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Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board



Meeting Date	21st November 2019	Agenda Item	
Report Title	Audit & Assurance Assignment Summary Report		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Report Sponsor	Paula O'Connor, Head of Internal Audit, NWSSP A&A		
Presented by	Paula O'Connor, Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Freedom of Information	Open		
Purpose of the Report	To advise the Audit Committee of the outcomes of finalised Internal Audit and Specialist Service Unit reports.		
Key Issues	<p>Ten final reports have been agreed with Executive leads since the last meeting. Their outcomes are summarised for information and discussion as appropriate. Full reports can be made available on request.</p> <p>The assurance levels derived can be summarised: <i>1 Substantial</i> <i>5 Reasonable</i> <i>1 Limited</i> <i>3 No rating applied</i></p> <p>The Report indicates the timescales for completion of actions agreed with management for each.</p>		
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance
			✓
Recommendations	<p>Members are asked to:</p> <ul style="list-style-type: none"> Note the summarised findings and conclusions presented, and the exposure to risk pending completion of action by management. Consider any further action required in respect of the subjects reported. 		








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

This report summarises the outcomes of the following finalised assignments:

Subject	Rating ¹
Internal Audit	
Commissioning: Service Level Agreements (Interim Review) (SBU-1920-010)	No rating applied
GP Out of Hours Services: Quality Standards Reporting (SBU-1920-012)	No rating applied
Welsh Risk Pool Claims (SBU-1920-015)	
Deprivation of Liberty Safeguards (Follow Up) (SBU-1920-023)	
Nursing Quality Assurance (Interim Follow Up) (SBU-1920-027)	No rating applied
Patient Environment (SBU-1920-038)	
Specialist Services Unit	
CRC Energy Efficiency Scheme	
Environmental Sustainability Report	
Neonatal & Post-Natal Capacity at Singleton Hospital	
Capital Systems: Financial Safeguarding	

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.

¹ Definitions of assurance ratings are included within Appendix A to this report. Explanations for reports without ratings are set out in the main body of the report.

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

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 COMMISSIONING: SERVICE LEVEL AGREEMENTS (INTERIM REVIEW) (SBU-1920-010)

No rating
assigned

Board Lead: Director of Strategy

3.1.1 Introduction, Scope and Objectives

The Bridgend Boundary Change took place on 1st April 2019 with the transfer of commissioning responsibility for Bridgend population to Cwm Taf Morgannwg UHB (CTM). As a result, two Clinical Services SLAs were agreed to support services to maintain patient flows across the border as well as 22 Corporate SLAs. The two documents cover services provided into the Bridgend area by Swansea Bay UHB (SBU), and the services provided into the Swansea and Neath Port Talbot Areas by Cwm Taf Morgannwg UHB.

On 12th June 2019, the Executive Board received a paper indicating that the Health Board had started a process to take a strategic view of the service change around the boundary to ensure:

- From a provider view – that the service configuration can remain safe, high quality, cost-effective, providing good access and fits with the Health Board’s Clinical Services Plan
- From a commissioner view – that the service configuration and flows are now optimal for the population of the Health Board (SBUHB).

It noted that arrangements for the monitoring of SLAs were being put into place and proposals were being developed in respect of governance arrangements and processes to progress the disaggregation of services.

An audit review of Commissioning was agreed as part of the 2019/20 internal audit plan in March 2019. The overall objective intended for the audit was to review the adequacy of controls in place for the commissioning of health care services via service level agreements. In particular, it featured within the internal audit plan in recognition of the recent boundary

change and the continued provision of services across organisational boundaries, with an intended focus to be given to the service level agreements introduced between SBU and CTM and the governance arrangements in place within SBU to support management and monitoring of services agreed, and to manage changes.

The audit was scheduled to commence in August and complete in September 2019. Audit review of meeting papers during planning for the review has found that the proposed governance arrangements which the Health Board intended progressing in partnership with CTM, were still developing at this time. The SBU Board was informed on 26th September 2019 of the key messages from the inaugural meeting of the Joint Executive Group with CTM, via the Joint NHS Partnership & Commissioning Update Report. Whilst these arrangements have been developing, a joint Commissioning & Contracting Group has operated.

Noting the position, we considered it too early to undertake a full scope assurance audit of arrangements in place. However, following our review of meeting papers agreed an interim report to present a summary of arrangements developed to date.

3.1.2 Overall Opinion

At the point of audit planning, the over-arching governance structure for the monitoring & disaggregation of services provided under SLA arrangements between SBU and CTM was continuing to develop.

Whilst this was the case our review of papers indicated that senior management of each organisation had been jointly progressing work, including the review of significant SLA service areas with the management leads from those services.

Additionally, a number of papers had been received by the Executive Board on progress and the full Board was informed of developments via the six-monthly partnership update report received in September – though we noted that there was more to do to agree and implement governance arrangements at that time.

We recommended that an update on the developing governance arrangements associated with the boundary change service level agreements be provided to the Board or appropriate Committee ahead of the next six-monthly, wider partnership update – perhaps following the meeting of the JEG in November at which the detailed timeline for the joint programme and resources required to deliver it plan were to be discussed.

We suggested that a further internal audit review of arrangements be considered for inclusion within the following year's audit plan.

Following issue of the Draft audit report, Internal Audit discussed the proposed design of the governance arrangements with the Interim Assistant

Director of Strategy. She indicated that a paper was being prepared for the November 2019 Board meeting to update on developments.

3.2 GP OUT OF HOURS SERVICES: QUALITY STANDARDS REPORTING (SBU-1920-012)

No rating
assigned

Board Lead: Chief Operating Officer

3.2.1 Introduction, Scope and Objectives

This assignment originates from the 2019/20 internal audit plan.

The out of hours medical service, usually referred to as the GP Out of Hours Service provides urgent primary care services to the population of Swansea Bay University Health Board, and Bridgend residents of the Cwm Taf Morgannwg Health Board under a service level agreement, across 115 hours each week in conjunction with the 111 Wales service (111). The 111 service is delivered by the Welsh Ambulance Services NHS Trust (WAST) and provides a single telephone number for members of the public to access health advice and the GP Out of Hours Service [OoH] following a telephone clinical triage by a nurse.

The 111 service was launched in October 2016, and a comprehensive set of standards were in place that provided targets and parameters for how the service should operate.

On 21st March 2019 the Health Board received formal notification that a single "universal" suite of standards and quality indicators had been created and issued for adoption by all health boards for the OoH / 111 service. The New Standards and Quality Indicators for 111 and Out of Hours are based on the existing standards and have been refined working with key service stakeholders, drawing on expertise from both clinicians, and those managing the OoH / 111 service. Some standards must be reported monthly, whilst others will be expected quarterly, six-monthly or annually. The Health Board and WAST are required to submit one combined reporting template to Welsh Government on a monthly basis.

The overall objective of this audit was to review arrangements in place to manage and monitor the provision of GP Out of Hours Services, and it focused on the Health Board's performance against the Standards (in particular the arrangements in place to report performance against the quality standards).

The scope agreed initially included consideration of the following:

- Arrangements in place to ensure the population of the reporting tool with all the information required, and its timely submission, including liaison with WAST partners as appropriate:
 - Part A: Telephony, Clinical Triage (CT) and Face-to-Face (F2F) standards

- Part B: Quality standards.
- The development of arrangements to report against those Part C standards required less frequently, and compliance with submission of those required to date:
 - Quarterly: Serious Incidents & Clinical Audit (current)
 - Bi-Annual: Equality (future)
 - Annual: Eight Standards (future).
- Management review & monitoring of performance information and action taken to address issues in respect of the information itself and/or performance highlighted.
- Mechanisms in place to provide assurance to the Board in respect of GP Out of Hours Services performance against its standards.
- Arrangements in place to monitor delivery of the Health Board's obligations under its service level agreement with Cwm Taf Morgannwg Health Board, and to share performance information with the latter accordingly.

However, during the course of fieldwork, we became aware of issues in respect of reporting arrangements affecting wider NHS Wales organisations using the 111 service, that have given us reason to close the audit and report the position.

3.2.2 Overall 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.

During the course of fieldwork, we have identified issues in respect of the reliability of reporting arrangements that affect not only Swansea Bay UHB but other NHS organisations using the 111 service. The solutions to these issues are not solely within the power of SBU to address, though it needs to work with its partners to resolve them. We are aware that this is progressing and there is ongoing engagement with colleagues within Welsh Government.

In view of the wider issues identified and partnership input required to resolve them we have not assigned an assurance rating but closed our work and reported the position, together with recommendations to ensure appropriate management assurance is communicated to the Health Board regarding progress. Key findings & recommendations were as follows:

- It was clear from our review and discussions with management that reliable quality performance data was not yet being received by Welsh Government from the Health Board and that SBU was not alone in this respect. It was evident that provision of this data required the Health Board to work with its partner organisation (WAST) and that there was ongoing engagement from SBU, other Health Boards, WAST and Welsh Government colleagues to address requirements together.

Whilst action was in hand and Welsh Government colleagues were aware of issues, there had been no formal reporting in respect of issues faced or progress in addressing them within the Unit or corporately.

R1: We recommended that a mid-year report be presented to the Unit Management Board and Executive Directors to update them on the development of reporting against each of the expected quality standards and action being taken with partner organisations and Welsh Government to address issues.

- Data reported to the Board on quality measures to date was unreliable.

R2: We recommended that reporting against the GP Out of Hours Quality Indicators be stopped until issues are resolved, or footnotes included within reports to indicate the caveats in respect of figures presented.

Action has been agreed with the Chief Operating Officer to be completed by the end of November 2019.

3.3 WELSH RISK POOL CLAIMS (SBU-1920-015)



Board Lead: Director of Nursing & Patient Experience

3.3.1 Introduction & Background

This assignment originates from the 2019/20 internal audit plan.

The Welsh Risk Pool (WRP) is a risk-pooling scheme that reimburses member organisations (i.e. Local Health Boards and Trusts) for losses incurred as described in WHC 2000(12). Claims for reimbursement must be made in accordance with the WRPS Reimbursement Procedure and will be considered by the WRP Services Advisory Board. All successful claims are subject to an excess of £25,000.

The WRP requires that a proportion of claimed costs submitted to it for reimbursement are subject to internal audit review. This audit was undertaken to meet that requirement.

The overall objective of this audit was to review a sample reimbursements sought from the Welsh Risk Pool to confirm their accuracy and compliance with the required process.

The audit scope considered the following:

- There is adequate documentation maintained in support of claim figures, and calculations are accurate;
- Claims are dealt with in line with the WRP reimbursement requirements.

3.3.2 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 low impact on residual risk exposure.

There were no key findings identified during the audit and no actions required of management.

3.4 DEPRIVATION OF LIBERTY STANDARDS (FOLLOW UP) (SBU-1920-023)



Board Lead: Director of Nursing & Patient Experience

3.4.1 Introduction, Scope & Objectives

In accordance with the 2019/20 Internal Audit plan agreed with the Audit Committee in March 2019, a follow up review has been undertaken of management action in respect of the Deprivation of Liberty Safeguards audit report that was issued in September 2018.

The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) provide protection for vulnerable people in care homes or hospitals who lack capacity to consent to the care or treatment they need. Within Swansea Bay UHB, DoLS apply to those who are considered to be deprived of their liberty within an inpatient hospital setting.

Internal Audit has completed two reviews previously of the Health Board's arrangements to comply with legislative requirements. On both occasions *limited* assurance reports were issued.

The overall objective of this audit was to confirm that action has been taken to address issues highlighted at the last audit review.

The scope of the audit was limited to a review of action taken in response to key recommendations made in the last report issued by Audit (ref ABM-1819-026).

3.4.2 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.

Audit recognised that the Health Board continues to be challenged in meeting demands for DoLS assessments within the required timescales.

While this was the case it was clear from our audit that action had been taken in key areas towards addressing issues raised previously and addressing capacity, and performance had been reported to the Mental Health Legislative Committee. The development of a central shared database, and appointment of two full-time dedicated best interest assessors to support the administration and conduct of assessments, are noted in particular, though there is more to do to maximise the benefit of the former. We note that the Committee paper analyses success so far and explores options for further improvement.

The previous audit made 11 recommendations, of which five were high priority and five were medium priority, with one low priority. Concluding testing of 10 agreed actions, we can confirm that 4 recommendations had been addressed, whilst 6 were partially addressed.

The following key findings were noted:

- Policies & procedures (for the approval of new best interest assessors, and for processing payments) and the Service Level Agreement had not been formally approved. Review of each indicates that improvements are required, and the engagement of colleagues within Workforce, Finance and Procurement is advised to ensure the content is sound before adoption.
- Payments have been made to some external best interest assessors without all the documentation required (though we recognise that there was other documentation present relating to assessments undertaken).
- DoLS breaches are not being uploaded onto DATIX. The process for recording breaches has recently changed to be recorded via the new SharePoint Dashboard, however no Standard Operating Procedure had been approved yet at DoLS Improvement & Support Group or communicated to all Service Delivery Units.
- Not all units have been granted access to the new DoLS Dashboard.

Actions have been agreed with the Director of Nursing & Patient Experience to address issues raised by the end of January 2020.

3.5 NURSING QUALITY ASSURANCE (INTERIM FOLLOW UP) (SBU-1920-027)

No rating
assigned

Board Lead: Director of Nursing & Patient Experience

3.5.1 Introduction, Scope and Objectives

This assignment originates from the 2019/20 internal audit plan.

The Quality Assurance Framework was launched in June 2018. An Internal Audit review of its implementation (ref ABM-1819-027) reported *Limited* assurance in March 2019 and recommended a review of the "Toolkit" and how it was used. Additionally, as part of a review of its impact, audit visits

to wards had highlighted issues with the completion of controlled drugs registers and the recording of resuscitation trolley checks. Action was agreed to address all issues raised.

When planning to follow up the above, a review of the recorded status of management action indicated that actions agreed with Units to address immediate controlled drug and resuscitation trolley issues were addressed at the end of June 2019; however, there was work ongoing to complete the review of the Quality Assurance Framework, the target date for which had been revised to 20th October 2019. Recognising that additional time would be required following its revision before an effective assessment could be made of its implementation, we agreed that an interim audit would be undertaken of those actions agreed to address controlled drugs records and resuscitation trolley checks in order to provide independent assurance to the Board in respect of progress. We agreed with the Director of Nursing & Patient Experience that a full follow up audit incorporating review of the implementation of the revised Quality Assurance Framework be considered for inclusion within the audit plan for 2020/21.

The overall objective of this audit was to provide assurance in respect of action taken at Unit level to address issues raised previously in respect of controlled drugs records and resuscitation trolley checks at ward level.

The audit scope considered the following:

- Controlled drugs register completion
- Resuscitation trolley check records.

The scope of the audit was limited to a review of action taken in response to key recommendations made in the last report issued by Audit (ref ABM-1819-027). The audit work comprised unannounced visits to those ward areas where issues were previously raised in order to determine improvements made. Additionally, we reviewed minutes & papers of unit nursing groups for consideration of the unit peer reviews conducted following the original Internal Audit review.

3.5.2 Overall Opinion

Recognising that this is an interim follow up audit, comprising a partial review of action reported to address issues previously raised (so not directly comparable with the original review), it was agreed with the Director of Nursing & Patient Experience that an assurance rating would not be assigned at its conclusion. Instead, a narrative commentary would be provided with details of any remaining issues for management action as appropriate. These have been summarised below:

We were informed that the Health Board's Controlled Drugs Accountable Officer has expressed concern to the Chief Executive in respect of the way controlled drugs are managed at ward level. Our testing at wards found continued instances of non-compliance with the dual-signature requirement for drug records, and entries being crossed out in the CD Register. At one ward it was suggested that agency staff may not be aware of requirements.

There was a need to take further action to address the causes of non-compliance in this area.

Improvement was evident in the completeness of resuscitation equipment checks at the Singleton wards, though there was scope for further improvement. At Morriston, whilst there was some improvement in resuscitation equipment checks on Ward R, further improvement was recommended within wards visited.

It was positive to note the reporting of peer review outcomes within the Singleton Unit nursing groups. However, we recommended enhancements to the checks undertaken as part of this process (findings reported did not include the review of drug error corrections), the approach to reporting the incidence of issues found, and the recording of action to address remaining issues.

Whilst 'First Thursday' inspections and the programme of matron checks was discussed at groups within the Morriston unit, the peer view of CD controls and resuscitation equipment was not evident within nursing or quality & safety meetings. The Interim Unit Nurse Director undertook to address this in October 2019. The findings and recommendations of this report should be considered as part of that process.

The majority of actions have been agreed with the Director of Nursing and Patient Experience to address issues raised by the end of November 2019.

3.6 PATIENT ENVIRONMENT (SBU-1920-035)



Board Lead: Chief Operating Officer

3.6.1 Introduction, Scope and Objectives

Healthcare Inspectorate Wales (HIW) has been delegated powers of inspection and investigation by the Welsh Assembly, and provided with rights of access to NHS bodies, rights to require documents and information, and the access to interview both staff and patients of Welsh NHS organisations. Following inspections, HIW provides the Health Board with reports on its findings with recommendations for improvement, and it has been critical previously of the lack of learning where it has found issues similar to those raised at earlier inspections.

Community Health Councils (CHCs) are statutory bodies set up to represent the public's interest in local NHS services. Regulations provide their members with the right of access and inspection of Health Board and primary care contractors' premises in order to undertake their duties. They furnish the Health Board with reports on their activities, including inspections, which may also highlight issues and areas for improvement.

Concerns in respect of the patient environment have featured across several reports.

The overall objective of this audit was to review arrangements in place to address issues identified by Healthcare Inspectorate Wales, and other inspections, with regard to environmental matters that may impact upon the safety of service users.

The audit scope considered the following:

- All reports and notices issued following external inspections are recorded centrally and reported at Board or Committee level;
- Where issues are highlighted actions, responsibilities and timescales to address them are agreed and documented;
- Clear arrangements are in place to monitor progress and confirm the completion of all actions agreed, or to escalate appropriately to senior management/executive level;
- Systems are in place to disseminate reports and notices to wider Unit Management Teams, and to obtain assurance that key issues are addressed at other locations;
- The Board is assured via its Committees that issues raised during external inspections are addressed.

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 was no overarching policy that outlined how external regulator or inspection reports should be managed across the Health Board. As a result there was variation in process for the management of CHC and HIW reports and the methods used for providing assurance to the Health Board.

Action has been agreed with the Chief Operating Officer to be completed by the end of January 2020.

3.7 ENVIRONMENTAL SUSTAINABILITY REPORT (SBU-1920-S10)



Board Lead: Chief Operating Officer

3.7.1 Introduction, Scope and Objectives

This assignment originates from the 2019/20 internal audit plan.

The review of sustainability data for the Health Board's 2018/19 Annual Report was completed in accordance with the agreed internal audit plan. The audit sought to assess the adequacy of management arrangements for the production of the sustainability report within the Annual Report.

The review focused on the following key areas:

- Compliance with relevant guidance;
- Accuracy of reported data;
- Underpinning systems for the collection and reporting of data; and
- Follow up of previously agreed recommendations.

3.7.2 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 format and content of the report was in line with the content required by the NHS Wales Manual for Accounts, with audit sample checking of data input (i.e. meter readings / consumption data) to the energy management system finding no issues.

However, Audit checking of data calculations found two errors:

- A formula error with a potential impact of 323,404kwh / £39,665 (circa 0.75% variance rate to the total reported electricity consumption) was corrected during the audit fieldwork, prior to submission of the report; and
- The inclusion of duplicate meter points (readings) resulted in an additional 936,797kwh electricity consumption / £120,972 expenditure being incorrectly reported (circa 2% variance rate to the total reported electricity consumption). Noting the draft Sustainability Report had been submitted by the time the error was identified, this could not be corrected.

Recommendations were made in respect of the need for reconciliation to a meter inventory at future reports, and liaison with Finance to agree the financial content of the report prior to submission.

All issues identified at prior audit reviews had been addressed and closed.

3.8 CRC ENERGY EFFICIENCY SCHEME (SBU-1920-S11)



Board Lead: Chief Operating Officer

3.8.1 Introduction, Scope and Objectives

This assignment originates from the 2019/20 internal audit plan.

The review of the Health Board's participation in the Carbon Reduction Commitment (CRC) Scheme has been completed in accordance with the agreed internal audit plan. The audit sought to assess the adequacy of management arrangements for participation in the Scheme, including mandatory and best practice elements.

The scope of the review was limited to the following aspects:

- Follow up of previous recommendations;
- A review of the 2018/19 annual report;
- Assessment of the management of the purchase of allowances; and
- Sufficiency of the evidence pack.

2018/19 was the final year of the scheme, and accordingly the final audit of the UHB's participation.

3.8.2 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 data required for the annual CRC report was generally found to be robustly prepared, with appropriate management review to ensure accuracy. It was also confirmed that the UHB had achieved £21,629 cost savings through purchase of a portion of its allowance requirement through the secondary market.

However, audit sample checking of calculations found two calculation errors. Whilst one error (representing circa 1.2% of the total reportable consumption, and with a potential cost impact of £5,225) was corrected during audit fieldwork, a further error remained in the reported data uploaded to the Registry (having a minor impact of £340 overpayment).

It was also noted that a meter inventory was not being utilised to reconcile the site data extracted from the energy management database, to ensure all meter points had been appropriately accounted for in the reportable data. This meant that neither management, nor Internal Audit, was able to confirm fully the accuracy of the reported data (in terms of inclusion of a complete set of meter data encompassing all meters within the UHB's remit). Noting this is the final year of the CRC Scheme, a recommendation

has been raised to enhance the accuracy of future reporting exercises i.e. Sustainability Reporting.

Additionally, enhancements to the structure and content of the evidence pack were recommended, in line with CRC guidance (noting the evidence pack has to be retained until 2025, in the event of any future audits by the regulators).

All issues identified at prior audit reviews had been addressed and closed.

3.9 NEONATAL PROJECT AT SINGLETON HOSPITAL (SBU-1819-S03)



Board Lead: Director of Strategy

3.9.1 Introduction, Scope and Objectives

This assignment originates from the 2019/20 internal audit plan.

The Neonatal & Post-Natal services project at Singleton Hospital aims to:

- Provide a new 7-bed Transitional Care Unit (TCU) with specialist 24/7 nursing to care for those babies who require more than normal Post-natal care, but do not require admission to the Neonatal Unit;
- Provide a fully compliant and permanent 12-cot Special Care Baby Unit (SCBU);
- Improve essential patient pathways within Singleton Hospital;
- Increase Neonatal High Dependency Unit (HDU) funded capacity by two cots and SCBU funded capacity by one cot;
- Support the future expansion of 5-HDU cots by providing space for expansion, and;
- Provide physical capacity for nine additional special care cot spaces.

The works include the refurbishment of a number of wards, and also encompasses a number of significant developments with moves (and improvements) for other areas of the hospital, including increased provision and space within the existing neo natal ward (22).

The business case was submitted to the Welsh Government in September 2017, and was approved in April 2018. The sum of £9.71m was approved, for the period April 2018 to March 2020.

This was the first audit of this project.

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, were 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 project is one of some complexity, with various stakeholder / user interests, and being progressed within an acute setting variously in live wards, and older wards containing asbestos / legacy issues. Live wards also placed limitations on invasive surveys pre-commencement.

At the time of the current review the overall completion date had been extended (by 5 weeks) via an agreed Compensation Event (CE6) to 27/02/2020. The agreed extension has had no cost implication.

Noting the above, the project manager was reporting an anticipated completion date of 23rd March 2020. However, the main contractor reported that they were seeking to recover the total delays incurred to date.

The delays have been attributed to the impact of the fire within ward 12 (a decant ward) and significant asbestos issues encountered following the fire within this area (as reflected in project reporting). Full funding (of c. £2.5 - 3m) was awaited from Welsh Government for fire rectification works, and the recent Gateway report has highlighted this as an ongoing risk to timely delivery.

The review noted the following positive aspects of project delivery:

- The robust project structure and governance framework implemented at the project;
- The delivery of the project within the allocated budget;
- Active cost and project control including internal and external reporting arrangements and ongoing dialogue with the Welsh Government; and
- General compliance with the defined change control process.

However, a key issue identified at the current review was the potential breach of EU procurement regulations at the appointment of the main contractor (and associated advisers). Whilst the BJC confirmed that the contract would be let through the UHBs' local framework, it did not identify the potential breach in local and EU procurement regulations (and the associated risks). The breach of EU procurement regulations could ultimately result in contractor challenge together with associated damages/fines and, in some cases, the cancellation of a contract.

Additional recommendations were raised aimed at improving the project control environment through to completion (and at future schemes). These included:

- The timely completion of adviser contracts – whilst all the appointments were made from the UHB's local adviser framework and were effectively call-off contracts (providing the UHB with a level of security/assurance). Formal terms and conditions of appointment (including design liabilities) etc., were not completed prior to the commencement of duties.
- The application of frozen design principles - 1:50 drawings were not signed off by users (i.e. frozen) until after the commencement of the construction phase. The same risks client/user/SCP changes to the

priced works packages and adversely impacting on the project's affordability.

- A review of the risk register was required to consider the total cost implication of "open" risks arising at the project and any associated impact on the anticipated outturn costs/remaining contingency through to completion; and
- Improved Cash flow reporting through to completion - the Supply Chain Partner's reported cash flow projections were inconsistent with those of the cost adviser, which could adversely impact on the UHB's ability to manage its Capital Resource Limit.

Management have agreed actions to implement all of the recommendations arising from the audit.

3.10 CAPITAL SYSTEMS: FINANCIAL SAFEGUARDING (SBU-1920-S07)



Board Lead: Chief Operating Officer

3.10.1 Introduction, Scope and Objectives

The assignment originated from the 2019/20 internal audit plan.

Fraud within the NHS Capital, Estates and Facilities functions has been more prevalent in recent years, with two recent examples being:

- A well-publicised incident within NHS Wales where three Estates officers were jailed in November 2018 after being found guilty of defrauding the NHS of £822,000; and
- Another in Gloucestershire Hospitals NHS Foundation Trust where a senior Estates official was similarly sentenced abusing his position and defrauding the NHS of £870,490.

The capital systems review sought to affirm that there are effective controls and systems operating to deter and safeguard against potential fraud within Swansea Bay University Health Board's ('the UHB') Estates function.

The scope of the audit was limited to procurement exercises associated with the Estates Department's pre-planned and reactive maintenance programmes. The current audit did not cover major capital projects, discretionary capital projects or the purchase of medical devices. It is proposed that reviews of these areas be progressed in future years.

Accordingly, the scope and remit of the audit included the following:

- **Quotation / Tender / Local Order processes** – to obtain assurance that:
 - An appropriate governance framework was in place in respect of the procurement, tender, contract letting, local order processes (both manual and automated); and

- Assurance that compliance was demonstrated against the established internal control framework (and best practice) for the selection and appointment of contractors/suppliers.
- **Segregation of duties/delegated authority** – assurance that:
 - Appropriate guidance and procedures existed for the segregation of duties in the management and selection of quotes/tenders/local orders; and compliance is demonstrated in respect of the same.
 - All approvals were appropriately sought and decision makers were appropriately authorised and adequately informed.
- **Verification of contractor/supplier arrangements** – assurance that:
 - Verification was undertaken prior to the appointment of contractors/suppliers including financial vetting, positions held by key directors etc.; and
 - Assurance that information was produced on the award of contracts, fair rotation of contractors, analysis of key suppliers etc. - allowing analysis of tender/quotation returns and to identify any patterns of unusual behaviour.
- **Stock control** – assurance that appropriate stock control systems were in place [including re-ordering, issue and return] to manage the materials utilised in delivery of Estates work.
- **Monitoring and reporting** – reporting and accountability lines were well defined, understood and applied.
- **Verification of works completed** – assurance that works were completed in accordance with the award criteria.
- **Other** – consideration of any other issues relevant to the general objectives above, which may arise during the review.

3.10.2 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.

We evidenced a sound control framework in place via the Health Board's Standing Orders (SOs) and Standing Financial Instructions (SFIs). Robust segregation of duty controls were observed through the management of procurement exercises by NWSSP Procurement Services, via the use of electronic systems such as Multiquote and Bravo.

However, examples of non-compliance with SO/SFI requirements at Estates procurement exercises were evidenced e.g.

- The utilisation of the UHB's Local Building & Engineering Framework for Estates Department's pre-planned and reactive maintenance programmes;
- A significant number of individual orders placed with certain contractors - whilst the individual orders placed were all below the £5k quotation limit, the cumulative value of orders placed during the review period ranged between £40k and £111k for the sample appraised. Noting the same, the following was not identified:
 - Competitive exercises demonstrating value for money;
 - Evidence of competency checks undertaken to ensure the contractors meet the required standards in terms of health and safety practices, industry accreditations, insurances etc.; and
 - Declarations of interest in relation to the "preferred contractors".
- Three examples of "contract splitting" were identified, whereby jobs had been potentially artificially disaggregated into smaller components each under the £5k At the utilisation of the UHB's Local Building & Engineering Framework for Estates Department's pre-planned and reactive maintenance programmes;
- Whilst recognising the benefits achieved through the use of the online Multiquote system (for procurements between £5-25k in value), the quotation processes applied did not fully comply with the requirements of the SOs/SFIs;
- The absence of financial/technical vetting of contractors employed.

Additionally, the current review has identified areas for improvement within the Estates' stock control systems e.g. the recording, ordering, issuing and disposal of stock and associated training requirements.

Whilst recognising that the financial values of the Estates procurement exercises reviewed were relatively low (compared with e.g. capital projects), the absence of the above increases the risk of fraudulent activity / poor practice.

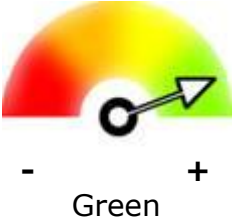
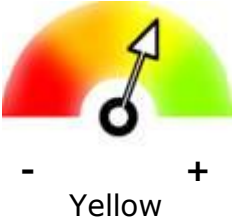
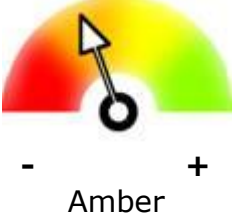
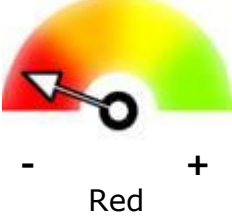
Management have agreed actions to implement all recommendations arising from the audit.

4. RECOMMENDATIONS

- 4.1 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.**
- 4.2 The Audit Committee is asked to consider any further action required in respect of subjects reported.**

APPENDIX A

AUDIT ASSURANCE RATINGS

RATING	INDICATOR	DEFINITION
Substantial assurance		<p>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.</p>
Reasonable assurance		<p>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.</p>
Limited assurance		<p>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.</p>
No assurance		<p>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.</p>