 2020 meeting. Both the QSGG and the QSC receive both qualitative and quantitative updates on SIs which include periodic updates on learning from SIs via the Patient Experience reports.

We identified only one **high** priority finding:

- In February and March 2020, the QSC received in-committee Patient Experience Reports which provided the age profile of open SI's. However, the age profile of open SI's has not been reported since.

The key findings by the individual objectives are reported below with full details on issues and associated recommendations in Appendix A.

3.2 Detailed Audit Findings

Objective 1: The framework for managing Serious Incidents sets out roles, responsibilities and accountability clearly, and promotes consistent approaches to investigation.

The health board has a clear framework in place for managing Serious Incidents (SIs), namely, the Concerns Management Policy which has replaced the previous Putting Things Right Policy (PTR) (which was due for review in February 2021). The new policy was ratified by the Quality and Safety Governance Group (QSGG) in February 2021 and replaced the previous policy on the health board's intranet in March 2021.

Additionally, the SI team has developed a SI Toolkit which details a five-phase process:

- Phase 1: Immediate actions;
- Phase 2: The review;
- Phase 3: Learning event;
- Phase 4: Report; and
- Phase 5: Learning.

We reviewed the toolkit and consider it is clear and comprehensive on roles and responsibilities, and actions required following a serious incident. The SI toolkit includes links to relevant documentation which promotes a consistent approach.

Datix is used to record and document SI investigations, and to provide an audit trail of review and authorisation. Additionally, Datix includes mandatory fields, with links for additional help / guidance if required, which also helps promote a consistent approach to fully recording SIs.

The health board's SI team lead on all Never Events and SIs that result in death or serious harm, and they are responsible for notifying the Welsh Government (WG) of SIs. The Concerns Management Policy details that "*Accountability and responsibility of the Serious Incident remains with the relevant Service Group Senior Team or nominated deputy*" and the 'Serious Incident Investigation and Learning Process' within the SI Toolkit provides a more comprehensive list of actions, roles and responsibilities in the process. The Concerns Management Policy also details that *"Further guidance and assistance regarding management of Serious Incidents or whether a matter is considered a Serious Incident can be sought from the Serious Incident Investigation Team within working hours"*. This ensures that any service group staff involved in an investigation can be signposted to relevant guidance, should they require it.

No matters arising.

Objective 2: Training is provided to staff to support effective incident investigation and response.

The SI team has prepared a power point presentation for delivery of SI training. We reviewed the presentation and confirmed that it was aligned to the SI Toolkit. The health board had planned to roll out training on the SI Toolkit in 2020 across all units / service groups. Due to the COVID-19 pandemic the planned delivery of the training had to be cancelled. However, prior to this in June 2019 the SI team had provided training on the SI toolkit to the Mental Health and Learning Disabilities (MHLD) service group, which had been identified previously by the Welsh Government Delivery Unit (DU) as having a different approach to investigations. Attendance records were unavailable to confirm who had attended. However, we were provided with

e-mail evidence of delegates invited to the training and the agenda for the day.

The SI team had promoted SI training intended for 2020 via a staff bulletin on the health board's intranet site in December 2019. We understand that there had been a lot of interest in the training, but not necessarily from individuals who would be routinely involved in a SI investigation. We were informed that a training needs assessment (TNA) has not been undertaken to identify and target training to individuals that would be involved in SI investigations. The SI team has made plans to re-commence rolling out training in September 2021 – there is potential to consider needs in the planning and booking of sessions before then to ensure those who require it receive it.

See Finding 1 in Appendix A.

Objective 3: Serious incident investigations and corrective actions are quality assured and approved by appropriate officers.

The health board uses Datix to record all incidents, including SIs. The health board's guidance '1013 – Serious Incident – Staff Information Leaflet' details *"When an incident occurs that is deemed as serious, it will be reported on Datix and escalated to the Unit Nurse and Medical Director as well as the Serious Incident Team. If the incident is declared serious then it will be reported to Welsh Government*".

We obtained a Datix report of all WG reportable SIs in 2020. There was a total of 166 WG reportable SIs in 2020, 40 of which were closed at the time of our review. We selected a sample of five closed SIs to include one each from Morriston, Singleton, Neath Port Talbot (NPT), Mental Health & Learning Disabilities (MHLD) and Primary and Community Services (PCS). We reviewed the documents on Datix for the sample of SIs selected and found that there was a clear audit trail for each, containing records with evidence of investigation, review and authorisation prior to the notification to WG. One, within MHLD, was downgraded following initial notification so did not proceed via the full SI investigation process. Our walkthrough for the remaining four found that three included sign-off from either the UMD or UND for the service, and the remaining SI had occurred within the Maternity Unit so was signed-off by the Head of Midwifery.

The SI Toolkit indicates that as part of the scrutiny and sign off process the 'Serious Incident Management and Report Checklist and Assurance Document' should be completed by the UND or the UMD. This form had not been completed for any in our sample and we were informed that it was present as a guide, but completion was not expected.

A letter from WG dated 18 March 2020 confirmed that the formal 60 day target for SI closure reporting to Welsh Government had been removed from the NHS Wales Delivery Framework from 1 April 2020. However, it

stated NHS organisations would still be required to work towards the 60 days as a guide, but they would not be formally monitored against it. In 2019/20, the health board had set an internal performance target of 80% achievement of the 60 days (an improvement target towards achieving a national target of 90%). Performance has continued to be monitored via the Integrated Performance Reports (IPR). We reviewed the IPRs presented to the Quality and Safety Committee (QSC) in January 2020 and January 2021. These showed that the health board has not met its local target of 80% since January 2019 – performance during 2020/21 peaked at 50% in August but rarely exceeded 30%. It was explained to us that this is largely due to a change in the national SI reporting requirement - SIs affecting any person who has been a MHLD patient within the last 12 months now have to be captured.

We note that the SI team produce weekly/fortnightly reports for discussion with service groups. These contain detail on individual SIs and progress made between meetings. Wider patient experience reports are generated for the Executive Nurse Director for use during monthly meetings with the unit/service group Nurse Directors which include reference to SIs occurring within the service. The report for MHLD detailed that there are outstanding SI investigations within the unit (As at March 2021 - Year 18/19 = 10; Year 19/20 = 47; Year 20/21 = 40). However, we note that the UND has developed an improvement plan to address the backlog by the end of 2021/22 and he has indicated that additional resources have been recruited into the service group's investigation team to support delivery of the plan.

See Finding 2 in Appendix A.

Objective 4: Clear pathways have been established for the sharing of learning from serious incidents.

The Concerns Management Policy details that the SI Team will *"Share learning from Serious Incidents investigated by the Serious Incident Team and Never Events with Service Groups via the Alerts System in RL Datix".* It also details that the *"Service Group will be responsible for ensuring that actions are taken in a timely manner to prevent a reoccurrence, for developing, implementing and monitoring its action plan and sharing its learning"*.

Each of the sample of four SIs we reviewed that proceeded to full investigation was managed within units/service groups. One related to a fall and another related to a pressure ulcer. The majority of patient safety issues relate to falls and pressure ulcers, consequently, the health board has dedicated policies in place for these, including the requirement for local scrutiny panels and corporate oversight – these have been subject to separate audits in the past so we have not reviewed these further here. The remaining two were SIs specific to the specialisms within which they

occurred (cardiac and maternity) and as such we noted the action and learning was appropriately shared within the departments, detailed on the WG Closure forms, and evidence was included on Datix.

The SI Team produces learning briefs for Never Events and SIs that they are involved with. In Quarter 3 of 2020/21 they produced a newsletter which included four learning briefs each one a concise, one-page bulletin detailing the situation, background and assessment and a bulleted list of learning outcomes. The SI Team also distribute via e-mail any safety alerts by INTERN. These also detail the Situation, Background and the Assessment and provide a link for the recipients to use to view and respond.

The QSGG is detailed in the Concerns policy as being the supporting group for SIs. We reviewed the papers presented at its meetings which confirmed that it receives information on actions and learning from Never Events and SIs via the Patient Experience Report. The report also provides a trend analysis of SIs, including the number of SIs reported; the thematic reason for the SI; year on year comparisons for the same period and graphs showing the month on month variances.

No matters arising.

Objective 5: The Quality and Safety Governance Group operates effectively and provides oversight of the health board's serious incident management processes.

We reviewed the Terms of Reference (ToR) for the QSGG which confirmed that primary objective of the Group is to provide timely and accurate information to the QSC, and this includes duties relating to SIs and lessons learned. We found that the ToR is largely aligned to the roles and responsibilities as set out in the policy.

The QSGG meet monthly and these meetings have continued throughout the COVID-19 pandemic, albeit remotely via Teams / Skype. We reviewed a sample of seven months of QSGG meetings between April 2020 and November 2020. We found that the meetings were generally well attended and quorate for all but one meeting, being July 2020 (less than three service groups represented).

The QSGG has standard agenda items which include updates from the Head of Patient Experience, Risk & Legal Services on 'Putting Things Right' agenda item which includes updates on SIs and the sharing of learning from SIs via the Patient Experience report. Updates from the Units/Service Groups are also standard agenda items and review of a sample of these confirms that they also include details of SIs for the Units. Consequently, the QSGG was providing a regular mechanism for oversight for the health board's SIs.

No matters arising.

Objective 6: The Welsh Government is alerted to the occurrence of serious incidents where required.

We selected a sample of five closed SIs from 2020. Our review of the audit trail for the sample on Datix confirmed that in all cases the health board had notified the WG of the SI and the WG Notification form had been appropriately reviewed by and included Executive sign off prior to submission to the WG. We also reviewed the WG Closure forms and in four of the five cases there was evidence of the form being reviewed and included Executive sign-off prior to submission to the WG. The remaining one of the sample, relating to MHLD, did not include a WG Closure form. Instead a 'Request to downgrade a Serious Incident' form was completed and had also received the appropriate Executive sign-off.

The IPR report includes narrative on how many SIs have been reported to the WG in the preceding month. We compared the number of SIs detailed as being reported to the WG from January 2020 to February 2021 to the SI report from Datix. The reported figures on the IPR agreed to the figures on the Datix report in all but one instance and adequate explanation for which was provided by management (a change in WG reporting expectations).

No matters arising.

Objective 7: The Quality & Safety Committee receives information on serious incidents for assurance on action taken and organisational learning.

The Concerns policy details *"A Patient Experience report will be provided as a minimum on a quarterly basis"*. We reviewed the QSC agendas and papers for the period of January 2020 to December 2020 and this confirmed that the QSC had received a total of six Patient Experience Reports in the 12-month period. The Patient Experience report provides a trend analysis on SIs and details any actions taken or learning from SIs and Never Events. Two of the papers presented (February and March 2020) were in-committee papers and these were more detailed in respect of actions taken and learning. Recognising there was a backlog they included the total number of SIs for closure. While reference is made narratively to the backlog in the covering paper for subsequent reports, figures have not featured to provide assurance regarding the position.

The committee also received eight updates from the QSGG outlining the key quality and safety areas discussed at its meetings. Additionally, the committee received eight performance reports during the period, providing the information on the health board's performance against targets in

relation to SIs and also provides some additional narrative on key issues which includes a section on the achievement of the 60-day closure target for SIs. We compared the SI numbers included QSC Performance Reports against the Datix reporting and found that the numbers were consistent - in the two months where they differed an adequate explanation was provided which related to changes in the WG reporting requirements.

See finding 3 in Appendix A

3.3 Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**2**	**1**	**4**

Finding 1 – Training (Design)	Risk
The health board was in the process of rolling out training to staff in 2020 with training dates arranged before the COVID-19 pandemic restrictions had been announced and it was cancelled. This training was advertised on the health board's staff bulletin board on the intranet. The SI Team provided training to MHLD in June 2019 (pre COVID-19 pandemic). While we were able to verify who had been invited to the training, attendance records were unavailable.	The approach to investigations may be ineffective / inconsistent across service groups and the health board.
Recommendation 1	**Priority Level**
The health board should undertake a training needs analysis ahead of delivery of the 2021 programme to identify individuals that would be responsible for undertaking and overseeing an investigation within each department and ensure training resource is directed at those who require it.	**Medium**
Attendance records should be maintained to support monitoring and provide assurance that all staff that are identified as requiring training have received training.	**Medium**
Management Response 1	**Responsible Officer / Deadline**
Training needs analysis completed end of March 2021, Service Groups asked to identify key investigators to attend the external training provided by Consequence UK.	Lead SI Investigator/March 2021
Consequence training programme commenced on 26th April 2021. All staff identified in training needs analysis will have completed training by end of August 2021.	Lead SI Investigator//August 2021
Following completion of Consequence Training, the Serious Incident Team will deliver training and produce an annual training programme for 2021/22.	Lead SI Investigator/September 2021

Finding 2 – SI Checklist and Assurance Document completion (Operation)	Risk
The 'Phase 4 - Report' section of the SI toolkit details that as part of the scrutiny and sign off process the Serious Incident Management and Report Checklist and Assurance Document would be completed by the Unit Nurse Director (UND) or the Unit Medical Director (UMD). Walkthrough on 4/5 of our sample confirmed that there was evidence of scrutiny by either the UND or the UMD, but the Serious Incident Management and Report Checklist and Assurance Document had not been completed. We were informed by the corporate team that this is not routinely completed but provided as a checklist for reference when scrutinising the report.	Actual practice expected is not consistent with the same recorded in the toolkit.
Recommendation 2	**Priority Level**
The SI toolkit should be updated to reflect the expected practice in respect the extent to which the report checklist is used i.e. whether to use the checklist as a tool to scrutinise the report, or sign it off and retain it as a detailed, formal record of checks done.	**Low**
Management Response 2	**Responsible Officer / Deadline**
The Toolkit has been updated to reflect that the Assurance Document should be completed by the Head of Patient Experience, Risk & Legal Services and the named Executive Lead for Serious Incident Team Investigations only. The Assurance Document should be used as a guide by the Service Group Directors when reviewing investigations undertaken by the Service Group.	Lead SI Investigator//Completed 5 May 2021.

Finding 3 – Timeliness (Operation)	Risk
The WG confirmed that the 60 day target for SI closure reporting to the WG would be removed from the NHS Wales Delivery Framework from 1 April 2020. However, NHS organisations would still be required to work towards the 60 day target as a guide. The health board has not achieved its internal 80% target of achieving the 60-day timescale for SI closure during 2020/21. The reported reason for the failure to meet the target is due to changes in the reporting requirements for Mental Health and Learning Disabilities (MHLD) serious incidents (SIs). In February and March 2020, the QSC received an In Committee report that provided data on the numbers of open SIs and the backlog from previous years. While reference is made narratively to actions to address backlog within subsequent reporting, the QSC has not received further figures to demonstrate progress against any backlog.	Failure to address issues from serious incidents in a timely manner could adversely affect future patient safety.
Recommendation 3	**Priority Level**
Reporting to the QSC should include information on the numbers and age profile of SIs that remain open to provide assurance on progress made in closing them and the sharing of any necessary learning.	**High**
Management Response 3	**Responsible Officer / Deadline**
Report to Quality & Safety Committee has been updated to include information on the numbers and age profiles of open SI's, the report will also highlight progress made from previous month.	Head of Patient Experience, Risk & Legal Services/June 2021

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, which are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

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

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. 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.

Office details:

SWANSEA Office
Audit and Assurance
Floor 2, Matrix House
Matrix Park
Swansea
SA6 8BX

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

Contact details:

Helen Higgs (Head of Internal Audit) – helen.higgs@wales.nhs.uk
Neil Thomas (Deputy Head of Internal Audit) – neil.thomas2@wales.nhs.uk
Johanna Butt (Principal Auditor) – johanna.butt@wales.nhs.uk