Bundle Audit Committee Part 1 15 July 2019

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5	PART 5 EXTERNAL AUDIT
5.1	Wales Audit Office Update Report
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6.1	Committee Forward Work Plan 2018/19
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7	PART 7 ANY OTHER URGENT BUSINESS
7.1	Items for Referral to other Committees
7.2	Closure of Part 1 of the meeting - Date and time of next meeting

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AUDIT COMMITTEE

Monday 15 July 2019
Ynysmeurig House, Abercynon
9.30am

AGENDA

		Lead / Attachment
PART 1. PRELIMINARY MATTERS		
1.1	Apologies for Absence	Chair / Oral
1.2	Welcome and Introductions	Chair / Oral
1.3	Declaration of Interests	Chair / Oral
1.4	Unconfirmed Minutes of the meeting held on: • 13 May 2019 • 30 May 2019	Chair **Attachment**
1.5	Action Log	Chair **Attachment**
1.6	Matters arising, not considered within the Action Log	Chair / Oral
Part 2. INTERNAL CONTROL AND RISK MANAGEMENT		
2.1	Audit Committee Annual Report 2018/19	Board Secretary/Director of Finance **Attachment**
2.2	Audit Recommendations Tracker	Interim Board Secretary **Attachment**
2.3	Procurements and Scheme of Delegation Report	Director of Finance **Attachment**
2.4	Losses & Special Payments Report	Director of Finance **Attachment**
2.5	Financial Control Procedure Medical Variable Pay	Director of Finance **Oral**

2.6	Clinical Audit Forward Plan 2019-2020	**Attachment**
Part 3. CHARITABLE FUNDS		
3.1	Charitable Fund Balances as at 31 May 2019	Director of Finance & Procurement **Attachment**
Part 4. INTERNAL AUDIT		
4.1	Internal Audit Progress Report	**Attachment**
4.2	Water Safety	**Attachment**
4.3	Health and Care Standards Review	**Attachment**
4.4	Prince Charles Hospital Redevelopment Follow Up Review	**Attachment**
4.5	Handover of Care at Emergency Departments Follow Up – Health Board related Recommendations	**Attachment**
4.6	Directorate Review Surgery – Management Arrangements	**Attachment**
4.7	Directorate Review Surgery – Compliance	**Attachment**
4.8	Directorate Review Radiology – Management Arrangements	**Attachment**
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4.10	Freedom of Information Review	**Attachment**
4.11	Retention of Staff Follow Up Review	**To follow**
Part 5. EXTERNAL AUDIT		
5.1	Wales Audit Office Update Report	Wales Audit Office **Attachment**
5.2	Terms of Reference Joint Review of Quality Governance by Wales Audit Office and Healthcare Inspectorate Wales	Wales Audit Office **Attachment**
Part 6. ITEMS FOR INFORMATION		
6.1	Committee Forward Work Plan 2019/2020	Chair **Attachment**
Part 7. ANY OTHER URGENT BUSINESS		
7.1	Items for referral to other Committees	Oral/Chair
7.2	Close of Part 1 of the meeting – Date and time of next meeting • 9.00am Monday 28 October 2019	

In accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960 it has been resolved that representatives of the press and other members of the public are excluded from the second part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting has been held in private session.

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 13 MAY 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT

Paul Griffiths	-	Independent Member (Chair)
Jayne Sadgrove	-	Independent Member
Maria K Thomas	-	Independent Member

IN ATTENDANCE

Allison Williams	-	Chief Executive Officer (In Part)
David Jenkins	-	Independent Advisor (In part)
David Jones	-	Local Counter Fraud Specialist (In Part)
Gareth Lucey	-	Wales Audit Office
Elisabeth Williams	-	Finance Manager (In part)
Paul Dalton	-	NHS Wales Shared Services Partnership (NWSSP) – Head of Internal Audit & Assurance
Simon Cookson	-	NWSSP – Internal Audit & Assurance
Steve Webster	-	Director of Finance
Robert Williams	-	Director of Corporate Services & Governance/Board Secretary
Emma Walters	-	Committee Secretariat
Kevin Smith	-	WHSSC Committee Secretary (In part)
Stuart Davies	-	WHSSC Director of Finance (In part)
Wendy Penrhyn-Jones	-	Head of Corporate Administration
Lucy Timlin	-	Directorate Manager (Observing In Part)
Stephen Harrhy	-	Chief Ambulance Services Commissioner (In part)
Ruth Treharne	-	Director of Planning & Performance (In part)
John Palmer	-	Chief Operating Officer (In part)

AC/19/069 **WELCOME AND INTRODUCTIONS**

Paul Griffiths, Chair, **welcomed** everyone to the meeting, particularly David Jenkins, who was currently (at the request of the Minister) supporting the Chair with governance arrangements.

The Chair **welcomed** Wendy Penrhyn-Jones who had joined the Corporate Services Team from the former ABMU Health Board and Lucy Timlin, Head of Business Support who was observing the meeting.

Members **NOTED** that John Palmer, Chief Operating Officer and Ruth Treharne, Director of Planning & Performance would be attending part of the meeting to present updates against some of the outstanding Internal Audit Recommendations.

The Chair also **welcomed** Stuart Davies and Kevin Smith from WHSSC who were attending to present an update on the WHSSC/EASC draft accounts and WHSSC Annual Governance Statement and Elisabeth Williams who would be presenting the Cwm Taf draft accounts.

The Chair advised members that Allison Williams would be in attendance at part of the meeting to answer any questions on the 'Draft' Accountability Report.

AC/19/070 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Dilys Jouvenat, David Thomas, Gwenan Roberts, Emma Samways and Sara Utley.

AC/19/071 **DECLARATIONS OF INTERESTS**

There were no additional declarations of interests, to those previously notified.

AC/19/072 **'UNCONFIRMED' MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 1 APRIL 2019.**

The Chair apologised for the late circulation of the minutes and advised that the Team would continue to try to circulate the minutes within two weeks of each meeting.

The minutes of the meeting held on 1 April 2019, were **CONFIRMED** as a true and accurate record, subject to the following amendments:-

Page 2: 18/099 JAG Accreditation Closure Report – Robert Williams advised that there did not appear to be a closure report and that Members may wish to clarify this with John Palmer later in the meeting.

Page 7: First bullet point – final sentence to read 'of the Bridgend area of Cwm Taf *Morgannwg* UHB.

Page 9: 19/060 Internal Audit Progress Report – second sentence of the second paragraph to read 'the *draft* limited assurance reports on Cyber, Security and Water Safety'. Paul Dalton advised that 'Water Safety' had now moved to a reasonable assurance rated report.

AC/19/073 **MATTERS ARISING**

There were no matters arising.

AC/19/074 **AUDIT COMMITTEE ACTION LOG**

The Committee Action Log from the meeting held on 1 April 2019 was reviewed by Members and the following was **NOTED:**

18/028 – Members **NOTED** that a meeting with the Auditors had been arranged to discuss the Audit Tracker process.

19/039 - Members **NOTED** the intention to present and discuss common issues identified within the Internal Audit Directorate Reviews at Directorate Clinical Business Meetings. Members **NOTED** that consideration had been given to strengthening reporting templates into each Committee meeting which would need to be considered further following the issues experienced within Maternity. The Chair requested that any changes being made were shared with Committee Members to enable them to comment on the revised processes. Robert Williams **AGREED** to share with Members any revised processes and advised that governance processes within Directorates would need to be revised with good practice being shared across Directorates.

19/044 – Members **NOTED** that further work was required to strengthen the Committee's Forward Work Plan.

19/059 – Robert Williams **AGREED** to confirm whether a discussion had been held with the Health Board Chair as to whether the Committee had the authority to approve the actions proposed for registering the name change and revised objects with the Charity Commissioner. Jayne Sadgrove reminded Members that this was a time-sensitive action.

19/007 – Post-Payment Verification - Jayne Sadgrove questioned whether this action had been completed. **AGREED** that the action would remain on the action log until a further update report had been received in 6 months.

19/023 – Internal Audit Report Raising Concerns - Jayne Sadgrove made reference to the action being marked as "in progress" and advised of the importance for staff having access to a person for advice, who was independent from Management and the Executive Team. Jayne Sadgrove added that she would like this action to be addressed as a priority. Robert Williams advised of the intention for the Director of Nursing, Midwifery and Patient Care, to review concerns, but that the Director of Workforce & Organisational Development and Board Secretary also had roles to how concerns would be escalated. Members **NOTED** that the Raising Concerns policy would need to be strengthened and its profile raised. Members **NOTED** that Dilys Jouvenat had taken on the role of Whistleblowing Champion who was not part of the Executive Team and would act as the nominated person if staff felt they could not raise their concerns with Executive Directors.

Maria Thomas **NOTED** the concerns raised by Jayne Sadgrove and advised that the Committee would need to review how concerns were being received and addressed. Jayne Sadgrove advised that it would be helpful if further clarity could be provided on the process moving forward.

A discussion was held in relation to how the Committee would be sighted on the proposed new governance arrangements and the related programme of work. Robert Williams advised that a discussion would be held at the Integrated Governance Committee which was in the process of being rearranged to take place at the June Board Development Session. Members **NOTED** that some of the agenda may be driven by Welsh Government as a result of the Health Board's recent further change in escalation status. Members **NOTED** that a discussion on risk appetite would need to be scheduled into the Board Development work programme thereafter.

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

AC/19/075 **'DRAFT' 2018/2019 ANNUAL ACCOUNTS**

Stuart Davies and Kevin Smith were in attendance for this item.

Stuart Davies presented the Welsh Health Specialised Services Committee (WHSSC) draft and unaudited financial statements for the financial year ended 31 March 2019 which incorporated accounts for the Emergency Ambulance Services Committee (EASC).

Members **NOTED** that main areas of difference, which included the format of the report now incorporated a number of accounts on fixed assets and leases with the main body of the accounts focussed on the income and expenditure position.

Members **NOTED** that the WHSSC position included an increase in expenditure of £30m, the majority of which was planned movement. Members **NOTED** that the expenditure with NHS Welsh Health Boards increased significantly by 5.9%. Members **NOTED** the net movement of 3.4%, the newest component relating to NHS England who spent in the region of 7%.

Members **NOTED** that within the 5.9% increase, there had been an increase in expenditure into new services, additional activity had been undertaken to address backlog issues and there had been an introduction of new drugs. Members **NOTED** that NHS Trust's had grown by 5% and there had been an impact on the WAST and EASC investment plans.

Members **NOTED** that in relation to staff costs, WHSSC was a small commissioning organisation which employed 50 staff out of an establishment of 70. Members **NOTED** that the organisation was now fully established and that the Direct Running Costs (DRC) liability had increased as a result of this. Members **NOTED** that a similar pattern was being experienced within EASC who had also invested in staff.

In relation to performance against the Public Sector Payments Policy, 99% performance had been achieved in relation to value. Members **NOTED** that performance had not been achieved in relation to volume, with a performance of 94-95% being achieved.

Members **NOTED** that there would be a notable shift this year in relation to balance and movements in operating segments as result of services being transferred from WHSSC to EASC and new services taken on by EASC.

Members **NOTED** that as a result of movement of balances and the achievement of the dispute with NHS England, WHSSC had managed to achieve a surplus as opposed to a deficit. Members **NOTED** that WHSSC had also ended the year with fewer creditor balances for English providers.

Members **NOTED** that in relation to HRG 4+, advice had been sought from Welsh Government who confirmed that they would fully fund the position this year and that negotiations would continue into next year.

Maria Thomas advised that she was pleased to see progress made in this area, which was still a risk, and questioned what the plans were to address the position in 2019/2020. Stuart Davies advised that negotiations would continue and it was hoped that a resolution would be reached within the next 3 months.

Maria Thomas expressed concern in relation to the CAMHS position. Members **NOTED** that even though progress had been made in repatriating low secure patients to local areas, patients were now being placed out of area. Maria Thomas advised that this was a risk. Stuart Davies advised that this was a management risk which was being fully incorporated into the position and advised that there would always be difficult to manage patients who would need to be treated out of area. Members **NOTED** WHSSC'S intentions to review contracting mechanisms within the Cwm Taf Morgannwg area.

Jayne Sadgrove advised that the cover report provided a detailed narrative in relation to WHSSC and was not as strong in terms of EASC. Stuart Davies advised that detail in relation to EASC had been included in the main accounts and added that additional detail could be included in the cover report if Members would find it useful. Stuart Davies also **AGREED** to review the format of future reports.

The Chair raised a question in relation to the statement made within the report regarding the under-performance of WAST. Stuart Davies advised that this related to financial under-performance.

The Chair sought clarity in relation to the staff cost increases referenced on page 27. Stuart Davies advised that what was being presented was 4.1% for the previous year compared with 5.2%, which equated to an increase of £1.4m. Stuart Davies **AGREED** to further review the position. Stuart Davies stated that the Wales Audit Office were involved in accounting judgements.

Gareth Lucey, Wales Audit Office stated that following an initial review of the draft accounts, there was nothing major to report, other than a need to make some minor presentational changes.

WHSSC Governance Statement

Kevin Smith presented an update in relation to the WHSSC Governance Statement. Members **NOTED** that this was a non-statutory document which supported the Governance Statement for Cwm Taf. Members **NOTED** that the statement was being reviewed by the Wales Audit Office and there had been no significant internal control or governance issues identified in the process.

The Chair referenced the 58 risks identified within the report, the majority of which appeared to require further mitigating action. Kevin Smith advised that the WHSSC Corporate Risk Assurance Framework continued to be refined and improved with a review of all risks being undertaken by the new Director of Planning.

Members **NOTED** that the nature of risks related to services from providers and consideration was being given as to whether these were commissioner risks or provider risks.

Maria Thomas questioned how stakeholders were involved with the development of the Governance Statements for EASC and WHSSC and sought clarity as to the level of engagement undertaken. Kevin Smith advised that external stakeholder engagement had been undertaken electronically. Maria Thomas suggested that far greater engagement was required with stakeholders.

Jayne Sadgrove expressed concern in relation to attendance levels for some members at Committee meetings. Members **NOTED** that two new Independent Members had been appointed and that a deputy would have been in attendance on behalf of Chief Executive Members. Jayne Sadgrove suggested that an explanation was added into the statement explaining this. Members **NOTED** that Associate Member attendance was also low and **NOTED** that Associate Members did not have voting rights. Robert Williams suggested that a paragraph was included in the report explaining the consequences of not being quorate.

EASC Governance Statement

Stephen Harrhy presented Members with the draft EASC Governance Statement, which had been submitted to the Wales Audit Office for comment and would be discussed at the Emergency Ambulance Services Committee the next day.

Members **NOTED** that issues had been experienced in the last year in relation to operational issues and functioning of the Committee. Issues had also been experienced in relation to attendance of certain members.

Members **NOTED** that a new Chair of EASC was now in post, following the post being vacant between April – November 2018.

Members **NOTED** that in relation to the Service, an Amber Review had been commissioned by the Minister in November which had been well received.

Members **NOTED** that the recommendations made were in the process of being implemented. Members **NOTED** the Minister's intention for the Non-Emergency Patient Transport Service (NEPTS) to be run by the Welsh Ambulance Services NHS Trust (WAST).

Members **NOTED** that at the end of the year, there had been a change in the types of vehicles used by the Emergency Medical Retrieval and Transfer Service (EMRTS) which had enabled the conveyance of children as well as adults.

Members **NOTED** that moving forward, the service would be focussing on:

- Delivery of Red Call performance
- Implementation of the Amber Review
- Roll out of the NEPTS model across Wales
- Extending the hours of operation for EMRTS to a 24/7 service across the whole of Wales

Members **NOTED** that the risks would be similar to those identified in previous years, and included protecting the red call performance and pre-hospital Unscheduled Care.

Maria Thomas advised that the report clearly identified the areas where improvement was required and advised that this would continue to be monitored via the risk register reports to Quality, Safety & Risk Committee. Stephen Harrhy advised that clinical risk assurance was being undertaken and progress would be reported to the Quality, Safety & Risk Committee.

The Chair made reference to the fact that there were three significant risks. Stephen Harrhy advised that a decision had been made to limit the risk register to key risks. Members **NOTED** that a discussion on risk appetite and managing risk at Commissioner level would take place at the July 2019 EASC Development Session to which Welsh Government representatives had been invited.

The Chair advised that a slightly different approach to risk had been undertaken in all three Governance Statements and suggested there was a need for clear alignment of risks in future years.

A typographical error as referenced contained within page 25 with regard to the year which should have been 2019 rather than 2018.

Stephen Harrhy left the meeting at 10:55 am.

Draft 2018/2019 Cwm Taf Annual Accounts

Elisabeth Williams presented Members with the draft 2018/2019 for the former Cwm Taf University Health Board Annual Accounts and advised that the draft accounts had been submitted to the Wales Audit Office on 26 April for review.

Members **NOTED** that this was a consolidated set of accounts and the cover report mainly related to the Health Board's element of the accounts.

Members **NOTED** that Cwm Taf had met all of the financial targets, which had been met for the last three years. There had been an under-spend on the Capital Resource Limit in year, with the accumulative position over the last three years being £23k.

Members **NOTED** that the Health Board had achieved an approved Integrated Medium Term Plan over the last three years and achieved a 96.1% performance against the Public Sector Payment Policy target.

Members **NOTED** that there had been an increase in expenditure of £20.8m compared with previous years and **NOTED** that this largely related to Continuing Care. Members **NOTED** that fixed asset improvements had increased by £38m, which was funded by Welsh Government.

Members **NOTED** that there had been an increase in staff costs, part of which related to the three year pay agreement. Members **NOTED** that there had also been an increase in director's costs as a result of including the Board Secretary and Interim Board Secretary salaries. Members **NOTED** that Welsh Government had confirmed that the salary of the Board Secretary needed to be included in the Remuneration Report.

Members **NOTED** that the miscellaneous income increase related to the new Care Home pooled budget, Integrated Care Funding and the donated assets from Macmillan.

Gareth Lucey confirmed the accounts were in the process of being audited.

Steve Webster advised that there was one issue which he had been made aware of which related to the funding for the pooled budget arrangement. Members **NOTED** that discussions had been held in relation to how the accounts had been classified and that there was no guidance available as to how this should be presented. Members **NOTED** that this would have no impact on the final financial position.

Members agreed that the accounts reflected information that had been received by the Board throughout the year and there were no new issues within the report.

A discussion was held in relation to the narrative contained within the table on page 52 of the accounts which Members suggested be amended to offer further clarity. Members **NOTED** that the wording used had been prescribed by Welsh Government.

Steve Webster **AGREED** to clarify the points raised by the Chair in relation to the financial position of PFI contracts. Steve Webster also undertook to review the wording contained on page 66 of the report in relation to the direction given by the Minister, which made reference to March 2011 (since confirmed as being correct).

Members **RESOLVED** to:

- **NOTE** the draft accounts for 2018/19 WHSSC/EASC annual accounts;
- **NOTE** the draft WHSSC Annual Governance Statement;
- **NOTE** the draft EASC Annual Governance Statement;
- **NOTE** the draft Cwm Taf Consolidated Accounts for 2018/2019.

Stuart Davies and Kevin Smith left the meeting at 11.15am

AC/19/076 **CHIEF EXECUTIVE 'DRAFT' ACCOUNTABILITY REPORT**

Allison Williams was in attendance for this item.

The Chair **welcomed** Allison Williams to the meeting and invited the Chief Executive to highlight any key issues.

Allison Williams presented the report. Members **NOTED** that information and data contained within the report had been gathered from Executive Directors and Committees of the Board and contained no issues which were new to the Committee.

Allison Williams advised that the key change in this year's Accountability Report related to the findings arising from the Royal College's Maternity Services Review and, as a consequence, the change in the Health Board's escalation status.

Members **NOTED** that page 24 of the report referred to weaknesses in the systems of internal control, including the specific issues with Maternity Services. Having reflected on these issues work was now being undertaken to join up the work of the sub Committees with the Board. Members **NOTED** that page 26 of the report made reference to the planned improvements to the Quality & Delivery Framework.

Members also **NOTED** that the Board would need to consider the capacity available to manage risk, particularly in relation to the additional risks that would need to be managed following the transition of the Bridgend locality into the Health Board. Allison Williams advised that this would be a key piece of work that would become the foundation of the Board's business moving forward and added that the Board would need to satisfy themselves that the work to strengthen the risk based approach over the next 12 months provides the additional assurances required.

In relation to the Risk & Assurance Framework, consideration would also need to be given to the outcomes of the quality reviews being undertaken by Healthcare Inspectorate Wales and the Wales Audit Office. Members **NOTED** that there would be an opportunity to learn lessons to strengthen the Board's quality and governance arrangements across the organisation.

Members **NOTED** that the section in relation to the Integrated Medium Term Plan reflected the core business and business areas for the former Cwm Taf University Health Board which would now be reviewed following the issues relating to maternity services and the planned quality governance review.

Members **NOTED** the references made to Civil Contingencies and Disaster Recovery outlined on pages 48 and 49 of the report. Members **NOTED** that preparations for Brexit had been the key component of Civil Contingencies work over the past year and the learning arising from this had been important.

Allison Williams advised that the risks relating to the NHS Pension Scheme had not been included in the report. The impact of some of the changes made to Her Majesty's Revenue and Customs (HMRC) rules may have had unintended consequences for the delivery of the Health Board's core business activity, availability of adequate medical staffing resource, particularly in relation to delivery of Referral to Treatment Targets and Clinical Leadership. Such consequences would have implications for all Health Boards, not just Cwm Taf Morgannwg.

Members **NOTED** the challenges that remained in relation to compliance with All-Wales Welsh Health Circulars (relating to national issues) and the considerable amount of work undertaken to increase awareness of and requirements of the General Data Protection Regulations (GDPR) and Welsh Language Standards.

In relation to the statement within the Accountability Report regarding 'service effectiveness', there was a recognition that this part of the report would need to take into consideration the response to the revised escalation status and the governance support to be provided to the Board over the coming months.

Allison Williams advised that the document referenced the response to the increase in the organisation's escalation status, the findings of WAO's Structured Assessment, including the resulting action plan as well as the required quality governance improvements. Internal Audit's 'Limited' assurance ratings were referred to in relation to Workforce Management, Retention of Staff and the Management of the Major Capital Scheme at Prince Charles Hospital (PCH). Allison Williams acknowledged that Workforce management was one of the organisation's biggest risks along with retention of staff. Members **NOTED** that significant progress had been made to implement the recommendations arising from the Management of Major Capital works at PCH.

Members **NOTED** and recognised the limited capacity and resource within the Counter Fraud Services team over the last year and the steps that had been taken to increase the resources as part of the Bridgend transition process to help complete the programme of planned work, particularly in relation to investigation, without further delay.

Allison Williams advised that whilst progress had been made, the change in the escalation status of the organisation highlighted the significant work that was now required to strengthen quality governance arrangements and it was her duty to ensure the Organisation took robust action in an open way to address the failings identified.

Allison Williams advised that the boundary changes brought opportunities to strengthen service delivery and to bring greater sustainability to the organisation's work.

Members **NOTED** that the learning from this work needed to be shared across the organisation to maximise the benefit.

Allison Williams advised that further detail and clarity would be required from Andrew Goodall in relation to the Health Board's escalation status although it was likely that significant changes would be required to internal and external scrutiny.

Members **NOTED** that the interconnectivity between Committees would be key in moving forward and that it was important to recognise the areas of good practice as well as the failings identified internally and as a result of external reviews.

The Chair advised that he was supportive of the conclusions outlined within the report which he found to be reasonable and fair, although he suggested that further consideration be given to some of the statements made within the report to recognise the serious nature of the issues facing the Organisation by providing a more balanced and sensitive tone to the approach. The Chair also suggested some areas that could be strengthened, particularly in relation to Counter Fraud work and the findings of the audit of Major Capital works at PCH. The Chair agreed to send a more detailed note to the Board Secretary for action.

Maria Thomas also suggested that it was important that the Accountability Report set the appropriate tone given the organisation's current circumstances and where we are able to do so, how the Health Board intended to take the various matters forward.

Maria Thomas requested that the work being undertaken through the Regional Partnership Board should be included in the report.

Jayne Sadgrove concurred with the comments made by colleagues and stressed the importance of there being consistency within the report. Jayne Sadgrove also highlighted that she had not been included in the list of Board Members outlined within the report's appendices.

Allison Williams agreed to undertake a further review of the areas highlighted.

Following a full discussion of the Director's report and the following comments were **NOTED**:

- Minor typographical errors as contained within table 1 of the report, need to be corrected;
- Table 2 suggested that some Independent Members had not attended all meetings simply because they were new Independent Members. The wording of this table needed to explain the position more clearly.

Paul Dalton suggested that it might be helpful if consideration was given to including reference to the Maternity Services review early in the report.

Robert Williams advised that all comments would be considered and included in the final draft of the report, including comments received from the Wales Audit Office.

Following discussion it was **AGREED** that the revised document be shared with the Chair for agreement prior to the document being circulated to Members of the Committee for further comment.

Members **RESOLVED** to:

- **NOTE** the draft Chief Executive Accountability Report.

Elisabeth Williams left the meeting at 12.15pm.

AC/19/077 **AUDIT RECOMMENDATIONS TRACKER**

Members **RECEIVED** an update against four key areas where Committee Members felt that insufficient progress had been.

Fire Management

Robert Williams presented Members with an update against the following areas:

- Capturing of information – Members **NOTED** that the Health Board had limited control on the system being used to capture information and that an outline case was being developed for provision of a new system
- Reporting on Fire Management matters – Members **NOTED** that work was being undertaken with Lead Directors to strengthen reporting with a recognition that there was a need to move towards a proactive arrangement. Members **NOTED** the revised completion date of July 2019
- Update on Dangerous Substances and Explosive Atmospheres Regulations (DSEAR) Reviews – Members **NOTED** that a commitment had been made to secure an 'external' solution and was a high priority for this financial year. Members **NOTED** that there was no expertise within the Health Board to undertake these reviews and a further update would be presented to the July 2019 meeting
- Audit of Fire Folders – Members **NOTED** that a percentage of fire folders had been audited and the Director General had been alerted of issues relating to the Princess of Wales Hospital site.

JAG Accreditation

John Palmer presented Members with an update and advised that it had been accepted that a number of the actions were quite historical. Members **NOTED** that the Prince Charles Hospital and Princess of Wales Hospital sites had received accreditation and focus had now changed to enabling accreditation to be gained at the Royal Glamorgan Hospital site.

John Palmer advised that all of the original recommendations had now been completed and advised that he would be happy to present an update in 3-6 months regarding progress made on gaining accreditation for the Royal Glamorgan Hospital site. Following discussion, Members **NOTED** that John Palmer and Paul Dalton would meet to discuss the original recommendations to determine whether they could be considered "closed".

Jayne Sadgrove advised that it would be helpful if Members could have access to the original Audit reports to enable Members to review the context of original recommendations. Robert Williams **AGREED** to provide access to previous reports to Members.

Facilities Management

John Palmer advised that Facilities had presented two deep dive reports to the Finance, Performance & Workforce Committee. A meeting was being held on the 29 May 2019 where it was hoped that a final agreement could be reached in relation to rota issues.

David Jenkins left the meeting at 12.36pm.

Performance Management

Ruth Treharne was in attendance for this item.

In response to a question raised by the Chair in relation to whether the recommendations were likely to be completed within the next few months, Ruth Treharne advised that this was an area which remained a challenge.

Members **NOTED** that Demand & Capacity planning was a joint responsibility of the Chief Operating Officer and the Director of Planning & Performance who both ensured that Directorates had robust Demand & Capacity plans in place.

Members **NOTED** that the level of support and resource that could be offered to Directorates at present was limited due to finite expertise within the Health Board and work was being undertaken with the Delivery Unit regarding support that may be available on an interim basis. Ruth Treharne advised that adverts had been placed for key roles.

In relation to the second recommendation which related to an interactive phased approach to Demand & Capacity planning, Members **NOTED** that resource issues would need to be resolved before this could be addressed.

The Chair thanked Ruth Treharne for the update and advised that the Committee would continue to monitor the position.

Members **RESOLVED** to:

- **NOTE** the updates provided

Ruth Treharne left the meeting at 12.58pm.

PART 3. INTERNAL AUDIT

AC/19/078 **INTERNAL AUDIT PROGRESS REPORT**

Paul Dalton, Head of Internal Audit & Assurance, presented the Internal Audit & Assurance progress report. Since the April 2019 meeting, Members **NOTED** that the following five reports had been finalised.

Commissioning	**Reasonable Assurance**
Mobile Phones	**Reasonable Assurance**
Emergency Ambulance Services Committee (EASC) Governance Arrangements	**Reasonable Assurance**
Annual Quality Statement (2019/2020 assignment)	**Reasonable Assurance**
Sustainability Reporting (2019/2020 assignment)	**Reasonable Assurance**

Paul Dalton advised that there was a slight update to the report, and advised that the Cyber Security report had been finalised and was being presented to the Committee today. Paul Dalton also advised that the Internal Audit Reviews into Surgery, Data Quality and Healthcare Standards were due to be finalised this week.

Members **NOTED** the report also identified progress being made against the plan for 2019/20 and it was **NOTED** that two of the reports were being presented to the Committee today.

Jayne Sadgrove sought clarity as to when the review of Water Safety would be presented to the Committee. Paul Dalton advised that the report had initially been given a limited assurance rating, and that following further discussions and information received from the Directorate, a reasonable assurance rating was now likely. Members **NOTED** that the report would be presented to the July meeting.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/079 **INTERNAL AUDIT & ASSURANCE AUDIT REPORTS**

Cyber Security – Limited Assurance

John Palmer was in attendance for this item.

Paul Dalton presented the report and advised that the review focussed on the governance structure in place for the management of Cyber Security and that a limited assurance rating had been given.

Members **NOTED** that there were two high priority findings which related to the visibility of an external assessment and how it was being addressed and resourced. Members **NOTED** that the management response referred to the risks involved but made no mention of resource issues.

Members **NOTED** that a Digital Strategy Steering Group had been put into place during the last year. Members **NOTED** that confirmation was being sought from Welsh Government in relation to the appointment of an Independent Member for Information, Communication & Technology (ICT). It had been agreed that an ICT Committee would be established to include Information Governance.

John Palmer advised that in relation to resourcing, a review of Cyber Security had commenced two years ago as a result of the "Wannacry" incident and a significant amount of work had been undertaken in terms of patching of software as a result.

Members **NOTED** that three years ago investment had been sought for 3 Cyber Security staff which was not agreed. Members **NOTED** that one of these posts had been released which allowed some modest work to be undertaken.

John Palmer advised that as a result of funding received from Welsh Government, the Health Board would now able to recruit to the remaining two Cyber Security posts.

Paul Dalton advised that a follow up review would be undertaken in 2019/20 and it was **NOTED** that the report would also be discussed at the Directorate's Governance meeting.

Jayne Sadgrove expressed concern at the report.

The Chair **AGREED** that this would be monitored closely by the Committee over the next few meetings.

Members **RESOLVED** to:

- **NOTE** the report.

Mobile Phones – Reasonable Assurance

Paul Dalton presented the report which had been given a reasonable assurance rating, with two medium assurance recommendations made. John Palmer advised that he had been content with the findings within the report and added that a Mobile Phone policy was being developed.

Jayne Sadgrove advised that issues in relation to mobile phones had initially been identified following a counter fraud investigation. Members **NOTED** that processes had been changed in following the issues identified to safeguard against a recurrence.

Members **RESOLVED** to:

- **NOTE** the report.

Sustainability Reporting – Reasonable Assurance

Paul Dalton presented the 2019/20 report which was a mandatory review undertaken on an annual basis. Members **NOTED** that the review had been allocated a reasonable assurance rating with two medium priority recommendations.

John Palmer welcomed the report and advised that the recommendations within the report had been accepted. Jayne Sadgrove advised that she was pleased to see the Health Board had secured ISO accreditation which was not easy to obtain and maintain.

Members **RESOLVED** to: **NOTE** the report.

- *John Palmer left the meeting at 13.05pm.*

Commissioning – Reasonable Assurance

Paul Dalton presented the report which focussed on arrangements between the Health Board and Powys Health Board and had been given a reasonable assurance rating, with one high priority finding made in relation to the commissioning register.

A discussion was held in relation to resuscitation services. Members **NOTED** that the Service Level Agreement (SLA) had not been updated for several years. Steve Webster advised that further work around the Bridgend transition had been prioritised by the Commissioning Team.

Members **NOTED** that there was a register in place of SLAs and Long Term Agreements (LTAs) between Swansea Bay and Cwm Taf Morgannwg Health Boards. Members **AGREED** to refer the report to the Finance, Performance & Workforce Committee for information (**Added to Action Log**).

Members **RESOLVED** to:

- **NOTE** the report
- **REFER** the report to the Finance, Performance & Workforce Committee for information.

EASC Government Arrangements – Reasonable Assurance

Members **RECEIVED** and **NOTED** the report and **AGREED** to refer the report to the EASC Committee for information.

Annual Quality Statement – Reasonable Assurance

Paul Dalton presented the 2019/20 report which had been given a reasonable assurance rating with one medium and one low priority recommendation made. This related to the lack of evidence available in relation to engagement with external stakeholders and the change made by the Health Board by its move to a more narrative based approach.

Robert Williams suggested that the report was referred to the Quality, Safety & Risk Committee and advised that this was a different version of the report which was originally received in March (Added to the Action Log).

Members **RESOLVED** to:

- **NOTE** the report
- **REFER** the report to the Quality, Safety & Risk Committee for information.

Draft Internal Audit Annual Report 2018/19

Paul Dalton presented the draft report which outlined the work that had been undertaken by Internal Audit during 2019/20.

Members **NOTED** that the final version of the report would be presented to the Audit Committee at the end of May and the report included the Head of Internal Audit Annual Opinion. Members **NOTED** that the overall opinion was reasonable assurance of which there were 8 domains, seven of which were reasonable and one limited domain. Members **NOTED** that the limited domain related to capital works at Prince Charles Hospital.

The Chair made reference to the report on NHS Wales Informatics Service (NWIS) and questioned whether the Committee could be able to have sight of this report. Simon Cookson advised that reports would not be shared until they had been presented to Velindre NHS Trust and added that the Audit Committee would not normally receive these type of reports.

PART 4. EXTERNAL AUDIT

AC/19/080 **WAO UPDATE ON PROGRESS WITH 2018/19 ACCOUNTS AUDIT**

Members N**OTED** that an update was provided earlier in the meeting.

PART 5. ANY OTHER URGENT BUSINESS

There was no other business to report.

AC/19/081 **ITEMS FOR REFERRAL TO OTHER COMMITTEES**

Members referred the following items:

- Internal Audit Report – Commissioning to the Finance, Performance & Workforce Committee for information;
- Internal Audit Report – Annual Quality Statement to the Quality, Safety & Risk Committee for information.

AC/19/082 **CLOSE OF PART 1 OF THE MEETING – DATE AND TIME OF NEXT MEETING:**

In closing part 1 of the meeting, Members **RESOLVED** that in accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960, that representatives of the press and other members of the public are excluded from the second part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting is to be held in private session.

The next meeting of the Committee would be held at 11:30hrs on Thursday 30 May 2019.

…….

Paul Griffiths, Chair

Date ……

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB)

'UNCONFIRMED' MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 30 MAY 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT

Paul Griffiths	-	Independent Member, CTMUHB (Chair)
Maria Thomas	-	Independent Member, CTMUHB
Jayne Sadgrove	-	Independent Member, CTMUHB
Dilys Jouvenat	-	Independent Member, CTMUHB

IN ATTENDANCE

Marcus Longley	-	Chair, CTMUHB
Ian Wells	-	Independent Member, CTMUHB (Observing)
David Jenkins	-	Independent Support to CTMUHB Chair
Allison Williams	-	Chief Executive, CTMUHB
Chris Turner	-	Chair, Emergency Ambulance Services Committee
Sian Lewis	-	Managing Director, WHSCC
Stephen Harrhy	-	Chief Ambulance Service Commissioner
Robert Williams	-	Board Secretary/ Director of Corporate Services & Governance, CTMUHB
Gareth Lucey	-	Wales Audit Office
Paul Dalton	-	NWSSP – Head of Internal Audit & Assurance
Steve Webster	-	Director of Finance & Procurement, CTMUHB
Stuart Davies	-	Director of Finance, WHSSC
Elisabeth Williams	-	Finance Manager, CTMUHB
Gwenan Roberts	-	Head of Corporate Services, CTMUHB
Kevin Smith	-	Committee Secretary, WHSSC
Wendy Penrhyn-Jones	-	Head of Corporate Administration/ Committee Secretariat CTMUHB

AC/19/083 **WELCOME AND INTRODUCTIONS**

Paul Griffiths, Chair **welcomed** everyone to the meeting.

Members **NOTED** that the Audit Committee had already had the opportunity at its meeting on 13 May 2019 when it had scrutinised the 'draft' annual accounts for 2018/19 along with the 'draft' accountability report and 'draft' Head of Internal Audit Opinion. The Chair stated that for this reason he would ask all report presentations to focus upon amendments that had been made since that time.

With regard to the purpose of the meeting, Members **NOTED** that this was, subject to scrutiny of the Accounts and related financial statements, for the Audit Committee to make a recommendation to the Health Board to approve the Annual Accounts and related financial statements (including the Letter of Representation to the Auditors) for 2018/19.

AC/19/084 **APOLOGIES FOR ABSENCE**

Apologies for absence were **received** from Vivienne Harpwood, Chair of WHSCC.

AC/19/085 **DECLARATIONS OF INTERESTS**

There were no additional Declarations of Interest to note other than those already registered.

AC/19/086 **REPORT ON THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) / EMERGENCY AMBULANCE SERVICES COMMITTEE (EASC) FINANCIAL ACCOUNTS 2018/19**

Stuart Davies presented the report on the WHSSC/EASC Financial Accounts for 2018/19. Members **NOTED** that the only changes to the financial accounts since these documents had been considered by the Audit Committee in May 2019 related to minor presentational adjustments. These were summarised as categorisation of receivables, transposition errors, roundings and changes to accruals from WHSCC to EASC. Members **NOTED** none of these adjustments impacted on the overall position.

Gareth Lucey concurred with the above summary of amendments and members **NOTED** that Wales Audit Office had no further comments to offer.

Members **RESOLVED** to:

- **ENDORSE** the final audited financial statements for the financial year ended 31 March 2019**;**
- **RECOMMEND** their inclusion and publication unchanged in the consolidated Cwm Taf Statutory Financial Statements**.**

AC/19/087 **WHSSC ANNUAL GOVERNANCE STATEMENT FOR 2018/19**

Kevin Smith presented the WHSSC Annual Governance Statement for 2018/19. Members **NOTED** this had been subject to minor revisions since it had been discussed by the Audit Committee in May 2019. These revisions were summarised as additional text providing clarity on those instances where meetings were not quorate as well as changes with effect from November 2018 to the voting rights of members.

Members **NOTED** that Welsh Government had also been approached regarding whether they wished to consider amending Members regulations.

Members **RESOLVED** to:

- **NOTE** the report
- **APPROVE** the WHSSC Annual Governance Statement for 2018/19.

AC/19/088 **EASC ANNUAL GOVERNANCE STATEMENT 2018/19**

Stephen Harrhy presented the Annual Governance Statement in relation to EASC for the period 2018/19. Members **NOTED** there had been two minor changes to the document relating to reference to an incorrect year and an erroneous electronic link.

Members **RESOLVED** to:

- **NOTE** the report
- **APPROVE** the EASC Annual Governance Statement for 2018/19.

AC/19/089 **REPORT ON THE FINANCIAL ACCOUNTS OF THE CWM TAF UHB FOR 2018/19**

Final Draft Annual Accounts 2018/19

Elisabeth Williams presented the Financial Accounts relating to the former Cwm Taf University Health Board for 2018/19. Members **NOTED** that details of the main changes to the accounts were summarised in the report. In particular, Elisabeth Williams drew the attention of Members to the reclassification of care home core budgets, financial account entries, a reduction in consultancy costs to £233k, changes to employee numbers and costs and an amendment to pay bandings for senior personnel. Elisabeth Williams also stated there had been an improvement in the percentage of NHS invoices paid within target by value (of 1.7%) to 98.9%, changes to losses and special payment whereby three cases had been removed and some declaration of interest changes.

Members **NOTED** Wales Audit Office had no further comments.

Audit of Financial Statements (ISA 260) Draft Report and Letter of Representation.

Gareth Lucey summarised the findings of the audit of the Accounts which Members **NOTED** was now largely complete with a single matter outstanding in relation to the Remuneration Report. Gareth Lucey stated that whilst the organisation had correctly sought approval from the Welsh Government in relation to pay rates, confirmation of the position had yet to be received from Welsh Government although this was expected imminently.

Gareth Lucey stated that Wales Audit Office were satisfied with the amendments made following their audit of the Accounts and thanked everyone involved.

Members **NOTED** that the Auditor General intended to issue an unqualified audit report on the financial statements which had no uncorrected misstatements and met the duty to break-even over a three-year period subject to the above outstanding matter being resolved.

Gareth Lucey stated that the Accounts were due for submission to Welsh Government the next day although the Auditor General was not due to certify these until 11 June 2019 which provided time for the required information to be received from Welsh Government.

The Chair stated that having been involved in the annual accounts process previously he was aware how challenging this could be and thanked everyone involved for ensuring the process had proceeded smoothly.

Members **RESOLVED** to:

- **NOTE** the report
- Recommend that the Board **APPROVE** the Annual Accounts for 2018/19 together with the letter of representation to the Auditors.

AC/19/089 **CWM TAF UHB ACCOUNTABILITY REPORT 2018/19**

The Chair stated that there had been productive discussion of the previous iteration of this Accountability Report at the Audit Committee in May 2019 following which a number of changes had been made. Members **NOTED** these mainly related to additional text in relation to counter fraud services, the audit of capital works at Prince Charles Hospital and general balance within the report.

Robert Williams reminded Members that Allison Williams had been invited to the Audit Committee meeting in May 2019 to inform scrutiny of the draft Accountability Report. Robert Williams said that following agreement over the changes that were required to the draft these were made and it had been recirculated to Audit Committee members who subsequently confirmed their contentment with the amendments.

Members **NOTED** there remained one amendment to be made to ensure consistency with the Head of Internal Audit End of Year Opinion relating to the outcome of an internal audit review of facilities where three out of four of the audits had been reasonable with the fourth being classed as 'limited assurance'.

Gwenan Roberts stated that she wished to record two late amendments made that morning to the Accountability Report as requested by Wales Audit Office colleagues in relation to payees and pension benefits.

The Chair extended thanks to Allison Williams and Robert Williams for their input into Accountability Report for 2018/19.

Members **RESOLVED** to:

- **ENDORSE** the accountability report and recommend that the Board **APPROVE** the report as part of its approval of the annual accounts for 2018/19**.**

AC/19/090 **HEAD OF INTERNAL AUDIT OPINION AND ANNUAL REPORT 2018/19**

Paul Dalton presented the report advising that as Head of Internal Audit he was of the opinion that the Board could take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control within those areas under review were suitably designed and applied effectively. Members **NOTED** that small changes had been made to Performance Indicators in terms of the timeliness of responses.

Members **RESOLVED** to:

- **NOTE** the update provided
- **NOTE** that reasonable assurance had now been allocated.

AC/19/091 **AUDIT ENQUIRIES CHECKLIST 2018/19**

Robert Williams advised that the checklist had been completed as a matter of routine and the responses were generally consistent with those in previous years.

Members **RESOLVED** to:

- **NOTE** the update.

AC/19/092 **ANY OTHER URGENT BUSINESS**

The Chair referenced the helpful work undertaken by Internal Audit over the past 12 months which provided assurances that the organisation was addressing various challenging issues.

There was no other business to report and the meeting was closed noting the next Audit Committee meeting was scheduled for 15 July 2019 commencing at 9am.

DATE OF NEXT MEETING
Monday 15 July 2019 at 9am

.....
Paul Griffiths, Chair

.....
Date

AUDIT COMMITTEE ACTION LOG
FOLLOWING MEETING ON 1 APRIL 2019

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT July 2019
~~18/028~~	~~16/4/ 2018~~	~~Audit Recommendations Tracker~~	~~Amend Audit tracker template to include specific dates for Director updates and to stipulate that if no progress made within a 3 month period the Director should attend an Audit Committee meeting to explain why limited progress made~~	~~May 2018~~	~~Interim Board Secretary~~	~~**On agenda** Executive Directors are invited to attend the Committee within 3 months.~~
18/081	09/07/ 2018	Standards of Behaviour Report	Board Secretary to undertake a review of the Declarations of Interests received to ensure all submissions had been captured.	October 2018	Interim Board Secretary	Ongoing – Update report to be presented at the October meeting **Was July**
18/099	8/10/ 2018	JAG Accreditation	Closure report to be presented to a future meeting.	January 2019	Deputy Chief Operating Officer / Interim Board Secretary	**To be confirmed**
19/023	14/1/ 2019	Internal Audit Report – Raising Concerns	Discussion to be held with the Executive Team in relation to introducing a nominated person who would be responsible for receiving any protected disclosures.	February 2019	Director of Workforce and OD / Interim Board Secretary	**In progress**
19/037	11/2/ 2019	Audit Recommendation Tracker	Consideration to be given as to whether the statement made within the report that recommendations had reportedly been completed would need to be reworded. Discussions to be held outside of the meeting as to whether the audit tracker process could be strengthened and refined.	April 2019	Interim Board Secretary	**In progress** Work remains ongoing in relation to refining the audit tracker

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT July 2019
19/039	11/2/ 2019	Internal Audit Report – Common Issues Identified within Directorate Reviews	Discussion to be held with the Executive Team in relation to putting a process in place to enable lessons learnt from Directorate reviews to be shared amongst Directorates	April 2019	Interim Board Secretary	**In progress** Email sent to Directorate Managers following meeting in April
19/059	1/4/19	Charitable Funds	A discussion was held as to whether the Committee had the authority to approve the actions proposed for registering the name change and revised objects with the Charity Commissioner. Following discussion, Gwenan Roberts **AGREED** to seek advice from the UHB Chair as to whether the Committee had this authority.	May 2019	Interim Board Secretary	**In progress**
19/079	13/5/19	Internal Audit on Commissioning	To be referred to Finance Performance and Workforce Committee	May 2019	Board Secretary	**Completed**
		Internal Audit on the Annual Quality Statement	To be referred to the Quality Safety and Risk Committee		Board Secretary	**Completed**

Cwm Taf University Health Board

Joint Advisory Group (JAG) accreditation - Endoscopy

Final Internal Audit Report

2017/18

January 2018

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating
Appendix C Management response supporting information appendices

Review reference:	CTU-1718-04
Report status:	Final Internal Audit Report
Fieldwork commencement:	28 September 2017
Fieldwork completion:	11 October 2017
Draft report issued:	20 October 2017
Management response received:	16 November & 21 December 2017
Final report issued:	5 January 2018
Auditors:	Liz Vincent, Emma Samways
Executive sign off:	Chris White, Chief Operating Officer/ Director of Therapies and Health Sciences Kath McGrath, Interim Chief Operating Officer / Director of Therapies and Health Sciences
Distribution:	Collette Kiernan, Directorate Manager, Acute medicine and A&E Neil Hawkes, Consultant Gastroenterologist Ruth Morrissey, Directorate Support Manager Medicine
Committee:	Audit Committee

ACKNOWLEDGEMENT

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

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The audit review of the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation process was completed in line with the 2017/18 Internal Audit Plan. The review seeks to provide Cwm Taf University Health Board (the 'Health Board') with assurance regarding the processes in place for achieving JAG accreditation.

The JAG undertakes the following work for endoscopy:

- sets standards for training in endoscopy;
- quality assures endoscopy units; and
- quality assures endoscopy training courses.

The JAG accreditation process is based on the Global Rating Scale (GRS) standards, which enable endoscopy units to assess how well they provide a patient-centred service. The JAG accreditation process requires GRS levels to be demonstrated though the submission of clear evidence.

The accreditation standards for JAG assessments are grouped into four domains: Clinical Quality; Workforce; Quality of Patient Experience; and Training. Across the four domains there are 19 standards to achieve by answering 78 questions. The Health Board's answers to the questions are scored on an A-D grade system, with grade 'B' being the minimum score required for each question under a standard to achieve accreditation. A standard is expressed as something that an endoscopy service must do as an overriding duty of principle in order to meet the requirements for accreditation. The standards provide the basis for evaluating quality of service, and they may evolve over time.

Accreditation is a cyclical process that provides an independent validation that an endoscopy service has demonstrated competence measured against the standards and is considered to be fit for purpose. Following the initial assessment visit, accreditation is annual through maintenance of the standards and satisfactory submission of an annual report card. Thereafter, there is a five yearly site assessment visit to validate the annual accreditation process. The Health Board is in the process of working towards its first accreditation.

The relevant lead for the assignment is the Chief Operating Officer/Director of Therapies and Health Sciences.

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's readiness for the JAG accreditation. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the achievement of accreditation are managed appropriately.

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

- There is an appropriate governance structure in place to oversee the accreditation process.
- There is an on-going plan in place to ensure all requirements needed to for accreditation are achieved.
- Evidence is retained to support the quarterly self-assessments and any other assessments required as part of the pre-accreditation process.

3. Associated Risks

The potential risks considered in this review were as follows:

- Poor governance arrangements and a lack of oversight.
- Accreditation criteria not achieved and supporting evidence not maintained.
- Services are not delivered in a safe and effective way.
- Reputational damage if accreditation status is not achieved.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place, to manage the risks associated with the Joint Advisory Group accreditation process for Endoscopy is limited assurance.

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

The JAG accreditation process within the Health Board is being implemented using a two phased approach. Initially when the Endoscopy Unit's at Prince Charles Hospital (PCH) and Royal Glamorgan Hospital (RGH) began the accreditation process, management identified that the 'waiting times for Endoscopy' procedures were posing the biggest risk to achieving accreditation, and would take the greatest amount of time to resolve. An action plan was created around waiting times and a JAG working group established, focussing on waiting time concerns. In addition to improving and maintaining the waiting list times the directorate also re-evaluated the administration process within Endoscopy which has aided the reduction in waiting list times.

Our review has identified that there is no clear governance structure in place that oversees the accreditation process, nor a clear reporting structure to ensure a suitable level of challenge when standards have not been achieved. Without these arrangements in place, or a comprehensive action plan, the progress against the accreditation process cannot be monitored effectively.

The Endoscopy units on both sites are in the process of addressing standards needed for the accreditation. However, there is no clear, overarching action plan or resource in place to address these. The current action plan focuses on the waiting time targets and does not include all the actions needed to achieve every standard to a grade 'B' level. Discussion

around the action plan only takes place during the fortnightly working group meeting; it is not reported to the Endoscopy Steering Group as this has not meet for some time.

Both RGH and PCH are submitting separate GRS self-assessments every six months, and at the time of their last self-assessment were scoring 16% and 37% respectively at a level 'B' and above. The Endoscopy units are not consistently maintaining the same level of scoring and in some instance the scoring is declining between self-assessments. To support their assessment, the units should upload evidence to support the standards achieved onto SharePoint, this is currently not happening.

At the time of the audit fieldwork, the Endoscopy operational policy was being written. We understand that this may address many of the standards that the units are not currently achieving. However, there is no agreed timescale for completing this policy.

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

5. Assurance Summary

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

Assurance Summary					
1	There is an appropriate governance structure in place to oversee the accreditation process.		✓		
2	There is an on-going plan in place to ensure all requirements needed for accreditation are achieved.		✓		
3	Evidence is retained to support the quarterly self-assessments and any other assessments required as part of the pre-accreditation process.			✓	

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

Design of Systems/Controls

The findings from the review have highlighted five issues that are classified as weakness in the system control/design for Joint Advisory Group (JAG) accreditation process for endoscopy.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for Joint Advisory Group (JAG) accreditation process for endoscopy.

6. Summary of Audit Findings

In this section we highlight areas of good practice that we identified during our review. We also summarise the significant findings (high and medium priority) made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: There is an appropriate structure in place to oversee the accreditation process.

We note the following areas of good practice:

- The Health Board adopted a two phase approach in working towards JAG accreditation. Phase one was to address the endoscopy waiting list targets as it was known that these would require a greater length of time to achieve. Significant progress has been made in this area.
- There is a 'virtual' JAG accreditation working group between staff at RGH and PCH. The meeting is held fortnightly with video conferencing connecting staff across the two sites to minimise service disruption. The Health Board have a named JAG lead in place.

We identified the following significant findings:

- There is no governance structure in place that oversees the accreditation process.

  There are no terms of reference in place for the JAG accreditation working group.

  While we were provided with minutes of the group meetings for the period June 2016 to January 2017, no further minutes have been provided at the completion of our audit fieldwork.
- The Endoscopy Steering Group has not met for some time and no evidence was provided to demonstrate that progress in achieving accreditation gets reported to relevant groups or committees within the Acute Medicine and A&E Directorate. There is no defined reporting structure in place to escalate any issues regarding the JAG accreditation process, nor is there any challenge of the progress being made.

Objective 2: There is an on-going plan in place to ensure all requirements needed for accreditation are achieved.

We note the following areas of good practice:

- There is a 'timeliness' JAG action plan in place that is discussed in the fortnightly JAG accreditation working group. We reviewed a sample of the action plans. Each had a specific lead and had progressed.

  Staff have undertaken considerable work to address the endoscopy administration process. This is a large project and is crucial for assisting in achieving the waiting time targets. Waiting times for endoscopy procedures is currently split into four categories; Cancer, Routine, Surveillance, and Urgent non-cancer. We reviewed reports

for the period January to October 2017 which showed the position of the waiting list for endoscopy. We note that improvements have been made in three of the categories during this period.

We identified the following significant findings:

- There is no overarching plan in place that incorporates all the actions that are required to meet the standards. The action plan that is in place does not include the domains and standards that the actions refer and there are no timescales identified against achieving those actions.
- The Endoscopy Operational Policy is in the process of being drafted, however there is no timescale in place for completion. Considerable work is also required to ensure that the relevant polices and appendices identified in the operational policy are also current.
- The Endoscopy units are not consistently maintaining the same level of scoring when completing the GRS self-assessments; particularly within RGH. As at April 2017 the endoscopy unit in RGH has only achieved 16% scores at level B and above, whereas in October 2016 PCH has achieved 37%. Further work is required by both units if accreditation is to be achieved.
- There is no mechanism in place to ensure that the standards once completed are signed off at board level and there is not a named person responsible for monitoring.

Objective 3 - Evidence is retained to support the quarterly self-assessments and any other assessments required as part of the pre-accreditation process.

We identified the following significant findings:

- Although most of the evidence could be found to support the standards in our testing exercise, none of this information had been uploaded on to SharePoint; the system that is used to store the evidence to support the JAG accreditation.
- Evidence has not been uploaded into SharePoint for some time. Currently there are two folders created for the JAG accreditation evidence and staff are unsure which folder to use and who has access to them.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**4**	**2**	**1**	**7**

Finding 1 - Governance structure (Control design)	Risk
The Health Board has not developed formal governance arrangements or structures to oversee the JAG accreditation process. There is an appointed JAG lead who is a consultant gastroenterologist. However, the consultant is not solely responsible for undertaking all of the work required to achieve accreditation. We understand that a JAG working group meets every two weeks via video conference across the PCH and RGH sites to progress the work required for accreditation. A number of staff attend these meetings and are involved in implementing changes, gathering and maintaining evidence, and completing self-assessments. However, the roles and responsibilities of the group and individuals, and their contribution to achieving accreditation and accountability within the process, has not been formalised in a terms of reference. While minutes for the group were provided to us for the period June 2016 to January 2017, we had not received any further minutes at the completion of our audit fieldwork. As such, there is no formal record of attendees or the key points discussed. In addition, there is no mechanism in place to ensure that the accreditation questions and standards, once believed to be completed, are reviewed and signed off by an appropriate officer.	Poor governance arrangements and lack of oversight.
Recommendation	**Priority level**
Management must develop a governance structure for the JAG accreditation process that clearly sets out the terms of reference for the JAG working group, the roles and responsibilities of individuals and the accountability of all parties.	**High**

Management Response	Responsible Officer/ Deadline
The JAG accreditation group will report to the newly reconvened Endoscopy steering group, which in turn will be reported at the monthly directorate combined governance group and CBM. An annualised schedule of meetings has been arranged and can be seen in Appendix 1. The terms of reference for this group will be discussed at the January meeting. The progress of work in relation to accreditation questions and standards will also be reviewed in the JAG accreditation group, signed off by the chair and reported as feedback from that meeting as described above. There has also been a Morbidity and Mortality Group established since December 2016 which will report via the same mechanism as the JAG accreditation group. The Terms of reference for this group are already in existence, and can be seen in Appendix 2.	Endoscopy steering group reconvened December 2017 - chair and responsible officer Dr Neil Hawkes JAG accreditation group – continues to meet fortnightly, Chair and responsible officer Dr Neil Hawkes Morbidity and Mortality Group – established and meets monthly, Chair and accountable officer Dr Peter Neville

Finding 2 - Reporting mechanisms (Control design)	Risk
There is no defined reporting structure in place to monitor the JAG accreditation process or to escalate any issues regarding the accreditation process within the Acute Medicine and A&E Directorate. We would expect progress in relation to JAG accreditation to be reporting to one of the operational groups within the directorate. However, the Endoscopy Steering Group meeting, which would appear to be the most appropriate forum for discussion, has not met for over a year, although we acknowledge that there is common membership with the JAG working group. In addition, we could not evidence that JAG accreditation progress and monitoring gets reported at other groups or committees within the directorate such as the Gastro Steering Group or the Acute Services Quality and Safety meetings.	Poor governance arrangements and lack of oversight.
Recommendation	**Priority level**
Management should ensure that there is a clear reporting structure in place within the Acute Medicine and A&E directorate to make sure there is a suitable level of oversight regarding progress in achieving accreditation status and that there is a suitable level of challenge where progress is lacking. Regular monitoring against all the standards needs to take place to ensure they are not compromised once the objective has been achieved.	**High**

Management Response	Responsible Officer/ Deadline
The Endoscopy steering group has been reconvened with an annual calendar of meetings already arranged for 2018. This group will report to the Directorate monthly combined Governance Group and also be reported as a standard item on the medicine directorate CBM on a monthly basis. A plan of meetings for the Endoscopy steering group has been established have a terms of reference.	As above in Finding 1 response

Finding 3 - Action plan (Control design)	Risk
We note that there is no overall project plan to oversee the necessary actions needed to achieve accreditation status, and no date has been set by which the service wants to be accredited. We were informed by the Directorate Support Manager that a decision had been made to focus on the standards linked to the timeliness of service delivery, which we understand is a critical governance, quality and safety requirement for patient care within the Health Board. We understand that these standards may take longer to implement and targets have to be achieved for a number of months before accreditation status can be applied for. However, there is no record of this decision being made. During the fortnightly JAG working group meetings, an action plan that focuses mainly on the timeliness of the service delivery is discussed. However, as there has been a focus on the 'timeliness' standards, the action plan does not make reference to the other standards required for accreditation. We reviewed a sample of action plans for the period June to August 2017. Although there was a specific lead identified for each action, no timescales had been allocated against them and there was no clear reference to the domain or relevant accreditation standard. The lack of an overall plan means effective monitoring of progress cannot take place.	Services are not delivered in a safe and effective way.

Recommendation	Priority level
Management should ensure that a project plan is in place that incorporates all the actions that are required to meet the JAG accreditation status by a required date. Each action identified should include reference to the domains and standards that it refers to, an identified lead, and the timescale for completion.	**High**
Management Response	**Responsible Officer/ Deadline**
There has been significant progress made on the timeliness of delivery of the service over the last year, not just in preparation for an improved position for JAG accreditation but to improve the quality of service for our patients. In addition, there has also been the development of a delivery plan for each site for JAG accreditation which is a live document for each site that is maintained via each JAG accreditation meeting. Within the plan each domain and progress is clearly shown. These plans will be used as the foundation for each JAG accreditation meeting. It will be used to focus the agenda and report progress.	Demand and Capacity, waiting times management – Ruth Morrissey, continual. JAG accreditation plan - Neil Hawkes & Carolyn John, in place and being used.

Finding 4 – Evidence to support compliance with standards (Control design)	Risk
We tested a sample of two completed questions from eight standards: four from the endoscopy unit at PCH; and four for the unit at RGH, to see if there was appropriate evidence retained to support the conclusion that the question has been completed. While two pieces of evidence requested from PCH, were not provided at the time of the audit, evidence was provided to support the assessment against the standards in the remaining 14 areas. However, we note that none of this information had been uploaded onto SharePoint, the system that is used by the Health Board to store the evidence necessary for JAG accreditation. From our discussion with staff we understand that there are a number of underlying reasons why SharePoint is not well used, these are: • The process of gathering and uploading evidence to support the questions within the standards can be time consuming, and the lead nurses at each unit are responsible for undertaking this role alongside their main duties. • In 2016 JAG amended the domains and standards which meant the original folders that were created within SharePoint were no longer valid. New folders were created to address these changes but staff are unclear which are the correct folders to use. • It is unclear who has access to these folders. Therefore, staff are reluctant to upload evidence that contains patient information as there is a risk that confidentiality may be breached.	Accreditation criteria not achieved and support evidence not maintained.

Recommendation	Priority level
Management should review the current system for uploading information onto SharePoint. The current file structure, access rights, and information within SharePoint should be reviewed and revised as necessary. Evidence collated to support the achievement of the standards should be stored in a consistent way and evidence that can be used for both units it is identified to prevent duplication of work. Sufficient resource should be allocated to allow a full assessment of the required evidence and gathering and uploading of that information to SharePoint.	**High**
Management Response	**Responsible Officer/ Deadline**
Availability of corporate support is being sourced following meetings with the directorate and Chief Operating Officer. This support will enable the scanning and uploading of evidence once a new shared portal is established on SharePoint which will mirror the new and updated domains. This is an element of work which will be captured on the plan with progress reported as outlined in the sections above (in finding 1 and 2).	COO / Collette Kiernan (DM) - March 2018

Finding 5 - Scoring the GRS self-assessment (Operating effectiveness)	Risk
To obtain JAG accreditation the Health Board has to be able to demonstrate a minimum of one year participating in the Global Rating Scale (GRS) self-assessment, and performing at the agreed GRS levels required for accreditation. Each GRS self-assessment is completed on-line via the JAG accreditation system. Scoring is based on an A-D system, with grade 'B' being the minimum score required for each question under a standard to achieve accreditation. The PCH and RGH endoscopy units are not consistently maintaining the same level of scoring when completing the GRS self-assessments. If the units are to achieve JAG accreditation status, there should be a continual improvement in scores between each self-assessment. Our review of the last two self-assessments undertaken by each unit identified: <u>PCH - Between April and October 2016</u> For 7 out of 19 standards the scoring level has remained the same. • For 7 out of 19 standards the scoring level has improved. • For 5 out of 19 standards the scoring level has decreased. As at October 2016; 7 out of 19 had achieved the required scoring level of 'B' and above. <u>RGH – Between October 2016 - April 2017</u> • For 5 out of 19 standards the scoring level has remained the same.	Services are not delivered in a safe and effective way.

• For 14 out of the 19 standards the scoring level had decreased. Nine of these were originally scoring as an 'A' grade but have been downgraded to 'D's' and 'C's'. As at April 2017 three out of 19 have achieved the scoring level of 'B'. As at October 2016 the endoscopy unit in PCH had achieved 37% of the standards scoring a level 'B' and above, whereas in April 2017 RGH had only achieved 16%.	
Recommendation	**Priority level**
Management should review and understand why the scoring rates have decreased when comparing the GRS self-assessment to the previous submissions. Action plans should be created to address the short comings, which must include realistic timescales and persons' responsible. Failure to comply with the action plan should be challenged by management.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Self-evaluations that were submitted in October 2017 have been reviewed and compared and moving forward for the April 2018 submission there are plans that each site will undertake the review independently and then this will be peer reviewed by the alternative acute site to ensure consistency in approach and to give assurance prior to submission. The most recent review shows the deficits in each domain that are not at level B (the required standard) and therefore informs the overall action plan for achieving accreditation. This review document can be seen in Appendix 3.	In Place; Dr Neil Hawkes – RGH Dr Jo Hurley – PCH Next Review April 2018

Finding 6 - Operational policy (Operating effectiveness)	Risk
An endoscopy operational policy is required to achieve JAG accreditation. In September 2017 the directorate began drafting a policy document. We understand that the Health Board has identified that the policy will require significant work to ensure that it meets the necessary standards for JAG accreditation. We understand that currently there is no timescale in place for the completion of the review of this policy and its associated documents.	Services are not delivered in a safe and effective way.
Recommendation	**Priority level**
Management must agree a timescale for the completion of the operational policy review. Progress against the policy and the supporting appendices should be discussed in the appropriate endoscopy working group or steering group. Once policies and appendices have been updated they need to be appropriately approved.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The directorate now have a formalised action plan relating to the development and completion of the operational policy. The plan gives structure and clarity around what is still required for completion of this significant document. This plan can be seen in Appendix 4.	Action Plan is in place and significant progress has been made. This work is led by Dr Jo Hurley, target completion date February 2018.

Finding - 7 Completion of GRS self-assessments (Control design)	Risk
The Health Board currently completes GRS self-assessments every April and October although JAG guidance suggests quarterly returns. Within the GRS system a clinical lead and nurse manager are set up to complete the self-assessments at each site. However, we note that different people undertake the self-assessments at the two sites leading to potential inconsistencies. Furthermore, during our fieldwork we noted one instance where the six-monthly GRS self-assessment had not been completed as both the clinical lead and the endoscopy nurse at PCH were not available. Given the lack of governance arrangements, there is no protocol in place to address this issue should both leads be unavailable at the time the assessment needs to be completed.	Poor governance arrangements and a lack of oversight.
Recommendation	**Priority level**
Management should ensure that the GRS self-assessments are completed when required and a protocol in place to address the problem should the appropriate staff not be available to complete the assessments. Furthermore, ensuring the same people undertake the assessments at both units provides the Health Board with an opportunity to remove inconsistencies across the units.	**Low**
Management Response	**Responsible Officer/ Deadline**
A plan has been put in place for cross site peer review of the GRS self-assessments prior to submission which should achieve improved consistency and assurance across the Health Board.	Dr Jo Hurley ad Dr Neil Hawkes. Will be delivered for April 2018 submission.

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Appendix C – Management response supporting information appendices

Appendix 1

Endoscopy Steering Group (all meetings VC between RGH &PCH)	Mortality & Morbidity Group (all meetings VC between RGH &PCH)	Gastro Strategy Meeting	Endoscopy Audit Meetings
5th December 2017 ***RGH - TR 8*** 12.15pm – 2pm ***PCH -Classroom 5***	5th January 2018	9th January 2018 Classroom 4, PCH	27th March 2018 Lecture Theatre, RGH
20th February 2018 12.15pm – 2pm ***RGH - TR 8*** ***PCH - Classroom 5***	16th February 2018 ***RGH - TR 8*** 12.30pm – 1.30pm ***PCH -Classroom 5***	14th March 2018 Training Room 9, RGH	
17th April 2018 12.15pm – 2pm ***RGH - TR 8*** ***PCH* - Boardroom**	6th April 2018 ***RGH - TR 8*** 12.30pm – 1.30pm ***PCH -Classroom 5***	8th May 2018 Classroom 4, PCH	
12th June 2018 12.15pm – 2pm ***RGH - TR 8*** ***PCH - Classroom 5***	18th May 2018 12.30pm – 1.30pm ***RGH - TR 8*** ***PCH -Classroom 5***	10th July 2018 Training Room 8, RGH	
7th August 2018 12.15pm – 2pm ***RGH - TR 8*** ***PCH - Classroom 5***	22nd June 2018 12.30pm – 1.30pm ***RGH - TR 8*** ***PCH - Board Room***	11th September 2018 Classroom 4, PCH	

2nd October 2018 12.15pm – 2pm ***RGH - TR 8*** ***PCH - Classroom 5***	3rd August 2018 12.30pm – 1.30pm ***RGH - TR 8*** ***PCH -Classroom 5***	13th November 2018 Training Room 8, RGH	4th October 2018 Lecture Theatre, PCH
27th November 2018 12.15 – 2pm ***RGH - TR 8*** ***PCH - Classroom 5***	14th September 2018 12.45pm – 1.30pm ***RGH - TR 8*** ***PCH -Classroom 5***		
	26th October 2018 12.30pm – 1.30pm ***RGH - TR 8*** ***PCH -Classroom 5***		
	14th December 2018 ***RGH - TR 8*** 12.30pm – 1.30pm ***PCH -Classroom 5***		

Appendix 2 TOR Endoscopy Mortality & Morbidity Group

Introduction

The Endoscopy Steering Group in Cwm Taf University Health Board has established the Endoscopy Mortality & Morbidity Group.

Purpose

The purpose of the Group is to review the following to identify learning and action points:

a. 30-day mortality
b. 8 day re-admissions
c. Concerns & Ombudsman referrals
d. Coroners Cases
e. Patient Safety Incidents (e.g. Complications, Near Misses)
f. Claims & Redress
g. Patient Experience

The Endoscopy Mortality and Morbidity Group will be primarily concerned with the safety and quality of patient care, ensuring competent and appropriately trained staff, effective communication arrangements within Endoscopy, and the overall priorities and processes supporting clinical governance arrangements demonstrating evidence based practice. The Group will ensure quality is the driving principle to improve patient outcomes.

The Trigger List (Appendix A) will aid reporting of patient safety incidents will be used. Those incidents where moderate and severe harm are encountered will be discussed at this meeting. Action plans will be developed and monitored and any learning points will be shared.

The Endoscopy Mortality & Morbidity Group will provide advice and recommendations for action to the Endoscopy Steering Group for its consideration.

Membership

Chairperson: Consultant Gastroenterologist

Vice Chair: to be agreed

Secretary: to be agreed

Consultant Representatives, Medicine and Surgery

Senior Nurse

Endoscopy Managers

Patient Safety Manager

By invitation: The Chair may extend invitations to others to attend meetings as required.

COMMITTEE MEETINGS

Quorum

A Quorum shall be eight members as long as there is at least one representative from each Directorate. In the absence of the Chair, the Head of Nursing will chair the meeting.

Frequency of Meetings

Meetings shall be held no less than bi-monthly, and otherwise as the Chair of the Acute Services Clinical Governance Committee requests.

Agenda items should be received 10 days prior to the clinical governance meeting. Papers for the meeting will be circulated 7 days prior to the meeting.

Urgent items which fall outside of the time frame should be discussed with the chair for inclusion.

REPORTING AND ASSURANCE ARRANGEMENTS

The Endoscopy Mortality & Morbidity Group will:

- Provide an exception report with recommendations to the Endoscopy Steering Group.
- Bring to the Directorates attention any significant matters which require action or further escalation outside the scope of the Endoscopy Steering Group.

REVIEW

These Terms of Reference shall be reviewed annually by the Mortality & Morbidity Group.

APPENDIX A

CWM TAF UNIVERSITY HEALTH BOARD

ENDOSCOPY DEPARTMENT

The definition of a patient safety incident has previously been defined by the former National Patient Safety Agency as "any unintended or unexpected incident which could have or did lead to harm for one or more persons receiving NHS care". Any incidents which do not fall within this definition are categorised as non-patient safety incidents.

The level of potential harm will vary according to the outcome for the patient as follows:

NO HARM

Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.

Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.

LOW HARM

Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.

MODERATE HARM

Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

SEVERE HARM

Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

DEATH

Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

The CTUHB vetting procedure (not formally approved by the HB) for new referrals, carried out by the Endoscopists, set the standards for appointments.

Appointments The delay in appointing or cancellation of clinical procedures is a patient safety incident as this could lead to harm for the patient due to a delay in diagnosis and associated treatment.
Routine • These are captured via on-going Demand and Capacity Review and is already on the Risk Register. Therefore there is **no** requirement to report these as incidents.
New Referral – Urgent / Urgent Suspected Cancer (USC) • These are monitored via the on-going Demand and Capacity Review and is on the Risk Register. Therefore there is **no** requirement to report these as incidents.
Cancellation of Appointment Leading to a Delay in Procedure
• Lack of Endoscopist cover for list • Insufficient staffing • Lack of appropriate cover for list due to level of skill required
Consent
• Absence of informed written consent prior to procedure • Incomplete documentation • Incorrect form • Incorrect information • Withdrawal of consent not honoured • Patient identification issues
Delays or Cancellation on the day of Procedure
• Lack of preparation, e.g. inadequate bowel preparation, patient not kept nil by mouth • Anticoagulation, e.g. medication not withheld as directed • Blood tests required, e.g. U&Es for patients receiving bowel preparation • Blood glucose levels too low • Inappropriate documentation sent with patient from the ward, e.g. no NEWS chart/medication chart • List over runs • Equipment failure

Complications
• Known risk, e.g., perforation • Patients admitted following procedure • PEGS – if not successfully sited
Equipment Failure
• Decontamination • Defects not being reported • Equipment being used before defects are remedied • Infusion error • Lack of consumables • Misuse of equipment • Not used in accordance with the manufacturer's instructions • Unauthorised use of equipment
Communication
• Between different teams/directorates/departments • Between visitor/relative/staff • Breakdown in communication route/method • Communication delay • Failure between staff and patient • Language barriers • Staff to staff • Within the team
Patient Information
• Wrong information given to the patient prior to procedure • Confidentiality – Wrong information given to patient post procedure
Medication
• Sedation – requiring reversal agent flumazenil/Naloxone

Please note that this list is not exhaustive and staff are required to report any incidents via Datix that meet the definition of an incident as outlined on Page 1.

Appendix 3. GRS Self-Evaluation Review November 2017

1. Clinical Quality	
RGH	**PCH**
D	**D**
***Actions Required*:** Completion of Operational Policy EUG / ESG Meetings Annual Endoscopy Report	

2. Safety	
RGH	**PCH**
B	**C**
***Issue*:** Evidence to support that 75% of in-patients with acute upper GI Bleeds are treated within 24 hours	

3. Comfort	
RGH	**PCH**
B	**B**

4. Quality	
RGH	**PCH**
Not completed	**A**
***Issue*:** Process in place to address KPI's for Endoscopists, information held with Clinical Lead.	

5. Appropriateness	
RGH	**PCH**
B	**B**

6. Results	
RGH	**PCH**
C	**C**
Issue: PCH – results go to the referrer only RGH – results go to the Endoscopists for their action and to the referrer for information.	

7. Respect & Dignity	
RGH	**PCH**
A	**D**
Issue: PCH cannot achieve B due to environmental issues – separation of pre & post procedures.	

8. Consent Process including Patient Information	
RGH	**PCH**
A	**C**
Issue: PCH – needs 2 stage consent for high risk procedures	

9. Patient Environment & Equipment	
RGH	**PCH**
A	**C**

Issue: PCH – Environmental Issues

10. Access & Booking	
RGH	**PCH**
B	**C**
Issue: In-patient procedures vetted & performed within 48 hours (evidence required)	

11. Productivity & Planning	
RGH	**PCH**
C	**C**
Action: Annual Report on Endoscopy required.	

12. Aftercare	
RGH	**PCH**
D	**D**
Action: Require information for A&E for the management of complications following Endoscopic procedures.	

13. Patient Involvement	
RGH	**PCH**
B	**B**

14. Teamwork	
RGH	**PCH**
C	**C**

Action: Require agreement and information on Team Ethos.

15. **Workforce & Delivery**	
RGH	**PCH**
D	**D**
Action: Completion of Skills Matrix and subsequent development of Action plan to address skills gaps.	

16. ***Professional Development***	
RGH	**PCH**
B	**C**
Issue: QA process to ensure competence of bank / locum staff (need to add section in Operational Policy)	

17. ***Environment, Training Opportunity & Resources***
18. ***Trainer Allocation & Skills***
19. ***Assessment & Appraisal***

Appendix 4. Action Plan – Operational Policy Development

Item for Action	Action Required	By Whom	Completion date	Comments
Management of diabetes	Needs updating & agreement from Diabetes Team.	JH /JP / DM	21/11/17	**Update 19/12/17** JH emailed Dr P Owen to request support from Diabetes team. Gaynor Harrison nominated as link for Diabetes team. (see email embedded)  RE Diabetic policy for endoscopy.msg
Anticoagulation including NOACS	Needs agreement between Cons for regime / BSG Guidance	NH / JH / PN	**Update 19/12/17** JH emailed Consultant Gastroenterologists for their views (see email embedded)  DOAC and anticoagulation pol	Procedures need to be considered: Barrett's IBD biopsy surveillance
Anti platelet agents	Consultant Gastro discussion re which Guidance to use - BSG	NH / JH / PN/ JP / DM	21/11/17 Updated 19/12/17 JH emailed Consultant	Possible discussion needed with Cardio & Haem

	guidance or CTUHB guidance Amend Patient Info leaflet to reflect potential risks from alteration to anti platelet treatment	JP/DM	Haematologist for their input (see email embedded)  Anti-platelet policy endoscopy.msg	
Antibiotic Use	Adopt BSG Guidance		21/11/17	
Implantable Devices	Needs writing and discussion with Cardiology Team / Physiologists	NH / JH / PN	**To be agreed Update 19/12/17** Meeting held with Cardiac physiologist lead & Lead Nurse for Cardiology and plan agreed. (please see email embedded)  RE ICD Endoscopy .msg	
Policy for Consent Withdrawal	Needs updating		21/11/17	Consent Audit

Training Policy	Have some information relating to Nurses that needs updating. Need to establish what is in place for Endoscopists.	JP/DM NH/ES/MF	28/11/17 **To be agreed**	GRS – Nurse mentorship Nursing Matrix for endoscopy procedures.
Plan for OOH Bleeds	To be confirmed			
System for Document Management	EUG / ESG	NH	**To be agreed**	
EUG / ESG	• Terms of Reference • Standard Agenda • Data noted in CQ2.4 ○ Data to support that 75% of patients admitted with acute upper gastrointestinal bleeding who are haemodynamically stable receive endoscopy within 24 hours of admission.	NH	**To be agreed** **Update 19/12/17** ESG Meeting held 05/12/17 Standard Agenda agreed (please see embedded doc).  Agenda 05 12 17.docx	

	○ Data to support that 50% of the quality measures in the 2013 NICE guidelines for acute upper gastrointestinal bleeding with supporting action plan. • M&M meeting Feedback • Patient Survey Feedback • D&C data from weekly meetings		Terms of Reference in the process of being re-written. Meeting Schedule for 2018 arranged (please see embedded doc) Endoscopy Meeting Schedule 2018.docx	
Business Plan	Refer to IMTP			
Roles and responsibilities for reporting any kit or decontamination failure and management.	Section to be written	JP/DM	21/11/17	
Section on safety monitoring,	Section to be written	JP/DM	21/11/17	

reporting and escalation.				
Vetting practices for inpatient procedures		NH/JH	**To be agreed**	

Joint Advisory Group (JAG) Accreditation- Endoscopy Follow up

Internal Audit Report
2018/19

Cwm Taf University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditors:	Emma Samways Elizabeth Vincent Sian George

Executive sign off:	John Palmer- Interim Chief Operating Officer
Distribution:	Collette Kiernan – Directorate Manager, Medicine, Outpatients and Medical Records
Committee:	Audit Committee

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared in accordance with the Internal Audit plan and Charter, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cwm Taf University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction

The follow-up review of Joint Advisory Group (JAG) Accreditation-Endoscopy was completed in line with the 2018/19 Internal Audit plan for Cwm Taf University Health Board (the 'Health Board').

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

The original Joint Advisory Group Accreditation Internal Audit report was finalised in January 2018 and highlighted a total of seven issues which resulted in an overall assurance rating of Limited Assurance.

2. Scope and objectives

The overall objective of this review was to provide the Health Board with assurance regarding the implementation of the agreed management responses from the Joint Advisory Group Accreditation review that was undertaken as part of our 2017/18 work programme.

The scope of this follow up review does not aim to provide assurance against the full review scope and objective of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

The main areas that this review sought to provide assurance on are:

- Appropriate progress has been made with the implementation of the agreed management responses within the agreed timescales.
- Adequate evidence is available to support the level of progress that has been made.
- The actions implemented have effectively addressed the issues highlighted during the original audit.

3. Associated risks

The potential risks considered in this review were as follows:

- Poor governance arrangements and a lack of oversight.
- Accreditation criteria not achieved and supporting evidence not maintained.
- Services are not delivered in a safe and effective way.
- Reputational damage if accreditation status is not achieved.

4. Opinion

This review considers all recommendations made (high, medium or low priority). This follow-up review **does not** aim to provide assurance against the full review scope and objectives of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

Reasonable assurance	 Yellow	**Follow up** - Some high and medium level recommendations implemented and progress on the medium and low level recommendations.

The Health Board has made progress towards implementing the agreed recommendations from the original review. More defined governance arrangements are in place that provide the much needed managerial oversight. It is evident that a lot of work has taken place in drafting the Operational Policy and to map out the current position and the future work necessary to achieve accreditation. However, the department is still in a position where it is not collating the necessary evidence required to support it submission for accreditation.

We consider two of the original four high priority findings to have been fully implemented, with one partially implemented and one, relating to the retention of evidence on SharePoint, not yet implemented. There is demonstrable evidence of marked on-going progress of actions in respect of the two medium priority findings and the one low priority finding.

The progress made against six of the seven original recommendations and agreed actions means that the level of assurance that can be given to manage the risks associated with the Joint Advisory Group Accreditation (Endoscopy) is **Reasonable Assurance**.

5. Summary of audit findings

In summary, progress against the seven agreed recommendations that required implementation is as follows:

Priority rating	No. of recommendations to be implemented	Fully implemented	Partially implemented	Not implemented
High	4	2	1	1
Medium	2	1	1	-
Low	1	-	1	-
Total	**7**	**3**	**3**	**1**

The action plan within Appendix A provides full details of the findings, priority ratings and management responses from the original review, along with details of the current position, as verified by our follow-up work. Revised recommendations and priority ratings are included where necessary.

Evidence was provided to confirm that three of the seven agreed recommendations have been fully implemented and as such the related issues identified in our original review have been addressed. Action has been taken towards implementing a further three of the recommendations, and due to them being partially implemented has brought two down to a low priority, with one remaining a low priority.

One high priority recommendations has not been implemented, and remains as a high priority.

Original Finding 1 – Governance Structure (Control Design)	Original Risk
The Health Board has not developed formal governance arrangements or structures to oversee the JAG accreditation process. There is an appointed JAG lead who is a consultant gastroenterologist. However, the consultant is not solely responsible for undertaking all of the work required to achieve accreditation. We understand that a JAG working group meets every two weeks via video conference across the PCH and RGH sites to progress the work required for accreditation. A number of staff attend these meetings and are involved in implementing changes, gathering and maintaining evidence, and completing self-assessments. However, the roles and responsibilities of the group and individuals, and their contribution to achieving accreditation and accountability within the process, has not been formalised in a terms of reference. While minutes for the group were provided to us for the period June 2016 to January 2017, we had not received any further minutes at the completion of our audit fieldwork. As such, there is no formal record of attendees or the key points discussed. In addition, there is no mechanism in place to ensure that the accreditation questions and standards, once believed to be completed, are reviewed and signed off by an appropriate officer.	Poor governance arrangements and lack of oversight.
Original Recommendation 1	**Original Priority level**
Management must develop a governance structure for the JAG accreditation process that clearly sets out the terms of reference for the JAG working group, the roles and responsibilities of individuals and the accountability of all parties.	**High**

Original Management Response 1	Original Responsible Officer/ Deadline
The JAG accreditation group will report to the newly reconvened Endoscopy steering group, which in turn will be reported at the monthly directorate combined governance group and CBM. An annualised schedule of meetings has been arranged and can be seen in Appendix 1. The terms of reference for this group will be discussed at the January meeting. The progress of work in relation to accreditation questions and standards will also be reviewed in the JAG accreditation group, signed off by the chair and reported as feedback from that meeting as described above. There has also been a Morbidity and Mortality Group established since December 2016 which will report via the same mechanism as the JAG accreditation group. The Terms of reference for this group are already in existence, and can be seen in Appendix 2.	Endoscopy steering group reconvened December 2017 - chair and responsible officer Dr Neil Hawkes JAG accreditation group – continues to meet fortnightly, Chair and responsible officer Dr Neil Hawkes Morbidity and Mortality Group – established and meets monthly, Chair and accountable officer Dr Peter Neville

Current Position
A more defined governance structure is now in place. Since December 2017 the Endoscopy Steering Group has reconvened and minutes of the meetings confirm that JAG accreditation status is discussed. A terms of reference for the JAG working group has been developed, outlining the remit of the group, its membership, frequency of meetings and quorum. However, we could not determine that the Endoscopy Steering Group had approved the Terms of Reference for the JAG accreditation group. As such, due to not being able to determine that the Terms of Reference have been approved, we consider this action to be **partially implemented**. However, as a consequence of the progress that has been made to date, the priority of this recommendation has been **re-assessed as a low priority**.

Updated Recommendation 1	Updated Priority Level
Approval of the Terms of Reference for the JAG working group should be documented to ensure it has been approved by an appropriate group or committee.	**Low**
Updated Management Response 1	**Updated Responsible Officer / Deadline**
This was completed in February 2018 meeting however it is acknowledged that the minutes do not acknowledge the different Terms of Reference that were discussed and approved. This will be revisited in the next Steering Group meeting on 7 August 2018 for completeness.	Senior Nurse Medical Specialities August 2018

Original Finding 2 – Reporting Mechanisms (Control Design)	Original Risk
There is no defined reporting structure in place to monitor the JAG accreditation process or to escalate any issues regarding the accreditation process within the Acute Medicine and A&E Directorate. We would expect progress in relation to JAG accreditation to be reporting to one of the operational groups within the directorate. However, the Endoscopy Steering Group meeting, which would appear to be the most appropriate forum for discussion, has not met for over a year, although we acknowledge that there is common membership with the JAG working group. In addition, we could not evidence that JAG accreditation progress and monitoring gets reported at other groups or committees within the directorate such as the Gastro Steering Group or the Acute Services Quality and Safety meetings.	Poor governance arrangements and lack of oversight.
Original Recommendation 2	**Original Priority level**
Management should ensure that there is a clear reporting structure in place within the Acute Medicine and A&E directorate to make sure there is a suitable level of oversight regarding progress in achieving accreditation status and that there is a suitable level of challenge where progress is lacking. Regular monitoring against all the standards needs to take place to ensure they are not compromised once the objective has been achieved.	**High**

Original Management Response 2	Original Responsible Officer/ Deadline
The Endoscopy Steering Group has been reconvened with an annual calendar of meetings already arranged for 2018. This group will report to the Directorate monthly combined Governance Group and also be reported as a standard item on the medicine directorate CBM on a monthly basis. A plan of meetings for the Endoscopy steering group has been established have a terms of reference.	As above in Finding 1 response
Current Position	
The Endoscopy Steering Group reconvened in December 2017, and the new reporting structure is in line with the group's Terms of Reference. We also note regular monitoring against the standards is now taking place. As such, we consider this action to be **fully implemented.**	

Original Finding 3 – Action Plan (Control Design)	Original Risk
We note that there is no overall project plan to oversee the necessary actions needed to achieve accreditation status, and no date has been set by which the service wants to be accredited. We were informed by the Directorate Support Manager that a decision had been made to focus on the standards linked to the timeliness of service delivery, which we understand is a critical governance, quality and safety requirement for patient care within the Health Board. We understand that these standards may take longer to implement and targets have to be achieved for a number of months before accreditation status can be applied for. However, there is no record of this decision being made. During the fortnightly JAG working group meetings, an action plan that focuses mainly on the timeliness of the service delivery is discussed. However, as there has been a focus on the 'timeliness' standards, the action plan does not make reference to the other standards required for accreditation. We reviewed a sample of action plans for the period June to August 2017. Although there was a specific lead identified for each action, no timescales had been allocated against them and there was no clear reference to the domain or relevant accreditation standard. The lack of an overall plan means effective monitoring of progress cannot take place.	Services are not delivered in a safe and effective way.

Original Recommendation 3	Original Priority level
Management should ensure that a project plan is in place that incorporates all the actions that are required to meet the JAG accreditation status by a required date. Each action identified should include reference to the domains and standards that it refers to, an identified lead, and the timescale for completion.	**High**
Original Management Response 3	**Original Responsible Officer/ Deadline**
There has been significant progress made on the timeliness of delivery of the service over the last year, not just in preparation for an improved position for JAG accreditation but to improve the quality of service for our patients. In addition, there has also been the development of a delivery plan for each site for JAG accreditation which is a live document for each site that is maintained via each JAG accreditation meeting. Within the plan each domain and progress is clearly shown. These plans will be used as the foundation for each JAG accreditation meeting. It will be used to focus the agenda and report progress.	Demand and Capacity, waiting times management – Ruth Morrissey, continual. JAG accreditation plan - Neil Hawkes & Carolyn John, in place and being used.
Current Position	
A comprehensive monitoring spreadsheet is in place listing the domains and highlighting those that still require action to ensure completion. Linked to this spreadsheet is an action plan outlining the work required for completion and a named lead. While we note that timescales still need to be put in place, sufficient progress has been made, and we consider this recommendation to be **fully implemented**.	

Original Finding 4 - Evidence to support compliance with standards (Control Design)	Original Risk
We tested a sample of two completed questions from eight standards: four from the endoscopy unit at PCH; and four for the unit at RGH, to see if there was appropriate evidence retained to support the conclusion that the question has been completed. While two pieces of evidence requested from PCH, were not provided at the time of the audit, evidence was provided to support the assessment against the standards in the remaining 14 areas. However, we note that none of this information had been uploaded onto SharePoint, the system that is used by the Health Board to store the evidence necessary for JAG accreditation. From our discussion with staff we understand that there are a number of underlying reasons why SharePoint is not well used, these are: • The process of gathering and uploading evidence to support the questions within the standards can be time consuming, and the lead nurses at each unit are responsible for undertaking this role alongside their main duties. • In 2016 JAG amended the domains and standards which meant the original folders that were created within SharePoint were no longer valid. New folders were created to address these changes but staff are unclear which are the correct folders to use. • It is unclear who has access to these folders. Therefore, staff are reluctant to upload evidence that contains patient information as there is a risk that confidentiality may be breached.	Accreditation criteria not achieved and support evidence not maintained.

Original Recommendation 4	Original Priority level
Management should review the current system for uploading information onto SharePoint. The current file structure, access rights, and information within SharePoint should be reviewed and revised as necessary. Evidence collated to support the achievement of the standards should be stored in a consistent way and evidence that can be used for both units it is identified to prevent duplication of work. Sufficient resource should be allocated to allow a full assessment of the required evidence and gathering and uploading of that information to SharePoint.	**High**
Original Management Response 4	**Original Responsible Officer/ Deadline**
Availability of corporate support is being sourced following meetings with the directorate and Chief Operating Officer. This support will enable the scanning and uploading of evidence once a new shared portal is established on SharePoint which will mirror the new and updated domains. This is an element of work which will be captured on the plan with progress reported as outlined in the sections above (in finding 1 and 2).	COO / Collette Kiernan (DM) - March 2018
Current position	
Whilst the current folder structure and access rights within SharePoint have been reviewed and revised as necessary, no further work has been undertaken. The collation of evidence to support achievement of the standards is still ongoing, with very little information saved into SharePoint.	

Little progress has been made to update evidence to SharePoint, and as such we consider this action to be **not implemented** and therefore **remains a high priority**.	
Updated Recommendation 4	**Updated Priority Level**
Evidence collated to support the achievement of the standards should be stored in a consistent way and evidence that can be used for both units is identified to prevent duplication of work. Sufficient resource should be allocated to allow a full assessment of the required evidence and gathering and uploading of that information to SharePoint.	**High**
Updated Management Response 4	**Updated Responsible Officer / Deadline**
The team has established JAG folders on a shared drive with access by key staff to enable the supporting information to be saved. The team are in the process of allocating specific areas of the GRS to individuals to lead on to avoid duplication and maximise the resources available. The team acknowledge that this is the next phase that needs considerable work and this will be the focus for the next three months. Progress with uploading evidence has already started ahead of schedule with minutes, action plans and GRS overviews already available electronically. Evidence in hard copy is also now available for a number of areas which is awaiting scanning and upload. Considerable progress has been made. The SharePoint site has now been established, with responsibility for specific sections being held by a number of individuals within the service. The list of responsible nursing staff is shown below. The medical responsibilities for the	JAG accreditation group – for oversight. End September 2018

remaining sections will be agreed on 28 June in the JAG accreditation meeting. It was felt that distributing this responsibility would ensure that the repository is maintained despite potential staff absence. The oversight of this will be managed via the JAG accreditation group. Nursing Workforce - Carolyn John Nurse Training - Ceri Holmes and Rachel Rees Dignity and privacy - Diane Morgan and Jacqui Price Patient Feedback, Audit and Patient Participation - Diane Morgan Environment and decontamination - Jacqui Price	

Original Finding 5 - Scoring the GRS self-assessment (Operating effectiveness)	Original Risk
To obtain JAG accreditation the Health Board has to be able to demonstrate a minimum of one year participating in the Global Rating Scale (GRS) self-assessment, and performing at the agreed GRS levels required for accreditation. Each GRS self-assessment is completed on-line via the JAG accreditation system. Scoring is based on an A-D system, with grade 'B' being the minimum score required for each question under a standard to achieve accreditation. The PCH and RGH endoscopy units are not consistently maintaining the same level of scoring when completing the GRS self-assessments. If the units are to achieve JAG accreditation status, there should be a continual improvement in scores between each self-assessment. Our review of the last two self-assessments undertaken by each unit identified: PCH - Between April and October 2016 For 7 out of 19 standards the scoring level has remained the same. • For 7 out of 19 standards the scoring level has improved. • For 5 out of 19 standards the scoring level has decreased. As at October 2016; 7 out of 19 had achieved the required scoring level of 'B' and above. RGH – Between October 2016 - April 2017 • For 5 out of 19 standards the scoring level has remained the same. • For 14 out of the 19 standards the scoring level had decreased. Nine of these were originally scoring as an 'A' grade but have been downgraded to 'D's' and 'C's'.	Services are not delivered in a safe and effective way.

As at April 2017 three out of 19 have achieved the scoring level of 'B'. As at October 2016 the endoscopy unit in PCH had achieved 37% of the standards scoring a level 'B' and above, whereas in April 2017 RGH had only achieved 16%.	
Original Recommendation 5	**Original Priority level**
Management should review and understand why the scoring rates have decreased when comparing the GRS self-assessment to the previous submissions. Action plans should be created to address the short comings, which must include realistic timescales and persons' responsible. Failure to comply with the action plan should be challenged by management.	**Medium**
Original Management Response 5	**Original Responsible Officer/ Deadline**
Self-evaluations that were submitted in October 2017 have been reviewed and compared and moving forward for the April 2018 submission there are plans that each site will undertake the review independently and then this will be peer reviewed by the alternative acute site to ensure consistency in approach and to give assurance prior to submission. The most recent review shows the deficits in each domain that are not at level B (the required standard) and therefore informs the overall action plan for achieving accreditation. This review document can be seen in Appendix 3.	In Place; Dr Neil Hawkes – RGH Dr Jo Hurley – PCH Next Review April 2018

Current position	
The monitoring of the achievement of each standard within each domain and any changes, is happening on a monthly basis and not just at the time of GRS submission. This monitoring is linked to the action plans that are produced and these are discussed and monitored at the JAG steering group and Endoscopy Steering Group. As such, we consider this action to be **fully implemented**.	

Original Finding 6 – Operational policy (Operating effectiveness)	Original Risk
An endoscopy operational policy is required to achieve JAG accreditation. In September 2017 the directorate began drafting a policy document. We understand that the Health Board has identified that the policy will require significant work to ensure that it meets the necessary standards for JAG accreditation. We understand that currently there is no timescale in place for the completion of the review of this policy and its associated documents.	Services are not delivered in a safe and effective way.
Original Recommendation 6	**Original Priority level**
Management must agree a timescale for the completion of the operational policy review. Progress against the policy and the supporting appendices should be discussed in the appropriate endoscopy working group or steering group. Once policies and appendices have been updated they need to be appropriately approved.	**Medium**
Original Management Response 6	**Original Responsible Officer/ Deadline**
The directorate now have a formalised action plan relating to the development and completion of the operational policy. The plan gives structure and clarity around what is still required for completion of this significant document. This plan can be seen in Appendix 4.	Action Plan is in place and significant progress has been made. This work is led by Dr Jo Hurley, target completion date February 2018.

Current position	
The Operational Policy and supporting appendices have been drafted although final approval is still to take place as the consultants within the directorate are required to read the policy and confirm their acceptance. This is due to take place by the end of June 2018. As such, we consider this action to be **partially implemented**. As a consequence of the progress that has been made to date, the priority of this recommendation has been **re-assessed as a low priority**.	
Updated Recommendation 6	**Updated Priority Level**
Review by the relevant consultants of the supporting appendices to the Operational Policy should be completed as soon as practically possible to allow for final approval of the Operational Policy.	**Low**
Updated Management Response 6	**Updated Responsible Officer / Deadline**
Lead clinician is aware of the need to complete this piece of work as promptly as possible, with virtual agreement to be sought prior to the Gastro Strategy Group meeting in July where this will be formally signed off (As Endoscopy steering group is not scheduled until August).	Consultant Gastroenterologist July 2018

Original Finding 7 – Completion of GRS self-assessments (Control design)	Original Risk
The Health Board currently completes GRS self-assessments every April and October although JAG guidance suggests quarterly returns. Within the GRS system a clinical lead and nurse manager are set up to complete the self-assessments at each site. However, we note that different people undertake the self-assessments at the two sites leading to potential inconsistencies. Furthermore, during our fieldwork we noted one instance where the six-monthly GRS self-assessment had not been completed as both the clinical lead and the endoscopy nurse at PCH were not available. Given the lack of governance arrangements, there is no protocol in place to address this issue should both leads be unavailable at the time the assessment needs to be completed.	Poor governance arrangements and a lack of oversight.
Original Recommendation 7	**Original Priority level**
Management should ensure that the GRS self-assessments are completed when required and a protocol in place to address the problem should the appropriate staff not be available to complete the assessments. Furthermore, ensuring the same people undertake the assessments at both units provides the Health Board with an opportunity to remove inconsistencies across the units.	**Low**

Original Management Response 7	Original Responsible Officer/ Deadline
A plan has been put in place for cross site peer review of the GRS self-assessments prior to submission which should achieve improved consistency and assurance across the Health Board.	Dr Jo Hurley and Dr Neil Hawkes. Will be delivered for April 2018 submission.
Current position	
Whilst the practice of completing the GRS collectively has commenced to ensure consistency of scoring, a protocol has not yet been developed to aid consistent completion should staff not be available. As such, due to the lack of protocol for addressing the issues of staff not being able to complete the assessment, we consider this action to be **partially implemented**. As a consequence of the progress that has been made to date, the priority of this recommendation **remains as a low priority**.	
Updated Recommendation 7	**Updated Priority Level**
A protocol should be put in place to address the problem should the appropriate staff not be available to complete the GRS assessments.	**Low**
Updated Management Response 7	**Updated Responsible Officer / Deadline**
A protocol will be written, discussed and minuted at the next Endoscopy Steering group meeting on 7 August 2018.	Senior Nurse Medical Specialties August 2018

Audit Assurance Ratings

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

Follow up - All recommendations implemented and operating as expected.

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

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

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

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

 **No Assurance** - The Board 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.

Follow up - No action taken to implement recommendations.

Prioritisation of Recommendations

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

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

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.1** **15 July 2019**

Audit Committee Report
'DRAFT' AUDIT COMMITTEE ANNUAL REPORT 2018-2019

Executive Lead: Director of Corporate Services & Governance / Board Secretary
Author: Director of Corporate Services & Governance / Board Secretary
Contact Details for further information: Robert Williams 01443 744800 or email Robert.Williams@wales.nhs.uk

Purpose of the Audit Committee Report
To purpose of this report is inform the Board of the work undertaken by the Audit Committee, and how it met its Terms of Reference during 2018-2019, and to request that members of the Committee complete the self-assessment questionnaire to provide a view on the effectiveness of the Committee.

Governance	
Link to Health Board Strategic Objective(s)	The Board's key role is to ensure its Strategy 'Cwm Taf Cares' and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed, these in summary align with: – To **improve** quality, safety and patient experience. – To **protect** and **improve** population health. – To **ensure** that the services provided are accessible and sustainable into the future. – To **provide** strong governance and assurance. – To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The report focuses on providing strong governance and assurance.
Supporting evidence	• The work of the Audit Committee throughout 2018-2019 – web link http://cwmtaf.wales/how-we-work/audit-committee/ • NHS Audit Committee handbook • Head of Internal Audit Opinion and Annual Report 2018-2019 presented to the Audit Committee on 30 May 2019
Engagement – Who has been involved in this work?	
Audit Committee Members, Internal and External Auditors	

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Audit Committee Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	
Recommendation	The Audit Committee is asked to: • **DISCUSS** and **ENDORSE** the draft Audit Committee Annual Report for 2018-2019 for approval by the Health Board; • **ENDORSE** the Terms of Reference for Board approval. • **DISCUSS** the attached self-assessment checklist at Appendix 3 for completion at the meeting.						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	No adverse equality and diversity issues have been identified. The reports submitted to the Committee throughout the reporting period would have considered the potential impact concerning equality and diversity for each subject matter						
Legal implications	This report complies with the requirement to submit an annual report to the Board through the Chair within 3 months of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.						
Population Health	No impact.						
Quality, Safety & Patient Experience	The Quality and accuracy of information presented to the Audit Committee is important to support and enable them to make fully informed decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.						
Resources	No impact.						
Risks and Assurance	This report provides an assurance to the Board that the Audit Committee is effectively monitoring the risks relating to the work of the Health Board.						
Health & Care Standards	The Audit Committee annual report demonstrates compliance with the governance, leadership and accountability overarching principle of the quality themes and the work of the Committee actively contributed towards demonstrating compliance with all themes within the Health and Care Standards framework. Access to the Standards can be obtained from the following link: http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf						
Workforce	No impact.						
Freedom of Information Status	Open						

DRAFT

AUDIT COMMITTEE 'DRAFT' ANNUAL REPORT
2018-2019

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to highlight the activities and performance of the Audit Committee during 2018-2019 and to set out how it met its Terms of Reference.

2. BACKGROUND / INTRODUCTION

The Chair of the Audit Committee is required to present an annual report outlining the Audit Committee's business throughout the financial year to the Health Board to provide an assurance on the monitoring and scrutiny undertaken of CTUHB's performance in relation to finance, risk and governance.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The publication of the Annual report demonstrates compliance with the Standing Orders, which stipulates that each Board Committee / Advisory Group is required to submit an annual report to the Board through the Chair within three months of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

The Audit Committee Annual Report for 2018-2019 is presented at **Appendix 1** for endorsement before submission to the Health Board.

The revised Terms of Reference for the Audit Committee were received and endorsed by the Audit Committee in September 2017 and were subsequently approved by the Board on 1 November 2017. To ensure that there are effective governance arrangements in place for the Audit Committee the Terms of reference are reviewed on an annual basis and are presented at **Appendix 2** for approval. No material changes have been made to the document.

Members of the Audit Committee regularly review the effectiveness of the Committee through open and honest discussion at each meeting and to support the feedback process all members are requested to complete the Audit Committee Self-Assessment Checklist 2018-2019 (from the Audit Committee Handbook pages 53-63) presented for completion during the meeting at **Appendix 3.**

A breakdown of the internal audits results presented to the Audit Committee and the Board in 2018-2019 is presented at **Appendix 4** for information.

A breakdown of the Audit results for the Hosted Bodies presented to the Audit Committee and the Board in 2018-2019 is presented at **Appendix 5** for information.

4. RECOMMENDATION

The Audit Committee is asked to:

- **DISCUSS** and **ENDORSE** the draft Audit Committee Annual Report for 2018-2019 for approval by the Health Board;
- **ENDORSE** the Terms of Reference for Board approval.
  DISCUSS the attached self-assessment checklist at **Appendix 3** for completion at the meeting.

Freedom of Information Status	Open

DRAFT

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix 1

DRAFT

Audit Committee

Annual Report 2018-2019

AUDIT COMMITTEE
ANNUAL REPORT 2018-2019

1. FOREWORD

Following the end of Chris Turner's tenure in December 2018 and my subsequent commencement as Chair of the Audit Committee, I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2018-2019.

On behalf of the Committee, I extend our heartfelt thanks to Chris Turner for his direction and leadership during his tenure, and wish him well with his ongoing commitments.

During the year, both Chris Turner and I have been greatly supported by both Maria Thomas and Jayne Sadgrove, who have contributed their considerable knowledge and wide-ranging experience to the Committee. It was also my pleasure to welcome our new Independent Member, Dilys Jouvenat to the Audit Committee.

I would like to express my sincere thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by the Internal Audit team at the NHS Wales Shared Services Partnership (NWSSP) and by the Wales Audit Office (WAO).

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long term aim to help further strengthen the governance arrangements of the Health Board.

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Paul Griffiths
Chair of the Audit Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The Committee's business cycle runs from the closure of the Annual Accounts in one financial year to the next. This reflects its key role in the development and monitoring of the Governance and Assurance framework for Cwm Taf UHB, which culminates in the production of the Annual Governance Statement.

The Terms of Reference for the Committee were reviewed and were formally approved by the Board in July 2018.

Members will be aware that all papers relating to the Committee (unless closed or 'in-committee') are available on the Health Board website: http://cwmtaf.wales/how-we-work/audit-committee/

This report sets out the role and functions of the Audit Committee and summarises the key areas of business undertaken during the year. In addition, the report sets out some of the key issues, which the Committee will be focussing on over the next few years.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Committee is to advise and assure the Board on whether there are effective arrangements in place – through the design and operation of the Health Board system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Organisation's system of internal control has been designed to identify the potential risks that could prevent Cwm Taf Morgannwg UHB achieving its aims and objectives. It evaluates the likelihood of the risks being realised, considers the impact should they occur, and seeks to manage them efficiently, effectively and economically. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, the assurance framework may be strengthened and developed further.

The Committee's Terms of Reference are reviewed annually and are included within the Standing Orders for the Cwm Taf Morgannwg UHB.

3.2 MEMBERSHIP

The membership of the Audit Committee comprises of four Independent members, enabling the Committee to provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2018-2019 is outlined in table 1 below:

Table 1 – Composition & Membership if the Audit Committee Apr-March 2019

Name	Period
Members	
Chris Turner (Chair & WHSSC Audit lead) Independent Member	Apr 2018 – Dec 2018
Maria K Thomas Independent Member	Apr 2018 - Mar 2019
Jayne Sadgrove Independent Member	Apr 2018 - Mar 2019
Paul Griffiths (Chair from Apr 19) Independent Member	Nov 2018 -Mar 2019
Dilys Jouvenat	Aug 2018 – March 2019
Executive Members In addition to the members, the following also attended Committee meetings during the 2018-2019:	
Director of Corporate Services & Governance / Board Secretary	
Director of Finance & Procurement	
Representatives of Internal Audit & Assurance (NHS Wales Shared Services Partnership)	
Representatives of External Audit (Wales Audit Office)	
Local Counter Fraud Specialist (LCFS)	
Head of Corporate Services / Interim Board Secretary	
Health Board Chair and Chief Executive (Accounts meeting only)	
Chair and Managing Director of Specialised Services	
Chief Ambulance Services Commissioner	
Other Executive Directors and senior staff as required for specific agenda items.	

3.3 ATTENDEES

The Committee's work is informed by reports provided by the Wales Audit Office (WAO), Internal Audit, Local Counter Fraud Services and Cwm Taf CTUHB personnel. Although they are not members of the Committee, auditors and other key personnel are expected to attend each meeting of the Audit Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed by the Audit Committee.

3.4 ATTENDANCE AT AUDIT COMMITTEE 2018-2019

During the year, the Committee met on seven occasions, one of which (31 May 2018) was devoted to scrutiny of the Annual Accounts. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2018-2019

In Attendance	16 April 2018	8 May 2018	31 May 2018	9 Jul 2018	8 Oct 2018	12 Jan 2019	11 Feb 2019	Total
Committee Members								
Chris Turner (Chair to Oct 2018)	✓	✓	✓	✓	✓			**5/5**
Maria Thomas – Independent Member	✓	✓	✓	✓	✓	✓	✓	**7/7**
Jayne Sadgrove (née Dowden) – Independent Member	✓	✓	✓	✓	✓	✓	X	**6/7**
Paul Griffiths - Independent Member (Chair from Jan 2019)	✓	✓	✓	✓	✓	✓	✓	**7/7**
Dilys Jouvenat (from Aug 2018)					✓	✓	✓	**3/3**
Wales Audit Office								
Audit Team Representative	✓x2	✓x2	✓x2	✓	✓	✓x2	✓x2	**7/7**
NWSSP Audit Service								
Head of Internal Audit for the Committee	✓x3	✓	✓x3	✓x3	✓x2	✓x4	✓x5	**7/7**
Counter Fraud Services								
Local Counter Fraud Specialist	✓	X	X	✓	✓	✓	X	**4/7**
Cwm Taf CTUHB								
Marcus Longley Chair	✓	X	✓	✓	✓	X	X	
Allison Williams, Chief Executive	X	X	✓	X	X	X	X	
John Palmer Chief Operating Officer	✓	X	X	X	X	✓	✓	**3/7**
Ruth Treharne Deputy Chief Executive	✓	X	✓	X	X	X	X	
Jo Davies Director of Workforce & OD	✓	X	X	X	X	✓*	X	
Steve Webster Director of Finance & Procurement	✓	✓	✓	X	✓	✓	✓	**6/7**
Huw Evans Head of Corporate Finance	✓	✓	✓	✓	✓	✓	X	**6/7**
Robert Williams Board Secretary/Dir Corporate Services & Governance	✓	✓	✓	✓	X	X	X	**4/7**
Miss G Roberts Head of Corporate Services	X	X	✓	X	✓	✓	X	**3/7**
WHSCC/EASC								
WHSCC	✓x2	✓x2	✓x4	✓x2	✓x2	✓x2	X	**6/7**
EASC	X	✓	✓	X	X	X	X	**2/7**
OBSERVERS								
OBSERVERS	✓	✓x2	✓	X	X	X	X	

✓* - denotes a suitably appointed Deputy was in attendance
✓** - denotes Board Secretary/Director of Corporate Services & Governance representing

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4. AUDIT COMMITTEE BUSINESS

The Audit Committee provides an essential element of the Health Board's overall assurance framework. It has operated within its Terms of Reference in accordance with the guidance contained within the NHS Wales Audit Committee Handbook.

The Audit Committee agenda broadly follows a standard format, comprising of specific sections, which are outlined below:

4.1 Main Areas of Audit Committee Activity – Part 1

The agenda for each meeting followed a standard format, broken down into the following 5 main parts:

1. Preliminary Matters

This included the apologies for absence, welcome and introductions, declarations of interest, receiving and approving the unconfirmed minutes of the last meeting and receiving the action log.

2. Internal Control and Risk Management

The following standard written reports were received by the Audit Committee and considered accordingly:

- Draft 2017/18 Annual Accounts
- CEO Draft Accountability Report including Remuneration Report
  Report on WHSSC/EASC Financial Statements 2017/18
- WHSSC Annual Governance Statement 2017/18
- EASC Annual Governance Statement 2017/18
- Report on Financial Accounts of the UHB 2017/18
  - Final Draft Annual Accounts 2017/18
  - Final Draft Remuneration Report
  - Audit of the Financial Statements (ISA 260) Draft Report
- Cwm Taf UHB Accountability Report 2017/18
- Head of Internal Audit Opinion and Annual Report 2017/18
- Response to the Audit Enquiries Checklist 2017/18
- Procurements and Scheme of Delegation Report
- Audit Recommendations Tracker
- Losses and Special Payments Report
- Standard of Behaviours Report
- Clinical Audit & Effectiveness Plan 2018/19 (and summary progress against the 2017/18 plan)
- Annual report of the Audit Committee 2017/18 (including Self-Assessment Checklist & Review of the Committee Terms of Reference)
- Update on Internal Audit Recommendations Tracker
- WHSSC Corporate Risk Assurance Framework
- EASC Committee Risk Register
- Post Payment Verification Report
- Wales Audit Office Closure Report – Review of Public Health Wales

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3. Charitable Funds

Standard reports were received in respect of activity and balances held within charitable funds. The Audit Committee plays a key role in overseeing the management of charitable funds to enable the Board to carry out its responsibilities as Corporate Trustee to the Cwm Taf NHS Charitable Fund. In fulfilling this role, the Committee requested that management constantly review the use of Funds and review those funds with little or no movement.

During the year the Committee monitored progress with its managed investment fund to maximise the charitable income received, within agreed ethical investment boundaries.

Charitable Fund balances were received at the meetings held on the 16 April 2018, 9 July 2018, 8 October 2018, and the 14 January 2019.

4. Internal Audit

NHS Wales Shared Services Partnership are the appointed internal auditors to the Health Board and provide an update on progress against the internal audit annual plan of business at each meeting together with finalised reports for each area that was subject to audit.

Each report contained an assessment on the level of assurance provided. Follow-up action was agreed for recommendations raised, which informed future audit plans.

5. External Audit

The Wales Audit Office (WAO) provide an Audit Position Statement at each meeting, summarising progress against its planned audit work.

4.2. MAIN AREAS OF AUDIT COMMITTEE ACTIVITY – PART 2 HOSTED BODIES

Welsh Health Specialised Services Committee (WHSSC)

Emergency Ambulance Services Committee (EASC)

As the host organisation, WHSSC and EASC (the latter established in April 2014) rely on Cwm Taf University Health Board (CTUHB) for its Audit Committee function, following a review and restructuring of its arrangements during 2013.

To support the Audit Committee requirements for the both EASC and WHSCC the Health Board's Audit Committee is separated into two parts, specifically Part 1 for Health Board business and Part 2 for the Hosted bodies. The relevant officers attend for the relevant components of the meeting.

Paul Griffiths, Independent Member and Chair of the Health Board's Audit Committee undertakes the role of the "Audit Lead" for WHSSC and reports all matters relating to the audit function to the Joint Committee.

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The Director of Corporate Services and Governance / Board Secretary at Cwm Taf also attends both parts of the meetings.

The WHSSC and the EASC share the same external and internal audit teams and Local Counter Fraud Services (LCFS) with Cwm Taf CTUHB. All these factors enable Cwm Taf to take necessary assurances from the hosted bodies, particularly in relation to the Accounts and the Annual Governance Statement and vice-versa for areas carried out by Cwm Taf on behalf of WHSSC/EASC as part of its hosting responsibilities.

In March 2014, the Joint Committee's approved the revised Governance and Accountability Framework for both WHSCC and EASC including the Standing Orders. These were reviewed and updated during 2018/19.

4.3. WORK/ACTION LOG

In order to monitor progress and any necessary follow up action, in line with recognised 'house style' templates a work log is maintained to capture all agreed actions from the Audit Committee and Joint Committees. This provides an essential element of assurance both to the Committee and from the Committee to the Board.

5. INTERNAL AUDIT - OVERALL SUMMARY

In overall terms the Head of Internal Audit opinion, provided **Reasonable Assurance** to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the following assurance domains:

- Corporate Governance, Risk Management & Regulatory Compliance
- Strategic Planning, Performance Management and Reporting
- Finance Governance and Management
- Clinical Governance, Quality and Safety
- Information Governance and Information Technology (IT) security
- Operational services and functional management
- Workforce management
- Capital and Estates Management

However, the Capital Estates management domain was allocated 'limited assurance', as two out of the four reviews undertaken in the domain during the year were given a 'limited assurance' rating. These reviews related to water safety (draft report), and to the capital project for the redevelopment of Prince Charles Hospital.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements

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- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module
- Other assurance reviews, which impact on the Head of Internal Audit opinion including audit work performed at other organisations

 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.

In total, 34 audit reviews were reported to the Audit Committee during the year.

A breakdown of the internal audits results presented to the Audit Committee and the Board in 2018-2019 is presented at **Appendix 4** for information.

A breakdown of the Audit results for the Hosted Bodies presented to the Audit Committee and the Board in 2018-2019 is presented at **Appendix 5** for information.

A number of follow up audits were also undertaken within key assurance areas.

The following internal audit reports were received by the Audit Committee in:

April 2018

- Internal Audit Progress Report – Audit & Assurance Services
- Internal Audit Annual Audit Plan 2018/19
- Risk Management
- Performance Management Monitoring & Reporting
- Governance Arrangements for Hosted Bodies
- Information Management and Technology Strategy
- Core Financials
- Scheme of Delegation
- WAST Handover of Care at Emergency Departments

8 May 2018

- Internal Audit Progress Report – Audit & Assurance Services
- E Rostering
- Private and Overseas Patients
- Governance Arrangements with Local Authorities and Third Sector
- Fire Management
- 'Draft' Head of Internal Audit Opinion and Annual Report 2017/18

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July 2018

- Internal Audit Progress Report – Audit & Assurance Services
- Directorate Review – Anaesthetics, Critical Care & Theatres – Management Arrangements
- Directorate Review – Anaesthetics, Critical Care & Theatres – Compliance
- Health and Care Standards
- Environmental Sustainability Reporting
- Annual Quality Statement
- Joint Advisory Group – Accreditation – Follow Up

October 2018

- Internal Audit Progress Report – Audit & Assurance Services
- General Data Protection Regulation (GDPR)
- Performance Management – Follow Up
- Carbon Reduction Commitment
- Governance Arrangements of Board Committees
- Directorate Reviews – Facilities – Compliance
- Draft – Directorate Reviews – Facilities – Management Arrangements
- WHSSC Internal Audit Report – High Cost Drugs
- WHSSC Internal Audit Report – Network Boards and Advisory Groups

January 2019

- Internal Audit Progress Report – Audit & Assurance Services
- Retention of Staff
- Directorate Reviews: Facilities – Management Arrangements
- Raising Concerns
- Wellbeing of Future Generations Act (Wales) 2015
- Continuing Healthcare
- EASC - Non-Emergency Patient Transport Follow Up

February 2019

- Internal Audit Progress Report – Audit & Assurance Services
- Internal Audit Report – Common issues identified within Directorate Reviews
- Management of Major Capital (CLOSED)
- Medical Equipment & Devices – Limited Assurance
- IT Systems
- Directorate Review – Primary Care Management Arrangements
- Mandatory Training
- Management of Absence Target
- Private & Overseas Management – Follow Up

During 2018-2019 one audit was deferred:

- Consultant Job Planning

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6. EXTERNAL AUDIT

6.1 Wales Audit Office (WAO)

The Wales Audit Office (WAO) provided a progress report at each meeting, covering both probity and performance audits. The audit strategy, audit letters and statements of responsibilities were received and the ISA260 report was approved as part of the Accounts approval process.

The following performance reports and management responses were also discussed during the year, with attendance from UHB Officers where considered appropriate:

- Wales Audit Office (WAO) Progress Report (at each meeting)
- Wales Audit Office Annual Report 2017
- Draft Structured Assessment Report 2017 and Management Response
- Wales Audit Office Annual Audit Plan for 2018/19
- Wales Audit Office Report and Management/Welsh Government Response – NWIS
- WAO Update on Progress with 2017/18 Accounts Audit
- Picture of Primary Care in Wales – National Report – Info only
- Wales Audit Office Review of Emergency Ambulance Services Commissioning (Closure Report)
- Wales Audit Office – Structured Assessment 2018
- Wales Audit Office – Primary Care Report
- Wales Audit Office – Annual Audit Report
- Wales Audit Office Report – All Wales Review on Follow Up Outpatients Not Booked
- Wales Audit Office – All Wales Review on Radiology Services
- Wales Audit Office – Recent Publication Agency Staff in Wales

6.2 Approval of the Annual Accounts

A special meeting of the Audit Committee was convened on 31 May 2018 to scrutinise the 2017-2018 Annual Accounts prior to approval by the Health Board including the letter of representation to Auditors and the Annual Governance Statement. The 2017-2018 Annual Accounts were scrutinised and approved by the Board on 31 May 2018. The meeting also scrutinised the Accounts and Statements for 2017-2018 from the Emergency Ambulance Services Committee (EASC) and the Welsh Health Specialised Services Committee (WHSSC).

7. PRIVATE MEETING WITH AUDITORS

In line with recognised good practice, a private meeting was held on the 16 April 2018, between Audit Committee members, Internal Audit, External Audit and the Local Counter Fraud Specialist. This provided an opportunity for free and frank discussion. No issues of concern arose from the meeting.

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8. LINKS WITH OTHER COMMITTEES

8.1 Other Sub Committees

The Audit Committee has close links with the Quality, Safety and Risk Committee and the three Committee Chairs meet with the Board Chair and Vice Chair, along with Chairs of other Board Committees, to form the Integrated Governance Committee. The Integrated Governance Committee met on three occasions during the period of this report, on the 26 April 2018, 30 August 2018 and the 20 December 2018. This ensured that the work of the three Committees supported each other and avoided duplication of effort.

The minutes of all Audit Committee meetings were included in the public Health Board papers and the Chair of the Audit Committee provided a report to the Board after each meeting.

9. LOCAL COUNTER FRAUD SERVICES

The work of the Local Counter Fraud Services is undertaken to help reduce and maintain the incidence of fraud (and/or corruption) within Cwm Taf Morgannwg UHB to an absolute minimum.

Regular reports were received by the Committee to monitor progress against the agreed Counter Fraud Plan.

As part of its work, the Counter Fraud Department has a regular annual programme of raising fraud awareness within the Health Board for which a number of days are then allocated and included as part of an agreed Counter Fraud Work-Plan which is signed off, by the Health Board's Director of Finance & Procurement, on an annual basis.

As part of that planned area of work, regular fraud awareness sessions are arranged and then held with various staff groups at which details on how and to who fraud can be reported are outlined.

In addition to this and in an attempt to promote an Anti-Fraud Culture within the Health Body, a quarterly newsletter is produced which is then available to all staff on the Health Board's Intranet and all successful prosecution cases are also publicised in order to obtain the maximum deterrent effect.

10. ASSURANCE TO THE BOARD

The Audit Committee provides an essential element of the overall governance framework for the organisation and has operated within its Terms of Reference and in accordance with the guidance contained in the NHS Wales Audit Committee Handbook.

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10.1 Internal Control & Risk Management - In addition to the audit reports received by the Committee during the reporting period, a wide range of internally generated 'governance' reports/papers were produced for consideration by the Audit Committee including, by way of example:

10.2 Annual Governance Statement - During 2018-2019, the Health Board produced its Annual Governance Statement, which explains the processes and procedures in place to enable the Health Board to carry out its functions effectively. The Statement was produced following a review of CTMUHB's governance arrangements undertaken by the Executive Board and the Board Secretary/Director of Corporate Services & Governance. The Statement brings together all disclosures relating to governance, risk and control for the organisation.

10.3 Tracking of Audit Recommendations - During the reporting period, the Committee gave specific attention to the audit results relating to new areas of activity and to areas of general concern. Nevertheless, the Committee has continued focus on the timely implementation of audit recommendations.

During the reporting period, the Committee reviewed ongoing progress against recommendations, and noted any areas of concern. The Committee explored the possible options for adopting a more sophisticated and user friendly tracker system for future use.

10.4 Audit Committee Effectiveness Survey - A Committee Effectiveness Survey was undertaken in 2018-2019 to obtain feedback from Committee members on potential areas for development.

The statements used in the survey were devised in accordance with the guidance outlined within the NHS Audit Committee Handbook.

11. CONCLUSION AND FORWARD LOOK

The Audit Committee in discharging its scrutiny and assurance role on behalf of the Board considers that on the basis of the risk based work completed by the Committee during 2018-2019, that there are effective measures in place **and that there are no outstanding issues that the Audit Committee wishes to bring to the attention of the Board.**

The Directors have been held to account and have responded positively in dealing with any concerns raised by the Auditors and the Audit Committee.

The Health Board is required by Welsh Government to remain within the:

- Revenue Resource Limit
- Capital Resource Limit

And both these targets were met.

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Overall, the financial performance of the Health Board represents a very significant achievement given the difficult financial environment in which the Health Board operates. Substantial savings have been delivered and expenditure has been appropriately controlled within the Board's objective of ensuring that the quality of care is a central part of the financial plan.

This Annual Report will be supplemented by the annual self-assessment questionnaire, which reviews the individual and collective function of the Committee against the NHS Audit Committee Handbook best practice guidance and helps to inform the work of the Committee going forward.

The Committee is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2019-2020in respect of:

- Strengthening the reporting and monitoring of top organisational risks (following discussion at a Board Development session in relation to the risk appetite of the Board and also comprehensively reviewing the risk register)
- Fully enacting and utilising the Board Assurance Framework
- Maintaining and strengthening the effectiveness of the Audit Tracker, including seeking and implementing best practice
- Discharging effectively the Board approved Committee Terms of Reference
- Reviewing the effectiveness of the application of the revised Standing Orders and Scheme of Delegation
- Monitoring the delivery of the Investment Strategy for Charitable Funds
- Improving the timeliness and completion of the Declarations of Interest forms for the organisation
- Ensuring all parties discharge their responsibilities appropriately as outlined within the Audit Charter
- Continue to strengthen processes and resources in place to prevent and respond to fraud activity.

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Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AUDIT COMMITTEE TERMS OF REFERENCE

INTRODUCTION

The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the organisation either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Audit Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

CONSTITUTION AND PURPOSE

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee).

The Committee is an independent member committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. The Committee will function in accordance with the NHS Audit Committee Handbook.

The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Welsh Health Specialised Services Committee and the Emergency Ambulance Services Committee. The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and hosted Committee business discussed and recorded separately.

The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

SCOPE AND DUTIES

Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurance, prior to endorsement by the Board;

- the structures, processes and responsibilities for identifying and managing key risks facing the organisation;

- the Board Assurance Framework;

- the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct and accountability requirements.

- the operational effectiveness of policies and procedures;

- the policies and procedures for all work related to fraud and corruption as set out in the National Assembly for Wales Directions and as required by NHS Protect and the Counter Fraud and Security Management Service.

- proposed changes to the Standing Orders, Standing Financial Instructions and Financial Control Procedures;

- the circumstances associated with each occasion where Standing Orders or Standing Financial Instructions are waived.

The Committee will also:

- Receive and determine action in response to the declaration of Board member and other officers interests in accordance with advice received from the Director of Corporate Services & Governance / Board Secretary;

- Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers;

- Review all losses and special payments;

- Retrospectively assure any purchase / expenditure above the delegated financial limit of the Chief Executive.

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Internal Audit

The Committee shall:

- consider the proposals for accessing internal audit services via a shared services arrangement (where appropriate), the audit fee and any questions of resignation and dismissal;

- review the internal audit programme, consider the major findings of internal audit investigations, ensure co-ordination between the Internal and External Auditors and ensure all management responses to recommendations are appropriate and timely;

- ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organization;

- assure itself that IA complies with the requirements of the public sector internal audit standards.

- Monitor the timely implementation by management of agreed audit recommendations.

Clinical Audit

- Ensure where appropriate and in line with the Audit Committee Handbook that the CTMUHB has a Clinical Audit Programme in place and the outcomes of Clinical Audit provide internal assurance to the Board.

External Audit

The Committee shall consider the work carried out by key sources of external assurance, in particular but not limited to the Health Board external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity.

The Committee will:

- from time to time, consider and make any necessary representations to the Auditor General for Wales on his appointment of an engagement partner;

- discuss with the External Auditor, in line with the agreed audit plan, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health economy and with Internal Audit;

- review External Audit reports, including value for money reports and annual audit letters, together with the management response;

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- Monitor the timely implementation by management of agreed audit recommendations;

- Receive a report from the Auditor General for Wales / Wales Audit Office on the results of his audit of the annual accounts before recommending adoption of those accounts to the Accountable Officer and the Health Board.

Financial Reporting

The Committee shall review the annual financial statements before submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices;

- major judgemental areas;

- significant adjustments resulting from the audit;

- compliance with legal requirements;

- review any material mis-statements identified during the Audit.

Charitable Funds

The Committee will:

- Ensure that the CTMUHB policies and procedures for charitable funds investments are followed and make decisions involving the sound investment of charitable funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with:
    - Trustee Act 2000
    - The Charities Act 1993
    - The Charities Act 2006
    - Terms of the fund's governing documents
    - Annual Reporting to the Trustees

- Receive at least twice per year reports for ratification from the Director of Finance on investment decisions and action taken through delegated powers upon the advice of the CTMUHB's investment adviser if appropriate.

- Oversee and monitor the functions performed by the Director of Finance and procurement as defined in Standing Financial Instructions.

- Monitor the progress of any associated Charitable Appeal Funds.

- Monitor and review the CTMUHB scheme of delegation for Charitable Funds expenditure and set and reflect in Financial Control Procedures the approved delegated limits for expenditure from Charitable Funds.

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AUTHORITY

The Committee is authorised by the Board to:

- investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the CTMUHB. It can seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee;

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements;

- by giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

MEMBERSHIP

The Committee shall be appointed by the Board from amongst the Non-Officer Members of the Health Board and shall consist of not less than 4 members.

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

The Health Board shall appoint the Chair of the Committee.

The Chair of the Health Board shall not be a member of the Committee.

The Director of Corporate Services & Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year, the Committee will meet privately with the External and Internal Auditors without any Executive Director or officer present. The opportunity to meet with Auditors privately will be available at each meeting.

The Chief Executive and Chair shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts. The Director of Finance for WHSSC and Committee Secretary will normally attend the meetings of the Audit Committee. The Director of Specialised and Tertiary Services and the Chair of the Welsh Health Specialised Services Committee shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts.

The Emergency Ambulance Services Commissioner and the Chair of the Emergency Ambulance Services Committee shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts.

Other Directors may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

The Health Board Local Counter Fraud Specialist will attend meetings of the Committee.

The Head of Internal Audit and the External Auditor shall have unrestricted direct access to the Chair of the Committee.

Member Appointments

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

The Independent Member who is the nominated Audit Lead for WHSSC and EASC must be a member of the Audit Committee.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

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

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- Co-ordinate the provision of a programme of organisational development for committee members.

COMMITTEE MEETINGS

Quorum

A quorum shall be two Independent Members one of whom must be the Chair or in the absence of the Chair, an Independent Member will be nominated to Chair the Committee.

Frequency of Meetings

Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

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The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

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

Circulation of Papers
The Director of Corporate Services & Governance / Board Secretary will ensure that all papers are distributed at least one calendar week in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports.

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the CTMUHB Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Corporate Services & Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

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RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

The Chair of the Audit Committee and the Director of Finance as the Executive Lead will meet with their counterparts on the Clinical Governance Committee, Corporate Risk Committee Finance & Performance Committee and the Mental Health Act Monitoring Committee as part of the Integrated Governance Committee on a quarterly basis to plan the agenda and agree what issues are being considered by each Committee and the timescales involved.

The Committee, through the Committee Chair and members, shall maximise cohesion and integration across all aspects of governance and assurance through the:

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

- sharing of information, as appropriate.

The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

REVIEW

These Terms of Reference shall be adopted by the Audit Committee at its first meeting and subject to review at least on an annual basis thereafter.

For review in July 2020.

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Appendix 3

AUDIT COMMITTEE: SELF ASSESSMENT CHECKLIST

Status Key: 1 = must do 2 = should do 3 = could do

(Audit Committee Self Assessment Checklist from the Audit Committee Handbook Pages 53-63)

Status	Issue	Yes	No	N/A	Comments / Action
	Composition, Establishment and Duties				
1	Does the Audit Committee have written terms of reference that adequately define the Committee's role in accordance with Welsh Government guidance?	√			
1	Have the terms of reference been adopted by the Board?	√			
1	Are the terms of reference reviewed annually to take into account governance developments (including good governance principles) and the remit of other committees within the organisation?	√			
1	Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?				
2	Are changes to the Committee's current and future workload discussed and approved at Board level?	√			
1	Are Committee members independent of the management team?	√			
1	Does the Committee report regularly to the Board?	√			
1	Has the Chair of the Committee a prior understanding of, or received training in, finance and internal control or other relevant expertise?	√			
1	Are new members provided with induction?				
1	Does the Board ensure that members have sufficient knowledge of the organisation's business to identify key risk areas and to challenge both line management and the auditors on critical and sensitive matters?				

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Status	Issue	Yes	No	N/A	Comments / Action
1	Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the Board?	√			
1	Does the Committee assess its own effectiveness periodically?	√			
	Meetings				
1	Has the Committee established a plan of matters to be dealt with across the year?	√			
1	Does the Committee meet sufficiently frequently to deal with planned matters and is enough time allowed for questions and discussions?				
1	Does the Committee's calendar meet the Board's requirements and financial and governance calendar?	√			
2	Are Committee papers distributed in sufficient time for members to give them due consideration?				
2	Are Committee meetings scheduled prior to important decisions being made?	√			
2	Is the timing of Committee meetings discussed with all the parties involved?				
	Compliance with the law and regulations governing the NHS				
1	Does the Committee review assurance and regulatory compliance reporting processes?	√			
3	Has the Committee formally assessed whether there is a need for the support of a "Company Secretary" role or its equivalent?				
3	Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?	√			

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Status	Issue	Yes	No	N/A	Comments / Action
	Internal Control and Risk Management				
1	Has the Committee formally considered how it integrates with other committees that are reviewing risk e.g. risk management and clinical governance?	√			
1	Has the Committee formally considered how its work integrates with wider performance management and standards compliance?	√			
1	Has the Committee reviewed the robustness and effectiveness of the content of the organisation's system of assurance?				
1	Has the Committee reviewed the robustness and content of the draft Annual Governance Statement before it is presented to the Board?	√			
1	Has the Committee reviewed the robustness and content of the draft Annual Quality Statement before it is presented to the Board?	√			
2	Has the Committee reviewed whether the reports it receives are timely and have the right format and content to enable it to discharge its internal control and risk management responsibilities?	√			
1	Has the Committee reviewed the robustness of the data behind reports and assurances received by itself and the Board?				
1	Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisation's responsibilities?	√			
1	Is the Committee's role in reviewing and recommending to the Board the Annual Report and Accounts clearly defined?	√			
1	Does the Committee consider the Auditor General's report to those charged with governance including proposed adjustments to the accounts?	√			

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Status	Issue	Yes	No	N/A	Comments / Action
1	Is there clarity over the timing and content of the assurance statements received by the Committee from the Head of Internal Audit?	√			
	Internal Audit				
1	Is there a formal 'charter' or terms of reference, defining Internal Audit's objectives, responsibilities and reporting lines?	√			
1	Is the Charter or terms of reference approved by the Committee and regularly reviewed?	√			
2	Are the key principles of the terms of reference set out in the Standing Orders/ Standing Financial Instructions?	√			
1	Does the Committee review and approve the Internal Audit plan at the beginning of the financial year?	√			
1	Does the Committee approve any material changes to the plan?	√			
2	Are audit plans derived from clear processes based on risk assessment with clear links to the system of assurance?	√			
1	Does the Audit Committee receive periodic reports from the Head of Internal Audit?	√			
1	Do these reports inform the Audit Committee about progress or delays in completing the audit plan?	√			
3	Has the Committee established a process whereby it reviews any material objection to the plans and associated assignments that cannot be resolved through negotiation?	√			
2	Does the Committee effectively monitor the implementation of management actions from audit reports?	√			
1	Does the Head of Internal Audit have a direct line of reporting to the Committee and its chair?	√			

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Status	Issue	Yes	No	N/A	Comments / Action
2	Is internal audit free of any scope restrictions and, if not, what are they and who establishes them?	√			
2	Is Internal Audit free from any operating responsibilities or conflicts that could impair its objectivity?	√			
2	Has the Committee determined the appropriate level of detail it wishes to receive from Internal Audit?	√			
1	Does the Committee hold periodic private discussions with the Head of Internal Audit?	√			
2	Does the Committee review the effectiveness of Internal Audit and the adequacy of staffing and resources within Internal Audit?				
2	Has the Committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?				
3	Has the Committee agreed a range of Internal Audit performance measures to be reported on a routine basis?	√			
1	Does the Committee receive and review the Head of Internal Audit's annual report and opinion?	√			
2	Is there appropriate cooperation with the Auditor General's representatives and inspectorate bodies?	√			
2	Are there any quality assurance procedures to confirm whether the work of the Internal Auditors is properly planned, completed, supervised and reviewed?				
	External Audit				
1	Do the Auditor General's representatives present their audit plans and strategy to the Committee for consideration?	√			

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Status	Issue	Yes	No	N/A	Comments / Action
2	Has the Committee satisfied itself that audit work not relating to the financial statements work is adequate and appropriate?				
2	Does the Committee receive and monitor actions taken in respect of prior years' reviews?				
2	Does the Committee consider the Auditor General's annual audit letter?	√			
1	Does the Committee consider the Auditor General's use of resources conclusion?	√			
1	Does the Committee hold periodic private discussions with the Auditor General's representatives?	√			
2	Does the Committee assess the quality and effectiveness of external audit work (both financial and non-financial audit)?				
3	Does the Committee require assurance from the Auditor General about the policies for ensuring independence and compliance with staff rotation requirements?				
3	Does the Committee review the nature and value of non-statutory work commissioned by the organisation from the Auditor General?				
	Clinical Audit				
1	Is the Committee clear about where clinical audit assurances are received and monitored?	√			
2	When the Audit Committee receives and monitors clinical audit assurances does it: • Review the clinical audit plan at the beginning of each year? • Confirm that clinical audit plans are derived from clear processes based on risk assessment with clear links to the system of assurance? •	√ √			

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Status	Issue	Yes	No	N/A	Comments / Action
	• Receive periodic reports from the person responsible for clinical audit? • Effectively monitor the implementation of management actions from clinical audit reports? • Ensure that person responsible for clinical audit has a direct line of access to the Committee and its Chair? • Hold periodic private discussions with the person responsible for clinical audit? • Review the effectiveness of clinical audit and the adequacy of staffing and resources available for clinical audit? • Evaluate clinical audit against the Annual Delivery Framework? • Confirm that there are quality and safety assurance procedures in place to confirm whether the work of clinical auditors is properly planned, completed, supervised and reviewed? • Confirm that there are terms of reference for clinical audit that define its objectives, responsibilities and reporting lines? • Review clinical audit's terms of reference regularly?		√		
	Counter fraud				
1	Does the Committee approve the counter fraud work plan at the beginning ofthe financial year?	√			
1	Does the Committee satisfy itself that the work plan adequately covers each of the four generic areas, (which include the 7 steps) defined in NHS counter fraud policy?	√			

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Status	Issue	Yes	No	N/A	Comments / Action
1	Does the Committee approve any material changes to the plan?	√			
2	Are counter fraud plans derived from clear processes based on risk assessment?				
1	Does the Audit Committee receive periodic reports from the Local Counter Fraud Specialist?	√			
2	Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports?	√			
1	Does the Local Counter Fraud Specialist have a right of direct access to the Committee and its Chair?	√			
1	Does the Committee review the effectiveness of the local counter fraud service and the adequacy of its staffing and resources?	√			
1	Does the Committee receive and review the Local Counter Fraud Specialist's annual report of counter fraud activity and qualitative assessment?	√			
1	Does the Committee receive and discuss reports arising from quality inspections by NHS Protect?				
	Annual accounts and disclosure statements				
1	Is the Committee's role in the approval of the annual accounts clearly defined?	√			
2	Is a Committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit?	√			
1	Does the Committee specifically review: • Changes in accounting policies? • Changes in accounting practice due to changes in accounting standards? • Changes in estimation techniques? • Significant judgements made?	√ √ √ √			

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Status	Issue	Yes	No	N/A	Comments / Action
3	Does the Committee review the draft accounts before the start of the audit?	√			
1	Does the Committee ensure it receives explanations as to the reasons for any unadjusted errors in the accounts found by the Auditor General's representatives?	√			
1	Does the Committee receive and review a draft of the organisation's Annual Governance Statement?	√			
1	Does the Committee receive and review a draft of the organisation's Annual Quality Statement?		√		
2	Does the Committee receive and review a draft of the organisation's Annual Report?	√			
	Other issues				
3	Has the Committee considered the costs that it incurs; and are the costs appropriate to the perceived risks and the benefits?				
2	Has the Committee reviewed its performance in the year for consistency with its: • Terms of reference? • Programme for the year?				
3	Does the Annual Report and Accounts of the organisation include a description of the Committee's establishment and activities?	√			

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Appendix 4

List of Internal Audits Undertaken within Cwm Taf UHB 2018-2019 and Assurance Ratings

	Internal Audit Assignment	Assurance Rating 2018-2019
1	Governance Arrangements of Board Committees	Substantial
2	Core Financial System	Substantial
3	Sustainability Reporting	Substantial
4	Carbon Reduction Commitment	Substantial
5	Directorate Review – Primary Care Management Arrangements – Performance & Plan	Substantial
6	Directorate Review – Primary Care Management Arrangements – Risk & Governance	Reasonable
7	Directorate Review – Primary Care Management Arrangements – Workforce	Reasonable
8	Annual Quality Statement (AQS)	Reasonable
9	Mandatory Training	Reasonable
10	Management of Absence Target	Reasonable
11	Directorate Review – Facilities Compliance	Reasonable
12	General Data Protection Regulations (GDPR)	Reasonable
13	IT Strategy Review	Reasonable
14	Governance Arrangements for Hosted bodies	Reasonable
15	Risk Management	Reasonable
16	Scheme of delegation	Reasonable
17	Governance arrangements with third sector partnerships and local authorities	Reasonable
18	Healthroster	Reasonable
19	Capital and Estates – Fire Safety	Reasonable
20	ACT directorate – compliance	Reasonable
21	ACT directorate management arrangements – performance and planning	Reasonable
22	Health and care standards	Reasonable
23	JAG Accreditation – Follow Up	Reasonable
24	Performance Management– Follow up	Reasonable
25	Well-being of Future Generations Act (2015)	Reasonable

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26	Continuing Healthcare	Reasonable
27	Private and Overseas Patients – Follow Up	Reasonable
28	IT Continuity	Reasonable
29	Performance Management Follow Up	Reasonable
30	Private and Overseas Patients	Limited
31	Retention of Staff	Limited
32	Raising Concerns	Limited
33	Medical Equipment and Devices	Limited
34	Directorate Review – Facilities Management Arrangements – Management of Major Capital – Prince Charles Hospital	Limited

	Substantial Assurance Rating	**5**

	Reasonable Assurance Rating	**24**

	Limited Assurance Rating	**5**

	Total	**34**

**NB – the above does not include the internal audit ratings for the reviews undertaken for the hosted bodies.*

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Appendix 5

List of Internal Audits Undertaken 2018-2019 and Assurance Ratings within

The Welsh Health Specialised Services Committee (WHSCC) & the Emergency Ambulance Services Committee (EASC)

	Internal Audit Assignment	Assurance Rating 2018-2019
Welsh Health Specialised Services Committee (WHSCC)		
1	High Cost Drugs	Reasonable
2	Review of network groups and advisory boards	Reasonable
3	Risk Management	Reasonable
4	Governance arrangements	Reasonable
Emergency Ambulance Services Committee (EASC)		
1	Governance and performance arrangements	Reasonable
2	EASC WAO Follow Up Report	Not rated

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GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.3** **15 July 2019**

Audit Committee Report
SCHEME OF DELEGATION REPORT

Executive Lead: Director of Finance
Author: Acting Head of Finance (Financial Accounts)
Contact Details for further information: Liz Williams on 01443 443803 or Elisabeth.williams@wales.nhs.uk

Purpose of the Audit Committee Report
To report transactions approved as "exceptions" within the Scheme of Delegation for the period 1.03.19 to 31.5.19; To provide an update on the work undertaken to improve the Purchase to Pay processes, in conjunction with the NHS Wales Shared Services Partnership (NWSSP).

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The main aim of this report is to improve governance and assurance.
Supporting evidence	N/A
Engagement – Who has been involved in this work?	
NHS Wales Shared Services Partnership	
Audit Committee Resolution to:	

APPROVE	√	ENDORSE		DISCUSS		NOTE	√
Recommendation	The Audit Committee is asked to: a) **NOTE** the position on procurement matters for the period 1.03.19 to 31.05.19; b) **NOTE** the update regarding Purchase to Pay. c) **APPROVE** the revision to the Scheme of Delegation						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	No specific impact						
Legal implications	No specific impact						
Population Health	No specific impact						
Quality, Safety & Patient Experience	No specific impact						
Resources	Assists in providing assurance that appropriate value for money is obtained where competitive tenders have not been sought, and ensures resources are deployed according to set control processes						
Risks and Assurance	Purchase to Pay processes are a key risk area for the UHB, which has contributed to a failure to meet the prompt payment target of 95% non-NHS invoices to be paid within 30 days in previous years.						
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources.						
Workforce	No specific impact						
Freedom of information status	Open						

SCHEME OF DELEGATION REPORT

1. SITUATION / PURPOSE OF REPORT

The purpose of the report is to:

- To report transactions approved as "exceptions" within the Scheme of Delegation for the period 1.03.19 to 31.05.19

- To provide an update on the work undertaken to improve the Purchase to Pay processes, in conjunction with the NHS Wales Shared Services Partnership (NWSSP).

2. BACKGROUND

The following areas within the Scheme of Delegation may be considered contentious and therefore the Audit Committee may wish to be given the opportunity to ask questions or request further information:

a) Engagement off contract of non-medical staff not paid via the payroll. The Director of Workforce and Organisational Development (W&OD) and the Head of Procurement would need to confirm agreement prior to any commitment.

b) Waiver of competitive tenders, as authorised by the Chief Executive.

c) Contracts requiring Ministerial approval (over £1m)

This report provides details of any such transactions within the period 1.03.19 to 31.05.19.

The report also provides an update on the Prompt Payment compliance for 2019-20

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Procurement Matters

a) Engagement off contract of non-medical staff not paid via the payroll

There were no engagements or contracts entered into during the period 1.03.18 to 31.05.19.

b) Waiver of competitive tenders, as authorised by the Chief Executive.

Standing Financial Instructions require 4 competitive tenders for supplies of goods and services over £25,000 up to OJEU thresholds (currently £118,133) and 5 competitive tenders above OJEU thresholds up to £1m. Purchases over £1m require Ministerial approval.

The Scheme of Delegation allows the Chief Executive to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Table A** below provides details of such actions during the period 1.03.19 to 31.05.19.

Table A – Single Tender Actions 1.03.19 to 31.05.19

STA	Division	Contract description	Supplier	Contract Value Exc Vat	Reason for approval	Date Returned
SQT1054	Clinical Engineering	Installation of profiling beds and removal of old beds	Arjo Huntleigh	£154,281	a)	11.03.19
SQT1056	Mental Health	Waiting list Management programme for Autism Service	Mental Health	£37,500	c)	11.03.19

Reasons for approval:
(a) service/work is follow-up, supplier has already undertaken initial work in same area (work undertaken via open competition)
(b) Compatibility issue
(c) Genuinely only one provider
(d) need to retain particular contractor for real business continuity issues; not preferences

c) Contracts requiring Ministerial approval (over £1m)

The following contract received ministerial approval during this period.

Division	Contract description	Contract period	Supplier	Contract Value excluding Vat	Ministerial Notification – pre-tender Approval – Contract award
ICT	Citrix Subscriptions	5 Years	Computacenter	£1,02,790	Approval

3.2. Purchase to Pay (P2P)

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-19	12,058	23,196,053	12,537	24,072,353	96.2%	96.4%
May-19	12,264	30,891,106	13,005	33,166,671	94.3%	93.1%
YTD	24,322	54,087,159	25,542	57,239,024	95.2%	94.5%

The Health Board is meeting its 95% target of paying non-NHS invoices within 30 days during 2019/20, with an accumulated position for the year of 95.2% (94.5% in value terms). This compares to 96.0% (value 95.7%) in 2018/19.

The NHS invoice position shows that 69.2% of invoices were paid within 30 days for the year to date. (74.7% in 2018/19).

Work continues, both locally and as part of the All Wales P2P Forum, in conjunction with NWSSP, to improve current processes and procedures and address issues that arise in the P2P process.

3.3 Scheme of Delegation/Financial Control Procedures

Final pay control is applicable to the 1995 section of the NHS Pension Scheme, including members who have retained final salary linking to the 1995 section, but have transitioned to the 2015 Scheme.

From April 2015 an additional charge may be applied to an organisation where a scheme member is awarded an increase to pensionable pay which exceeds an 'allowable amount'. The 'allowable amount' is the amount that pensionable pay can increase by, in comparison to previous years, before a final pay control charge applies. If the allowable amount is exceeded in any of the three years leading up to retirement, or leaving the NHS pension scheme, then the employer may be liable for a final pay control charge. This charge is calculated by NHS Pensions and verified by NWSSP Employment Services.

Currently in the Scheme of Delegation (under the section Expenditure commitments made outside of the ORACLE requisition process), Pension Agency Invoices are further classified as Injury Benefit/Compensation. This needs to be updated to reflect the addition category for 'Final pay controls'.

The limits and delegated authority would remain unchanged.

4. RECOMMENDATION

The Audit Committee is asked to:

a) **NOTE** the position on procurement matters for the period 1.03.19 to 31.05.19;

b) **NOTE** the update regarding Purchase to Pay.

c) **APPROVE** the revision to the Scheme of Delegation

Freedom of information status	Open

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.4** **15 July 2019**

Audit Committee Report
LOSSES AND SPECIAL PAYMENTS 01.03.19 TO 31.05.19

Executive Lead: Director of Finance
Author: Financial Accountant
Contact Details for further information: Daxa Varsani on 01443 443808 or Daxa.Varsani@wales.nhs.uk or Liz Williams Elisabeth.Williams@wales.nhs.uk on 01443 443803.

Purpose of the Audit Committee Report
To advise the Audit Committee on the losses and special payments made by the Health Board for the period 1 March 2019 to 31 May 2019, as required in Standing Financial Instructions.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The main aim of this report is to improve governance and assurance.
Supporting evidence	N/A

Engagement – Who has been involved in this work?
NWSSP – legal services and Risk Pool

Audit Committee Resolution To;							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	The Audit Committee is requested to: • **NOTE** the losses and special payments incurred for the period 1 March 2019 to 31 May 2019						

Summarise the Impact of the Audit Committee Report	
Equality and diversity	No specific impact
Legal implications	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim
Population Health	No specific impact
Quality, Safety & Patient Experience	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee
Resources	The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments.
Risks and Assurance	Standing Financial Instructions require all losses to be reported to the Audit Committee. This report is therefore a key element of the governance process around losses and special payments.
Health and Care Standards	Standards for Health Services Reference Governance & Accountability Framework (1);
Workforce	No specific impact
Freedom of information status	Open

LOSSES AND SPECIAL PAYMENTS 01.03.19 to 31.05.19

1. SITUATION / PURPOSE OF REPORT

This report advises the Audit Committee on the losses and special payments made by the University Health Board (CTMUHB) for the three month period from 1 March 2019 to 31 May 2019, as required in Standing Financial Instructions.

2. BACKGROUND / INTRODUCTION

The report summarises the overall financial impact of losses in the period from 1 March 2019 to 31 May 2019 and provides detail on individual payments for write-off.

The Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP) managed by the NHS Wales Shared Services Partnership (NWSSP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the CTMUHB. Where the WRP would be liable for a reimbursement to the CTMUHB then there will be timing differences between payments being made and any reclaim from the Risk Pool. There is a strict protocol in place for reclaiming from the WRP.

In accounting for losses on claims, liability is recognised when legal advice states that there is a probability in excess of 50% of the Health Board having to settle. The quantum of the claim, and associated plaintiff costs are therefore recognised as "expenditure" at this point, with the risk pool recovery element also being recognised. Other losses are recognised as and when they arise.

There is therefore a significant timing issue (which can be several years) between expenditure being recognised within the Health Board's accounts and cash payments being made. Write-off approval action is only required for cash payments. This report highlights:

a) Amounts that have been charged to expenditure for which payments are yet to be made. These amounts are held within the balance sheet as future amounts owing (or owed by the WRP) at the appropriate Balance Sheet date;

b) Amounts charged to expenditure during the current year (together with income from the WRP), and which therefore has a budgetary impact against the Health Board's Revenue Resource Limit; and

c) Cash payments made during the period for which write-off action is required, with details being provided within the appendices.

a) Provision and Creditors as at 31 May 2019

This is shown in table 1 below, together with equivalent figures at the end of the last three financial years, and the end of February 2019 which is the previous reporting date to the Audit Committee.

Table 1

	31.05.19	31.03.19	28.02.19	31.03.18	31.03.17
	£000	£000	£000	£000	£000
Medical Negligence claims/costs	80,417	81,897	87,985	78,961	68,215
Personal Injury claims/costs	507	532	467	1,618	784
Recoverable from Welsh Risk Pool	(99,905)	(99,137)	(99,509)	(87,408)	(75,527)
Net claim provision	**(18,981)**	**(16,708)**	**(11,057)**	**(6,829)**	**(6,528)**
Permanent Injury Benefit	4519	4517	4,738	3,258	3,413
Other	0	0	0	0	0
Net Provision	**(14,462)**	**(12,191)**	**(6,319)**	**(3,571)**	**(3,115)**
Number of live cases on losses system (LaSPaR)					
	31.05.19	**31.03.19**	**28.02.19**	**31.03.18**	**31.03.17**
Medical Negligence claims	328	317	328	397	502
Personal Injury claims	71	67	97	91	100

The reduction in personal injury provision for the financial year 2018-19 compared to the previous year is mainly attributed to one particular case where the Legal & Risk Department has revised the original estimated settlement payment of damages.

The table above shows increase in the net claim provision to the value of £9,879k compared to the previous year. This is mainly due to large payments made during the year, not yet reflected in a corresponding reduction in the amount owed by the Risk Pool.

The increase in permanent injury benefit provision for 2018-19 is due to one new case as detailed within Section B of this report.

b) Expenditure incurred for the year to 31 May 2019

This is shown in table 2 below, together with equivalent figures for the last three complete financial years and last reporting period to the Audit Committee (28.02.2019).

The net claim expenditure for the financial year 2018/19 was £1,351k (monthly expenditure of £112k), which is lower than the previous financial year (monthly expenditure £132k). However the expenditure for 2018-19 is consistent with that of the financial year 2016-17.

The annual budget for net claim expenditure for 2018-19 was £1,334k. There is therefore an overall overspend on claims of £17k included within the Health Board's position for 2018-19.

The annual budget for net claim expenditure for 2019-20 is £2,513k (year to date £418k). There is therefore underspend on claims of £342k included within the Health Board's position as at 31 May 2019. The under-spend during the earlier months of the year is expected to be phased out as the impact of the claim expenditure for the Bridgend population start to materialise.

The increase in Permanent Injury Benefit expenditure of £1,635k for 2018-19 compare to the previous year is mainly due to the new case which was reported to the Committee previously. Welsh Government have funded the total cost of this claim, thus negating any financial impact to the Health Board.

The "other" category mainly consists of payment of retirement gratuities, Employment Matters and voluntary early releases (see appendix 4).

Table 2 **Expenditure incurred year to date**

Definition - Payments made during the year +/- changes in provisions

	Year to	Year ended	Year to	Year ended	Year ended
	31.5.19	**31.3.19**	**28.2.19**	**31.3.18**	**31.3.17**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs	845	18,300	18,435	29,014	18,932
Personal Injury claims/costs	30	(405)	(520)	1,612	555
Recoverable from Welsh Risk Pool	(799)	(16,544)	(16,344)	(29,033)	(18,164)
Net claim expenditure	**76**	**1351**	**1,571**	**1,593**	**1,323**
Permanent Injury Benefit	(23)	1,697	1,703	62	384
Other	4	306	91	174	310
Net I/E impact	**57**	**3,354**	**3,365**	**1,829**	**2,017**

c) Cash Write-Offs made for the period 1 March 2019 to the 31 May 2019

Table 3 shows the cash impact for financial year 2018-19 and up to 31 May 2019 of the current financial year. More detail is provided within the appendices for the current reporting period.

An analysis of medical negligence payments and receipts over cases for the last quarter is shown in **Appendix 1a+1b.** A similar analysis is provided for personal injury claims in **Appendix 2a+2b** and Permanent Injury Benefit (PIB) in **Appendix 3a+3b.**

Other write-offs relate to ex-gratia payments approved by the Chief Executive or Deputy Chief Executive, Employment Claim Matters and debt write offs. The ex-gratia payments include gratuities provided to staff on retirement with more than 20 years' service, in line with HR policy, and voluntary early release payments. These are shown in **Appendix 4a+4b**.

Table 3a
Cash write-offs made during 18/19

	01.03.19 - 31.03.19 £000	Previously reported £000	2018-19 £000
Medical Negligence (Appendix 1a)			
Claims	5,798	6,539	12,337
Costs	142	2,389	2,531
Defence Fees	13	482	495
Personal Injury (Appendix 2a)			
Claims	3	358	361
Costs	2	170	172
Defence Fees	46	103	149
Permanent Injury Benefit (Appendix 3a)	216	222	438
Other (Appendix 4a)			
Ex-Gratia	11	47	58
Debt Write Off	0	0	0
Employment Matter	205	45	250
Total	**6,436**	**10,355**	**16,791**
Recovered from Welsh Risk Pool	(572)	(4,243)	(4,815)
Net Cash Write-Off	**5,864**	**6,112**	**11,976**

Table 3b

Cash write-offs made during year to date 19/20

	01.04.19-31.5.19 £000
Medical Negligence (Appendix 1b)	
Claims	1,704
Costs	473
Defence Fees	148
Personal Injury (Appendix 2b)	
Claims	42
Costs	8
Defence Fees	5
Permanent Injury Benefit (Appendix 3b)	(25)
Other (Appendix 4b)	
Ex-Gratia	4
Debt Write Off	0
Employment Matter	0
Total	**2,359**
Recovered from Welsh Risk Pool	(31)
Net Cash Write-Off	**2,328**

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Standing Financial Instructions require all losses to be reported to the Audit Committee. This report is therefore a key element of the governance process around losses and special payments.

The number of claims, both Medical Negligence and Personal Injury, continues to result in significant levels of expenditure. These levels of expenditure are determined case by case and are based on information supplied by Welsh Legal Services.

4. RECOMMENDATION

The Audit Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 March 2019 to 31 May 2019.

Freedom of information status	Open

Appendix 1a

Medical Negligence Payments 01/03/2019 - 31/03/2019

Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
08RVEMN0013	0	0	4,650,000	0	4,650,000	113,730	4,763,730
12RYLMN0037	0	955	0	0	955	16,875	17,830
13RYLMN0079	0	1,320	0	0	1,320	20,531	21,851
14RYLMN0006	0	1,645	0	0	1,645	29,080	30,725
14RYLMN0090	0	0	0	- 202,124	- 202,124	227,124	25,000
14RYLMN0127	0	3,005	1,074,000	0	1,077,005	151,255	1,228,260
14RYLMN0189	0	- 50	50	0	0	50	50
14RYLMN0200	70,000	1,800	0	0	71,800	798,714	870,514
14RYLMN0214	30,000	2,500	0	0	32,500	277,376	309,876
15RYLMN0106	0	1,060	0	0	1,060	33,330	34,390
15RYLMN0169	0	40	0	0	40	4,038	4,078
16RYLMN0052	0	100	0	0	100	700	800
16RYLMN0090	0	0	10,000	0	10,000	7,433	17,433
16RYLMN0130	0	815	0	0	815	727	1,542
16RYLMN0142	1,120	0	0	0	1,120	36,892	38,012
16RYLMN0145	0	- 1,115	0	0	- 1,115	6,265	5,150
16RYLMN0156	0	- 90	1,690	0	1,600	20,521	22,121
16RYLMN0205	0	500	0	0	500	6,050	6,550
17RYLMN0004	0	250	0	0	250	1,095	1,345
17RYLMN0024	0	- 122	122	0	0	122	122
17RYLMN0030	- 1,600	100	1,500	0	0	18,100	18,100
17RYLMN0037	0	250	0	0	250	4,933	5,183
17RYLMN0061	22,000	0	0	0	22,000	90,420	112,420
17RYLMN0073	0	2,016	0	0	2,016	550	2,566
17RYLMN0089	- 1,750	1,750	0	0	0	6,150	6,150
17RYLMN0111	580	- 580	0	0	0	580	580
17RYLMN0113	- 233	233	0	0	0	6,667	6,667
17RYLMN0120	0	1,050	0	0	1,050	1,585	2,635
17RYLMN0126	16,000	0	0	0	16,000	42,354	58,354
17RYLMN0142	4,035	- 4,035	0	0	0	27,235	27,235

Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
17RYLMN0144	- 1,600	- 94	1,694	0	0	5,294	5,294
17RYLMN0175	- 1,600	- 2,000	3,600	0	0	26,200	26,200
17RYLMN0191	0	600	0	0	600	50	650
18RYLMN0039	1,250	- 1,250	0	0	0	1,250	1,250
18RYLMN0050	4,180	- 4,180	0	0	0	4,180	4,180
18RYLMN0053	1,080	- 1,080	0	0	0	1,080	1,080
18RYLMN0063	1,500	- 1,500	0	0	0	1,500	1,500
18RYLMN0068	0	1,690	0	0	1,690	2,995	4,685
18RYLMN0079	0	0	22,500	0	22,500	650	23,150
18RYLMN0118	- 1,600	- 501	2,101	0	0	21,201	21,201
18RYLMN0119	- 2,993	1,247	1,746	0	0	8,739	8,739
18RYLMN0120	0	- 43	543	0	500	43	543
18RYLMN0124	209	- 209	0	0	0	209	209
18RYLMN0126	- 1,600	1,600	0	0	0	6,522	6,522
19RYLMN0009	0	0	1,200	0	1,200	0	1,200
19RYLMN0013	0	0	500	0	500	0	500
19RYLMN0018	1,013	0	0	0	1,013	0	1,013
19RYLMN0030	0	2,625	0	0	2,625	6,000	8,625
19RYLMN0036	- 1,600	1,600	0	0	0	12,600	12,600
19RYLMN0037	504	0	1,100	0	1,604	0	1,604
19RYLMN0044	0	0	350	0	350	0	350
19RYLMN0046	0	750	0	0	750	0	750
19RYLMN0056	0	1,495	0	0	1,495	0	1,495
19RYLMN0068	375	- 375	0	0	0	375	375
19RYLMN0070	1,781	- 1,500	0	0	281	1,500	1,781
19RYLMN0071	950	- 950	0	0	0	950	950
19RYLMN0088	0	798	0	0	798	0	798
19RYLMN0089	0	396	0	0	396	0	396
19RYLMN0090	194	0	0	0	194	0	194
19RYLMN0091	0	252	0	0	252	0	252
19RYLMN0098	0	0	17,500	0	17,500	0	17,500
19RYLMN0123	0	0	8,000	0	8,000	0	8,000
Total 01/03/2019 - 31/03/2019	**142,193**	**12,768**	**5,798,196**	**- 202,124**	**5,751,033**		
Total						**2,051,820**	**7,802,852**

Medical Negligence Payments 01/04/2019-31/05/2019 — Appendix 1b

Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
05RVEMN0022	0	290	0	0	290	15,073	15,363
08RVEMN0013	60,000	15,343	0	0	75,343	113,730	189,073
12RYLMN0037	0	2,950	0	0	2,950	16,875	19,825
12RYLMN0070	0	0	10,000	0	10,000	96,155	106,155
13RYLMN0096	0	0	100,000	0	100,000	154,480	254,480
13RYLMN0103	0	1,800	0	0	1,800	0	1,800
13RYLMN0131	75,000	12,049	0	0	87,049	844,614	931,663
14RYLMN0006	0	7,100	0	0	7,100	29,080	36,180
14RYLMN0010	0	0	0	0	0	470,060	470,060
14RYLMN0127	80,000	13,750	1,415,846	0	1,509,596	151,255	1,660,851
14RYLMN0178	0	31,700	0	0	31,700	85,815	117,515
15RYLMN0004	0	1,271	0	0	1,271	4,448	5,719
15RYLMN0075	15,000	2,915	0	0	17,915	32,040	49,955
15RYLMN0079	0	1,633	244	0	1,877	117,600	119,477
15RYLMN0104	0	1,000	0	0	1,000	5,231	6,231
15RYLMN0124	0	490	0	0	490	25,000	25,490
15RYLMN0133	0	3,000	0	0	3,000	100	3,100
15RYLMN0136	3,800	842	0	0	4,642	64,200	68,842
15RYLMN0167	0	1,560	0	0	1,560	2,950	4,510
15RYLMN0203	0	795	0	0	795	0	795
16RYLMN0002	15,000	0	0	0	15,000	600	15,600
16RYLMN0052	0	0	25,000	0	25,000	700	25,700
16RYLMN0078	40,000	0	0	0	40,000	908,911	948,911
16RYLMN0090	33,000	500	0	0	33,500	7,433	40,933
16RYLMN0098	0	294	0	0	294	29,892	30,186
16RYLMN0104	0	625	0	0	625	2,765	3,390
16RYLMN0131	0	4,913	0	0	4,913	39,864	44,777
16RYLMN0138	0	4,010	0	0	4,010	40,942	44,952
16RYLMN0139	15,500	230	0	0	15,730	5,765	21,495
16RYLMN0144	0	1,000	0	0	1,000	50	1,050
16RYLMN0145	0	5,605	0	0	5,605	6,265	11,870
16RYLMN0165	20,000	0	0	0	20,000	9,450	29,450

Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
16RYLMN0205	0	175	0	0	175	6,050	6,225
17RYLMN0004	0	0	3,000	0	3,000	1,095	4,095
17RYLMN0028	0	1,200	0	0	1,200	0	1,200
17RYLMN0061	6,000	0	0	0	6,000	90,420	96,420
17RYLMN0070	20,000	0	0	0	20,000	61,907	81,907
17RYLMN0082	0	900	0	0	900	1,802	2,702
17RYLMN0113	0	0	0	- 5,307	- 5,307	6,667	1,360
17RYLMN0120	0	500	0	0	500	1,585	2,085
17RYLMN0142	0	0	0	- 26,162	- 26,162	27,235	1,073
17RYLMN0150	0	875	0	0	875	6,000	6,875
17RYLMN0160	0	1,100	0	0	1,100	50	1,150
17RYLMN0161	0	525	0	0	525	1,120	1,645
18RYLMN0008	0	0	12,000	0	12,000	0	12,000
18RYLMN0018	0	2,040	0	0	2,040	93	2,133
18RYLMN0056	0	1,500	0	0	1,500	0	1,500
18RYLMN0063	0	1,600	500	0	2,100	1,500	3,600
18RYLMN0068	80,000	16,701	85,000	0	181,701	2,995	184,696
18RYLMN0079	5,000	0	0	0	5,000	650	5,650
18RYLMN0107	0	0	3,600	0	3,600	0	3,600
18RYLMN0108	0	1,500	0	0	1,500	600	2,100
18RYLMN0120	0	1,600	0	0	1,600	43	1,643
19RYLMN0027	0	0	36,000	0	36,000	750	36,750
19RYLMN0049	0	0	2,000	0	2,000	2,500	4,500
19RYLMN0056	0	2,138	0	0	2,138	0	2,138
19RYLMN0081	5,000	0	10,000	0	15,000	0	15,000
19RYLMN0106	0	0	300	0	300	0	300
20RYLMN0001	0	0	1,000	0	1,000	0	1,000
Total 01/04/2019 - 31/05/2019	**473,300**	**148,017**	**1,704,490**	**- 31,469**	**2,294,337**		
Total						**3,494,404**	**5,788,741**

Personal Injury Payments 01/3/2019-31/03/2019							Appendix 2a
Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
16RYLPI0010	0	10,476	0	0	10,476	46,560	57,036
16RYLPI0020	0	3,610	0	0	3,610	12,089	15,700
17RYLPI0024	0	5,202	0	0	5,202	15,416	20,617
18RYLPI0028	0	1,372	0	0	1,372	6,322	7,693
18RYLPI0016	0	1,109	0	0	1,109	3,710	4,819
14RYLPI0055	0	0	0	- 369,697	- 369,697	394,697	25,000
16RYLPI0026	0	1,506	0	0	1,506	8,170	9,676
16RYLPI0031	0	680	0	0	680	50	730
16RYLPI0036	0	1,517	0	0	1,517	50	1,567
16RYLPI0046	0	0	2,500	0	2,500	0	2,500
16RYLPI0047	0	963	0	0	963	0	963
17RYLPI0016	0	8,271	0	0	8,271	0	8,271
17RYLPI0020	0	713	0	0	713	0	713
18RYLPI0004	0	1,035	0	0	1,035	2,400	3,435
18RYLPI0005	0	433	0	0	433	0	433
18RYLPI0009	0	2,286	0	0	2,286	7,169	9,455
18RYLPI0023	0	2,464	0	0	2,464	0	2,464
18RYLPI0036	1,741	440	0	0	2,181	0	2,181
19RYLPI0002	0	1,021	0	0	1,021	3,056	4,077
19RYLPI0011	0	546	0	0	546	0	546
19RYLPI0018	0	1,991	0	0	1,991	655	2,646
19RYLPI0033	0	50	0	0	50	0	50
Total 01/03/2019 - 31/03/2019	**1,741**	**45,683**	**2,500**	**- 369,697**	**- 319,773**		
Total						**500,344**	**180,571**

Personal Injury Payments 01/4/2019-31/05/2019							Appendix 2b
Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
15RYLPI0047	0	500	0	0	500	8,598	9,098
16RYLPI0046	3,865	0	0	0	3,865	0	3,865
17RYLPI0017	0	300	0	0	300	1,100	1,400
17RYLPI0018	2,636	0	5,250	0	7,886	0	7,886
18RYLPI0036	0	0	1,500	0	1,500	0	1,500
18RYLPI0039	1,710	0	2,000	0	3,710	0	3,710
19RYLPI0007	0	0	33,000	0	33,000	1,800	34,800
19RYLPI0014	0	3,810	0	0	3,810	1,950	5,760
Total 01/04/2019 - 31/05/2019	**8,211**	**4,610**	**41,750**	0	**54,571**		
Total						**13,448**	**68,019**

Permanent Injury Benefit 01/03/2019 - 31/03/2019			Appendix 3a
Laspar Number	**In period Payments £**	**Previous Write-Offs £**	**Cumulative £**
01RRSPI0020	3,304	186,083	189,387
02RVEPI0001	1,573	40,970	42,543
02RVEPI0003	2,486	135,144	137,630
02RVEPI0004	1,705	92,758	94,464
03RRSPI0020	11,586	670,093	681,679
03RVEPI0028	3,127	212,619	215,745
04RRSPI0009	3,396	177,522	180,918
04RRSPI0024	2,821	115,584	118,405
05RRSPI0020	1,351	57,867	59,218
05RRSPI0021	2,958	144,459	147,417
05RVEPI0033	4,580	220,466	225,046
05RVEPI0034	1,310	65,318	66,628
08RVEPI0009	3,098	140,305	143,403
10RYLPI0070	1,749	79,957	81,706
11RYLPI0065	5,032	165,157	170,189
12RYLPI0059	1,738	46,272	48,010
13RYLPI0020	921	23,544	24,465
13RYLPI0050	3,025	94,913	97,938
98RVEPI0005	98	5,486	5,584
19RYLPI0022	159,725	55,601	215,326
Total 01/03/2019 - 31/03/2019	**215,584**		
Total		**2,730,118**	**2,945,701**

Permanent Injury Benefit 01/04/2019 - 31/05/2019			Appendix 3b
Laspar Number	In period Payments £	Previous Write-Offs £	Cumulative £
01RRSPI0020	0	189,387	189,387
02RVEPI0001	0	42,543	42,543
02RVEPI0003	0	137,630	137,630
02RVEPI0004	0	94,464	94,464
03RRSPI0020	0	681,679	681,679
03RVEPI0028	0	215,745	215,745
04RRSPI0009	0	180,918	180,918
04RRSPI0024	0	118,405	118,405
05RRSPI0020	0	59,218	59,218
05RRSPI0021	0	147,417	147,417
05RVEPI0033	0	225,046	225,046
05RVEPI0034	0	66,628	66,628
08RVEPI0009	0	143,403	143,403
10RYLPI0070	0	81,706	81,706
11RYLPI0065	0	170,189	170,189
12RYLPI0059	0	48,010	48,010
13RYLPI0020	0	24,465	24,465
13RYLPI0050	0	97,938	97,938
98RVEPI0005	0	5,584	5,584
19RYLPI0022	- 24,686	215,327	190,641
Total 01/04/2019 - 31/05/2019	**- 24,686**		
Total		**2,945,702**	**2,921,016**

Other Payments 01/03/2019 - 31/03/2019			Appendix 4a
Case Reference	**Nature of Loss**	**Details**	**Amount £**
19RYLEG0171	Ex-Gratia	Loss of Personal Items	94
19RYLEG0152	Ex-Gratia	Retirement Gratuity	361
19RYLEG0153	Ex-Gratia	Retirement Gratuity	347
19RYLEG0154	Ex-Gratia	Retirement Gratuity	332
19RYLEG0155	Ex-Gratia	Retirement Gratuity	300
19RYLEG0156	Ex-Gratia	Retirement Gratuity	294
19RYLEG0157	Ex-Gratia	Retirement Gratuity	118
19RYLEG0158	Ex-Gratia	Retirement Gratuity	343
19RYLEG0159	Ex-Gratia	Retirement Gratuity	371
19RYLEG0160	Ex-Gratia	Retirement Gratuity	290
19RYLEG0161	Ex-Gratia	Retirement Gratuity	426
19RYLEG0162	Ex-Gratia	Retirement Gratuity	351
19RYLEG0163	Ex-Gratia	Retirement Gratuity	267
19RYLEG0164	Ex-Gratia	Retirement Gratuity	244
19RYLEG0165	Ex-Gratia	Retirement Gratuity	235
19RYLEG0166	Ex-Gratia	Retirement Gratuity	353
19RYLEG0167	Ex-Gratia	Retirement Gratuity	356
19RYLEG0168	Ex-Gratia	Retirement Gratuity	267
19RYLEG0169	Ex-Gratia	Retirement Gratuity	431
19RYLEG0170	Ex-Gratia	Retirement Gratuity	218
19RYLEG0172	Ex-Gratia	Retirement Gratuity	312
19RYLEG0173	Ex-Gratia	Retirement Gratuity	254
19RYLEG0174	Ex-Gratia	Retirement Gratuity	229
19RYLEG0175	Ex-Gratia	Retirement Gratuity	439
19RYLEG0176	Ex-Gratia	Retirement Gratuity	441
19RYLEG0177	Ex-Gratia	Retirement Gratuity	353
19RYLEG0178	Ex-Gratia	Retirement Gratuity	90
19RYLEG0179	Ex-Gratia	Retirement Gratuity	390
19RYLEG0180	Ex-Gratia	Retirement Gratuity	394
19RYLEG0181	Ex-Gratia	Retirement Gratuity	400
19RYLEG0182	Ex-Gratia	Retirement Gratuity	312
19RYLEG0183	Ex-Gratia	Retirement Gratuity	376
19RYLEG0184	Ex-Gratia	Retirement Gratuity	455
19RYLEG0185	Ex-Gratia	Retirement Gratuity	347
19RYLEM0008	Employment Matter	Employment Litigation	57,500
19RYLEM0009	Employment Matter	Employment Litigation	59,670
19RYLEM0010	Employment Matter	Employment Litigation	87,400
Total 01/03/2019 - 31/03/2019			**215,357**

Other Payments 01/04/2019 - 31/05/2019			Appendix 4b
Case Reference	**Nature of Loss**	**Details**	**Amount £**
20RYLEG0001	Ex-Gratia	Loss of Clothes	37
20RYLEG0002	Ex-Gratia	Retirement Gratuity	255
20RYLEG0003	Ex-Gratia	Retirement Gratuity	363
20RYLEG0004	Ex-Gratia	Retirement Gratuity	274
20RYLEG0005	Ex-Gratia	Retirement Gratuity	341
20RYLEG0006	Ex-Gratia	Retirement Gratuity	392
20RYLEG0007	Ex-Gratia	Retirement Gratuity	419
20RYLEG0008	Ex-Gratia	Retirement Gratuity	341
20RYLEG0009	Ex-Gratia	Retirement Gratuity	351
20RYLEG0010	Ex-Gratia	Retirement Gratuity	263
20RYLEG0011	Ex-Gratia	Retirement Gratuity	245
20RYLEG0012	Ex-Gratia	Retirement Gratuity	248
Total 01/04/2019 - 31/05/2019			**3,529**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.6** **15 July 2019**

Audit Committee Report
FORWARD PLAN FOR CLINICAL AUDIT 2019 - 2020

Executive Lead: Medical Director
Authors: Head of Clinical Audit & Quality Informatics
Contact Details for further information: **email:** Mark.Townsend@wales.nhs.uk **Tel:** 01443 744800

Purpose of the Audit Committee Report
This Report has been developed to provide assurance to the Audit Committee that a Clinical Audit Forward Plan for 2019-20 for Cwm Taf Morgannwg University Health Board (CTMUHB) is in place along with the associated Clinical Audit Operational Plan. This will ensure that robust evidence of the monitoring and escalation of audit compliance is in place, and that audit outcomes are an integral part of the organisations continuous improvement programme of work.

Governance	
Link to Health Board Strategic Objective(s)	The Board's key role is to ensure its Strategy 'Cwm Taf Cares' and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed, these in summary align with: – To **improve** quality, safety and patient experience. – To **protect** and **improve** population health. – To **ensure** that the services provided are accessible and sustainable into the future. – To **provide** strong governance and assurance. – To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The report focuses on **improving** quality, safety and patient experience.

Supporting evidence	The Clinical Audit Forward Plan is based on the following key publications: • NHS Wales National Clinical Audit and Outcome Review Plan • National Institute of Health and Care Excellence (NICE) Guidance • The Health & Care Standards (2015) • All Wales Medicines Strategy Group publications • Welsh Risk Pool Management Standards • Regional Cancer Strategy Network publications • Cwm Taf Morgannwg University Health Board's Quality Strategy and Delivery Plan • 1000 Lives Improvement

Engagement – Who has been involved in this work?
This Clinical Audit Forward Plan has been produced through engagement with the Clinical Audit and Quality Improvement Operational Group and Directorate Clinical Audit Leads and is representative of all clinical specialities within the Health Board. Each clinical audit has an assigned clinical lead. The Clinical Audit Forward and Operational plans will be monitored for compliance continuously and formally on a monthly basis by the Head of Clinical Audit and Quality Informatics to ensure appropriate escalation where a deviation from plan is identified. Compliance with the Clinical Audit Forward Plan will be reviewed and monitored on a quarterly basis through the Clinical Audit and Quality Improvement Operational Group. Clinical audit report findings will be released to support the organisation continuous improvement work and all learning outcomes will be reported to an appropriate quality and governance forum within the Health Board.

Audit Committee Resolution To;							
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√
Recommendation	The Audit Committee is asked to: • **DISCUSS** and **NOTE** the Clinical Audit Forward Plan for 2019 - 20						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	Sets out the organisation 'must do' priority clinical audit activities for all clinical areas including vulnerable patient groups (i.e. dementia care, learning disabilities) to enhance the delivery of safe and effective care.						
Legal implications	There are no specific legal implications resulting from this report.						

Population Health	Is required to meet the health needs of our changing population through the provision of safe and effective care models to respond to patients reducing inequalities with the aim of improving population outcomes.
Quality, Safety & Patient Experience	The Clinical Audit Forward Plan identifies all the clinical audit projects that must be undertaken by CTMUHB in 2019-20. It is essential that they are treated as priorities and that appropriate resources are provided to support them. They form the core of the annual clinical audit programme of work. The outcomes from this work will be used to improve the quality and safety of care provided to our patients and to improve their experience.
Resources	Resources to implement the forward plan will require the resource of 'Time' of staff to collect the data to provide quality assurance and to ensure that we put safe and effective care at the centre of everything we do.
Risks and Assurance	Implementation of the forward plan will enable the health board to exercise arrangements to compare practice against evidence-based care standards to help mitigate risks and provide assurance.
Health and Care Standards	Standard 3.1 – Safe and Clinically Effective Care Standard 3.3 – Quality Improvement, Research and Innovation.
Workforce	Key workforce implication is time to participate in quality improvement activities, including data collection and analysis to inform changes in practice.
Freedom of Information Status	Open

CLININCAL AUDIT FORWARD PLAN FOR 2019 - 2020

1. SITUATION / PURPOSE OF REPORT

This report has been developed to provide assurance to the Audit Committee that a Clinical Audit Forward Plan 2019-20 for CTMUHB is in place along with the associated Clinical Audit Operational Plan. This will ensure that robust evidence of the monitoring and escalation of audit compliance is in place, and that audit outcomes are an integral part of the organisations continuous improvement programme of work. The Clinical Audit Forward Plan is attached for information at **Appendix 1**.

2. BACKGROUND / INTRODUCTION

The Plan has identified the projects the Health Board must participate in, for example, the National Clinical Audit and Outcome Review Plan (NCAORP) which have been designed to support the delivery of the NHS Wales Quality Delivery Plan and the Health and Care Standards for Wales. Information from these national audits is also a central component for the implementation of a suite of Delivery Plans for NHS Wales.

Organisational internal local 'must do' audits are reflective of; clinical priorities; patient and public experience initiatives; and compliance with regulatory requirements, e.g. audits with the aim of providing evidence of implementation of NICE guidance, Cancer Standards, All Wales Medicines Strategy Group Guidance and Welsh Risk Management Standards.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The Clinical Audit Forward Plan sets out a programme of prioritised continuous improvement activities, including clinical audit, and is designed to help to embed the above principles into the everyday working practice of individuals and clinical teams to improve clinical outcomes for patients, through focussed and structured work.

The plan for 2019-20, is determined at both corporate and directorate level based around priority categories established by the Healthcare Quality Improvement Programme (HQIP) and defined as:

1. **External "must do"** - Externally monitored audits that are driven by commissioning and quality improvement are treated as the priority and appropriate resources are provided to support these. Failure to participate or deliver on these externally driven audits may carry a penalty for the Health Board

2. **Internal "must do"** - Based on the classic criteria of high risk or high profile identified by Health Board management. They may include national initiatives with Health Board-wide relevance but no penalties exist for non participation. Many of these projects will emanate from Health Board governance issues or high profile local initiatives.

Risks

The planning process for clinical audit and continuous improvement priorities for each year starts in the January of the previous financial year, based on the above prioritised categories. The 8th annual National Clinical Audit and Outcomes Review Plan was published in April 2019. It confirmed the list of National Clinical Audits and Outcome Reviews which all Health Boards and Trusts are expected to participate in 2019-20 (when they provide the service). The plan also confirms how the findings from audits and reviews will be used to measure and drive forward improvements in the quality and safety of healthcare services in Wales.

In respect of performance against the former Cwm Taf University Health Board (CTUHB) and former Bridgend Locality element of the former Abertawe Bro Morgannwg University Health Board (ABMUHB) forward plans for 2018-19.

At the 31 March 2019, CTUHB participated fully with 31 out of 32 audits for which the organisation delivers a service, 1 audit had a backlog, but a plan was in place to comply with the national audit deadline. A national audit proforma was also completed and submitted to Welsh Government for the Fracture Liaison Service audit as this has been identified through the Integrated Medium Term Plan (IMTP) process as an essential service that the organisation is not currently able to provide.

In March 2019, the Clinical Audit and Quality Informatics department undertook a baseline assessment of the national clinical audit position for the Bridgend Locality as at the 31/03/2019, prior to the creation of CTMUHB, at the request of the Transition Board.

ABMUHB (Bridgend Locality) participated fully with 26 out of 30 national audits for which they delivered a service, 1 audit had a backlog, but a plan was in place to comply with the national audit deadline. They did not participate in 3 national audits for which they did provide a service, but CTMUHB have put in place resources from 1 April 2019 to ensure full participation for 2019-20.

ABMUHB (Bridgend Locality), as for the former CTUHB, did not participate in the Fracture Liaison Service audit because they were also not resourced to provide this service.

Clearly identified responsibilities and timeframes for completion of audit work and continuous monitoring of progress against the plan has ensured the improved compliance position for the former CTUHB. However, this has remained a time consuming process without the procurement of a Clinical Audit Management system highlighted as a risk in the internal audit findings from 2018. This will become more critical with the increase in monitoring requirements for the new organisation.

The department has secured investment in staff as part of the creation of the new organisation in addition to the 0.9 Whole Time Equivalent (WTE) staff that transitioned across from the former ABMUHB and outstanding vacancies have been filled during the last 12 months. This has enabled the reshaping of clinical audit services across for the new organisation improving the monitoring and governance processes for the organisation national and local 'must do' priority audits, ensuring that the Health Board participates fully in the national clinical audit programme.

Governance

Welsh Government expects more robust scrutiny of Health Board actions to address national clinical audit and review findings hence assurance proforma containing a Part A that lists the national findings and local implications and Part B details the actions and timescales for improvement. Where a financial or workforce recommendation is identified there is a section requesting whether the issue is included in the Health Board IMTP.

A key role of the Clinical Audit and Quality Improvement Operational Group is to monitor progress against the forward plan. Regular updates and issues identified requiring attention will be brought to the attention of the respective Directorate Integrated Governance Group and/or escalated to the Quality, Safety & Risk Committee or discussed at Executive Catch-Up meetings.

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2019/20 was released on the 1 April 2019. A review was undertaken by the Clinical Audit and Quality Improvement Operational Group (CA&IOG) of the draft plan at the meeting held on the 21 February 2019. The CA&IOG signed off the CTMUHB Clinical Audit Forward plan, subject to 2 minor updates at the CA&IOG on the 25 June 2019.

4. RECOMMENDATION

The Audit Committee is asked to:

- **DISCUSS** and **NOTE** the report and Clinical Audit Forward Plan for 2019-20.

Freedom of Information Status	Open

GIG CYMRU NHS WALES

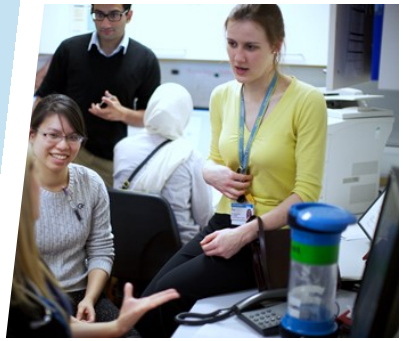
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Knowing How Well We Are Doing

Clinical Audit Forward Plan 2019-20









HQIP Healthcare Quality Improvement Partnership

Standard 3.1:
Safe and Clinically Effective Care
Effective Care

Version 1.3, 31 June 2019

All organisations in Wales are required as part of their Quality Strategy to have an annual Clinical Audit Forward Plan in place to fully participate in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.

The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan identifies all of the clinical audit projects from the National Clinical Audit and Outcome Review Plan for 2019/20 that must be undertaken by CTMUHB in 2019-20. It is essential that they are treated as priorities and that appropriate resources are provided to support them. Failure to participate or deliver on these externally 'must do' audits may carry a penalty for the health board, either financially, or in the form of a failed target, or non-compliance with regulations.

Clinical audit is a fundamental component of the organisations quality assurance process, based on transparency and candour. Quality assurance provides a systematic approach to maintaining consistently high quality by constantly measuring and reporting on effectiveness, highlighting the need for improvement and enabling the sharing of good practice.

National clinical audits are a major source of information aimed at measuring and benchmarking the improvement of healthcare services in Wales. The audit data are used to assess the quality and effectiveness of the healthcare provided by health boards and trusts and can make a big difference to the way we provide services when coupled with suitable improvement actions. It is essential all parts of NHS Wales participate fully in the national programme.

The Plan details the role each of us has for taking this work forward and includes the list of National Clinical Audits and Outcome Reviews which all healthcare organisations must fully participate when they provide the service.

Key aims of participation include:

- Improved communication and encouragement of audit feeding back on the **benchmarked performance of individual health board and trusts** within clinical audits and reviews to organisations as appropriate for reflection and action.
- Identifying areas needing a national approach to improvement **ensuring the findings and recommendations from audits are fully considered by health boards and trusts** and include in appropriate Delivery Plan implementation groups.
- **Addressing clinical services where performance may give cause for concern** ensuring issues are considered in regular performance review meetings between health boards/trusts and the Welsh Government Performance & Delivery Unit.
- Developing, publishing and confirming the arrangements for the identification and handling of sites or organisations identified in audits and reviews as being "**Outliers**" including such activity designed to improve and encourage quality improvement

What are the responsibilities of Welsh health boards and trusts?

Welsh health boards and trusts should provide appropriate clinical audit and clinical resources to enable their staff to participate in all audits, reviews and national registers included in the annual plan (where they provide the service). They should ensure the full audit cycle is completed and that findings and recommendations from audit link directly into the quality improvement programme and lead to improved patient care and outcomes.

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales. This draft report establishes the baseline clinical audit position for the Bridgend Locality (whilst part of Abertawe Bro Morgannwg University Health Board) and Cwm Taf University Health Board, as at the 31/03/2019 prior to the creation of Cwm Taf Morgannwg University Health Board.

Compliance Key

RED	Cause for concern. Full compliance not achieved by audit deadline.
AMBER	Tier 1: **National audit** delayed, backlog exists but plan in place to comply with national audit deadline. Tier 2: **Organisation priority audit** delayed by one quarter, but plan in place to comply with revised audit deadline.
GREEN	Audit on track at 31/03/2019 or completed, evidence of audit compliance provided.
BLUE	Audit completed, audit report assurance proforma completed by audit leads and signed off by Clinical Lead, Clinical Audit and Quality Improvement on behalf of the Medical Director (nominated executive).

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2019/20

Outcome Reviews in which all Welsh health boards and trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2018/19	RAG Status 2018/19	
						Bridgend	CTUHB
Acute							
National Joint Registry (NJR)	operates continuous data capture	**June 2019** for 2016 -2017	September 2019	Trauma and Orthopaedics	Backlog for current audit period for POWH as at 31/03/2019, but resource in place to address.	**AMBER**	**GREEN**
National Emergency laparotomy Audit (NELA)	operates continuous data capture	**N/A**	12 September 2019	Surgery / Anaesthetics	Organisation wide compliance for NELA audit.	**BLUE**	**BLUE**
Case Mix Programme (CMP) ICNARC	operates continuous data capture	**N/A**	December 2019	Anaesthetics	Organisation wide compliance.	**GREEN**	**GREEN**
Major Trauma Audit # (TARN)	operates continuous data capture	**April 2020**	Themed Clinical Feedback Report (produced 3 times per year - March, August, November)	Emergency Medicine	Plan agreed to address POWH TARN compliance with weekly clinically led TARN review sessions, supported by the clinical audit team at the POWH.	**RED**	**GREEN**
National Ophthalmology Audit (Adult Cataract surgery) * (NOD)	This national audit ceases to be a required national audit from September 2019	**September 2020** for 01/09/2019 – 31/08/2020	July 2019: Year 4 Annual Report - the third prospective audit report	Ophthalmology	National Audit due to complete in September 2019. Unable to retrospectively input POWH data for 2018/19.	**RED**	**BLUE**

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2019/20

Outcome Reviews in which all Welsh health boards and trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2018/19	RAG Status 2018/19	
						Bridgend	CTUHB
Long Term Conditions							
National Diabetes Audit * **Note this covers the following areas :** • National Diabetes Foot Care Audit (NDFCA)	operates continuous data capture	**April 2020**	9 May 2019	Therapies	Organisation wide compliance.	**BLUE**	**BLUE**
• National Diabetes Inpatient Audit (NaDia)	September - October 2019	**N/A**	9 May 2019	General medicine	Organisation wide compliance.	**BLUE**	**BLUE**
• National Pregnancy in Diabetes Audit (NPIA)	operates continuous data capture	**April 2020**	October 2019	Obstetrics and Gynaecology	Organisation wide compliance.	**GREEN**	**GREEN**
• National Core Diabetes Audit (NCDA)	operates continuous data capture	**April 2020**	October 2019	General medicine	Organisation wide compliance.	**GREEN**	**GREEN**
• National Diabetes Transition Audit (NCDA)	N/A	**Data will be collated from existing submissions**	TBC	Primary / Secondary Care	New Audit 2019/20 data to be reviewed from NDA and NPDA existing data	N/A	N/A
National Diabetes Paediatric Audit (NPDA) * #	operates continuous data capture	**April 2020**	9 May 2019	Paediatrics	TBC	**BLUE**	**BLUE**
National Asthma and COPD Audit Programme (NACAP)* #	operates continuous data capture	**N/A**	September 2019	General medicine	Organisation wide compliance.	**BLUE**	**BLUE**

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2019/20

Outcome Reviews in which all Welsh health boards and trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2018/19	RAG Status 2018/19	
						Bridgend	CTUHB
National Early Inflammatory Arthritis Audit * # (NEIRT)	May 2019 to March 2020		November 2019	Rheumatology	backlog exists but plan in place to comply with national audit deadline.	AMBER	AMBER
All Wales Audiology Audit #	operates continuous data capture	**N/A**		Ears, Nose and Throat	Organisation wide compliance.	GREEN	GREEN
Older People							
Stroke Audit (SSNAP) *	operates continuous data capture	**N/A**	TBC	General medicine	Organisation wide compliance.	GREEN	GREEN
Falls and Fragility Fractures Audit Programme Including: • Inpatient Falls * (IFA)	operates continuous data capture	**N/A**	March 2020	General Medicine / Trauma & Orthopaedics	Organisation wide compliance.	GREEN	GREEN
• National Hip Fracture Database (NHFD)	operates continuous data capture	**N/A**	September 2019	General Medicine / Trauma & Orthopaedics	Organisation wide compliance.	GREEN	GREEN
• Fracture Liaison Service Database *(Currently no fracture liaison service established with CTMUHB)*	N/A	**N/A**		General Medicine / Trauma & Orthopaedics	Proforma submitted for this audit to WG, but POWH/ RGH/PCH currently no service established. Business Case Submitted for review as part of IMTP process.	N/A	N/A
National Dementia Audit * (NDA)	April – May 2019 TBC	**TBC**	Spotlight report 01/12/2019 TBC	Mental Health	Organisation wide compliance.	GREEN	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2019/20

Outcome Reviews in which all Welsh health boards and trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2018/19	RAG Status 2018/19	
						Bridgend	CTUHB
National Audit of Breast Cancer in Older People (NABCOP)	operates continuous data capture	**N/A**	9 May 2019	General Medicine	Organisation wide compliance. Managed through cancer services.	GREEN	BLUE
End of Life							
National Audit for Care at the End of Life (NACEL) *	03/06/2019 - 11/10/2019		11 July 2019	Palliative Care / Medicine	Following feedback from WG, preparations in place for 2019/20 Audit.	GREEN	GREEN
Heart							
National Cardiac Audit Programme (NCAP) • National Heart Failure Audit * (NHFA)	operates continuous data capture	**N/A**	TBC	Cardiology	Organisation wide compliance.	GREEN	GREEN
• Cardiac Rhythm Management * (CRM)	operates continuous data capture	**N/A**	TBC	Cardiology	Advised by ABMUHB that the audit not applicable to POWH	N/A	GREEN
• Myocardial Ischaemia National Audit Project (MINAP)*	operates continuous data capture	**May 2019**	TBC	Cardiology	Organisation wide compliance.	GREEN	GREEN
• National Vascular Registry Audit (includes Carotid Endarterectomy Audit) * (NVRA)	operates continuous data capture	**N/A**	27 November 2019	Surgery	Organisation wide compliance.	N/A Vascular surgery moved to Morriston	BLUE
Cardiac Rehabilitation Audit (CRA)	operates continuous data capture	**N/A**	TBC	Cardiology	Organisation wide compliance.	GREEN	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2019/20

Outcome Reviews in which all Welsh health boards and trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2018/19	RAG Status 2018/19	
						Bridgend	CTUHB
Cancer							
National Lung Cancer Audit * (NLCA)	operates continuous data capture	**N/A**	9 May 2019	Respiratory Medicine	Organisation wide compliance. Managed through cancer services.	GREEN	BLUE
National Prostate Cancer Audit * (NPCA)	operates continuous data capture	**N/A**	TBC	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN	GREEN
National Gastrointestinal Cancer Audit Programme * (NGCAP)	operates continuous data capture	**N/A**	13 June 2019 - OGC Short Report 1	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN	GREEN
Women's and Children's Health							
National Neonatal Audit Programme Audit * # (NNAPA)	operates continuous data capture	**N/A**	N/A 2019/20	Paediatrics	Organisation wide compliance.	GREEN	GREEN
National Maternity and Perinatal Audit *# (NM&PA)	operates continuous data capture	**N/A**	11 July 2019 - NMPA Organisational report	Obstetrics / Midwifery	Organisation wide compliance.	GREEN	GREEN
Other							
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) *# (NASECYP)	TBC	**TBC**	TBC	Paediatrics	No actions required.	BLUE	BLUE
National Clinical Audit of Psychosis * (NCAP)	August 2019 - October 2019	**???**	June 2019	Mental Health	Organisation wide compliance.	GREEN	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2019/20

Outcome Reviews in which all Welsh health boards and trusts must participate (across sites where services are provided)

(* denotes NCAPOP Audits)
(# denotes reports likely to include information on children and / or maternity services)

Cwm Taf Morgannwg University Health Board Organisation (Tier 2) Priority Annual Audit Programme 2019/20

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2018/19	RAG Status 2018/19	
						Bridgend	CTUHB
Health & Care Standards Annual Audit	October 2019 – November 2019	**December 2019**	April 2020	Nursing Unit	ABMUHB data and report inclusive of Bridgend complete. CTUHB audit data complete, report for completion in July 2019.	**BLUE**	**GREEN**
National Early Warning Score (NEWS) Audit	January 2020 – March 2020	**March 2020**	May 2020	Anaesthetics / ITU	CTUHB specific audit for 2018/19. Report in draft format pending review of 6 cases. Report due for publication in May 2019.	**NA** (will include POWH for 2019/20)	**GREEN**
Case Note Documentation Audit	April 2019 – June 2019	**July 2019**	August 2019	All relevant specialities	Due to competing transition and tier 1 pressures 2018/19 audit deferred to qtr. 1 2019/20.	**NA**	**AMBER**
Consent to Treat Audit	July 2019 – September 2019	**October 2019**	December 2019	Surgery	Awaiting consent group decision on audit focus. Therefore, 2018/19 audit delayed and deferred to qtr. 2 2019/20.	**NA**	**RED**
Local Safety Standards for Invasive Procedures (LocSSIPs) Audits: • Reducing the harm of misplaced nasogastric tubes	TBC				N/A	**NA**	**NA**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 3.1** **15 July 2019**

Audit Committee Report
CHARITABLE FUNDS

Executive Lead: Director of Finance
Author: Financial Accountant
Contact Details for further information: Daxa Varsani on 01443 443808 or Daxa.Varsani@wales.nhs.uk or Liz Williams Elisabeth.Williams@wales.nhs.uk on 01443 443803.

Purpose of the Audit Committee Report
To advise the Audit Committee of the activity and balances on charitable funds for the period 1 March 2019 to 31 May 2019 and provides an update on the transfer of balances associated with the Bridgend Boundary Change.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient • Experience • To **protect** and **improve** population health • To **ensure** that the services provided are • accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The main aim of this report is to improve governance and assurance.
Supporting evidence	N/A

Engagement – Who has been involved in this work?							
Finance Workstream – Bridgend Boundary Change Project							
Audit Committee Resolution to:							
APPROVE	√	**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation		The Audit Committee is requested to: • **NOTE** the current balances and investment performance of Cwm Taf funds. • **NOTE** the details and the fund balances transferred by the Swansea Bay UHB on 31 May 2019. • **NOTE** the successful completion of the name change of the charitable funds with the Charity Commission. • **APPROVE** the actions proposed for revised objects with the Charity Commission.					

Summarise the Impact of the Audit Committee Report	
Equality and diversity	There are no specific equality and diversity issues
Legal implications	Charitable funds are required to be managed in accordance with charity legislation and requirements of the Charity Commissioner.
Population Health	No specific population health issues
Quality, Safety & Patient Experience	No specific quality, safety or patient experience issues
Resources	Investment of surplus funds assists in maximising income whilst safeguarding funds
Risks and Assurance	The report is a key element of the charitable funds governance and assurance process, and which enables Trustees' to discharge their responsibilities over the management of the charitable fund.
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources. The work reported in this summary takes into account many of the related quality themes.
Workforce	No specific workforce implications
Freedom of Information Status	Open

CHARITABLE FUNDS

1. SITUATION / PURPOSE OF REPORT

To advise the Audit Committee of the activity and balances on charitable funds for the period 1 March 2019 to 31 May 2019. The report also provides an update on the transfer of balances associated with the Bridgend Boundary Change from 1 April.

2. BACKGROUND / INTRODUCTION

The previous report to the Audit Committee highlighted balances and transactions up to 28 February 2019. This report updates the position as at 31 May 2019 and provides further analysis over their use by both fund type and location. An update is also provided on the investment performance, and impact of Bridgend Boundary Change.

BALANCES HELD BY THE CHARITABLE FUND

Balances held by the Charitable Fund as at 31 May 2019 are summarised in **Appendix A1** and **A2** analysed by fund type and location. Income received and expenditure incurred during the period 1 March to 31 May is also shown.

The balance at the end of May is £2.922m which is inclusive of £1.039m transferred from the Swansea Bay UHB on 31 May 2019 for the charitable funds transferred due to the Bridgend Boundary Change Project (additional information to follow within section 2a of this report).

These balances exclude the unrealised gain on investment referred to below.

LOW VALUE AND SLOW MOVING FUNDS

A listing of all funds below £1,000 as at 31 May 2019 is shown in **Appendix B.** Actions agreed with fundholders and other relevant observations are included within the comments section.

It should be noted that certain funds with low balances are very active and are being constantly used. This meets the objective of using funds for the purposes intended rather than allowing balances to accumulate. Also shown therefore within **Appendix B** are those funds with higher balances where there has been no expenditure activity during the previous six months, again with comments where appropriate.

INVESTMENT

The total units held remain at 783,307.83.

The market value at 31 May was £1.907m (an increase of £117k from the end of February), compared to £1.5m invested (i.e. a surplus of £407k – 27.1%).

Due to the volatility of the markets during the previous financial year, Trustees decided not to distribute any surpluses to individual funds at its annual meeting in October 2018. Any surpluses will therefore be retained centrally as a buffer in the event of any future falls in investment values for the time-being.

Forecast income for 2019-20 is currently £62k – an income yield of 3.25%. Actual income received for 2018-19 was £63k

A graphical presentation of the investment performance by week, along with a FTSE100 comparator, is shown in **Appendix C**.

BRIDGEND BOUNDARY CHANGE

a) **Name Change**

The Charity has been renamed to Cwm Taf Morgannwg NHS General Charitable Fund from 1 April to reflect the geography of the population for which it serves, and to be consistent with the Health Board's name change. This has been enacted on the Charity Commission website effective from 1 April.

b) **Funds Transfer**

Subsequent to the approval of the name change proposal by the Charity Commission, fund balances totalling £1.039m relating to the services which have been transferred to Cwm Taf Morgannwg were formally transferred by the Swansea Bay UHB on 31 May 2019. Attached **Appendix D** provides additional information and detailed breakdown of this balance.

c) **Change of Charitable Fund Purposes**

As reported to the Committee previously, the current purposes or objects of the Charity are:

"*The Trustees shall hold the funds upon trust to apply the income, and at their discretion so far as permissible, the capital, for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by Cwm Taf UHB.*"

A part of a fund on Africa Health Links has now transferred and we therefore need to ensure that this can continue to be used for the purpose intended. With this in mind it is therefore proposed to amend the objects to incorporate wording previously used within ABMU; namely:

"The Trustees shall hold the funds upon trust to apply the income, and at their discretion so far as permissible, the capital, for any charitable purpose or purposes relating to the National Health Service (wholly or mainly for the service provided by Cwm Taf ***Morgannwg*** *UHB)* ***and for any other Health Services for which specific monies have been donated for use within the UK or overseas****"*

The incorporation of this additional wording will also enable the Health Board to set up funds in the future in relation to other International Health Links for which donations may be received (e.g. Vanuatu).

A written consent has now been received from the Charity Commission for the proposed changes to amend the objects of the charitable funds.

The effective date for this change will be 1 April 2019 and the proposed change will need to be formally accepted by the Charity Commission prior to utilising this fund.

The next step is the formal completion of the Supplemental Deed which is required to be signed on behalf of the Trustees by the Chair of the Health Board and the Chief Executive Officer. This will then be submitted to the Charity Commission in order for the change to be actioned. In addition, the Charity Commission may require a copy of the minutes of the Committee being asked to approve this change.

Once the Trustees approve this proposal, the Supplemental Deed as attached at **Appendix E** will be required to be signed under seal and a copy will be submitted to the Charity Commission in order to progress with this action.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

This report is a key element of the charitable funds governance and assurance process, and which enables Trustees' to discharge their responsibilities over the management of the charitable fund. It also demonstrates due process around the transfer of funds from the Swansea Bay UHB and the setting up of arrangements moving forward post the boundary change

4. RECOMMENDATION

The Audit Committee is requested to:

- **NOTE** the current balances and investment performance of Cwm Taf funds.
- **NOTE** the details and the fund balances transferred by the Swansea Bay UHB on 31 May 2019.
- **NOTE** the successful completion of the name change of the charitable funds with the Charity Commissioner.
- **APPROVE** the actions proposed for revised objects with the Charity Commission.

Freedom of Information Status	Open

APPENDIX A1

Summary of Funds and Transactions 01.04.18 - 31.03.19

No of Funds 31.03.17	No of Funds 31.03.18	No of Funds 31.05.18		Balance 31.03.18	Previous Period(s) Income	Expend.	Revised Balance	Income Mar	Expend Mar	Balance 31.03.19
				£	£	£	£	£	£	£
A			**By TYPE**							
10	10	10	General Purposes	444,335.88	18,786.75	(29,414.19)	433,708.44	15,753.44	(13,755.63)	435,706.25
65	62	58	Specific Purposes	1,159,581.84	88,829.25	(90,302.85)	1,158,108.24	55,437.60	(44,722.85)	1,168,822.99
5	5	5	Post Graduate Education	35,194.64	300.00	(7,667.83)	27,826.81	1,131.80	(785.28)	28,173.33
13	13	13	Research	248,587.40	17,523.95	(33,490.21)	232,621.14	11,167.24	(17,459.64)	226,328.74
93	**90**	**86**	**Total**	**1,887,699.76**	**125,439.95**	**(160,875.08)**	**1,852,264.63**	**83,490.08**	**(76,723.40)**	**1,859,031.31**
B			**By Location**							
33	32	31	RGH	264,692.22	17,575.60	(14,270.62)	267,997.20	19,639.92	(11,221.76)	276,415.36
17	15	15	PCH	409,986.32	51,222.19	(91,020.44)	370,188.07	16,839.12	(22,917.73)	364,109.46
9	11	11	RGH/PCH Combined	478,767.32	23,954.64	(8,717.56)	494,004.40	18,202.05	(11,731.52)	500,474.93
7	6	6	YCR	28,473.59	4,306.46	(3,987.86)	28,792.19	1,456.91	(3,430.49)	26,818.61
6	6	6	YCC	312,404.46	20,387.68	(24,136.96)	308,655.18	14,090.62	(11,679.82)	311,065.98
1	1	1	Dewi Sant	565.52	26.00	0.00	591.52	19.41	(13.71)	597.22
1	1	1	Y Bwthyn	62,799.90	665.00	(2,011.32)	61,453.58	2,106.81	(1,488.08)	62,072.31
4	3	1	YGT	5,269.46	1,995.00	(2,458.04)	4,806.42	165.85	(142.05)	4,830.22
5	5	5	Mental Health Unit	17,088.44	5,094.90	(9,184.82)	12,998.52	583.41	(390.00)	13,191.93
1	1	1	CAMHS	10,566.07	80.97	(225.00)	10,422.04	358.58	(253.42)	10,527.20
4	4	3	Community	10,419.37	60.00	0.00	10,479.37	353.44	(249.63)	10,583.18
3	4	4	LHB Wide	286,667.09	71.51	(4,862.46)	281,876.14	9,673.96	(13,205.19)	278,344.91
1	1	1	Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
92	**90**	**86**		**1,887,699.76**	**125,439.95**	**(160,875.08)**	**1,852,264.63**	**83,490.08**	**(76,723.40)**	**1,859,031.31**

APPENDIX A2

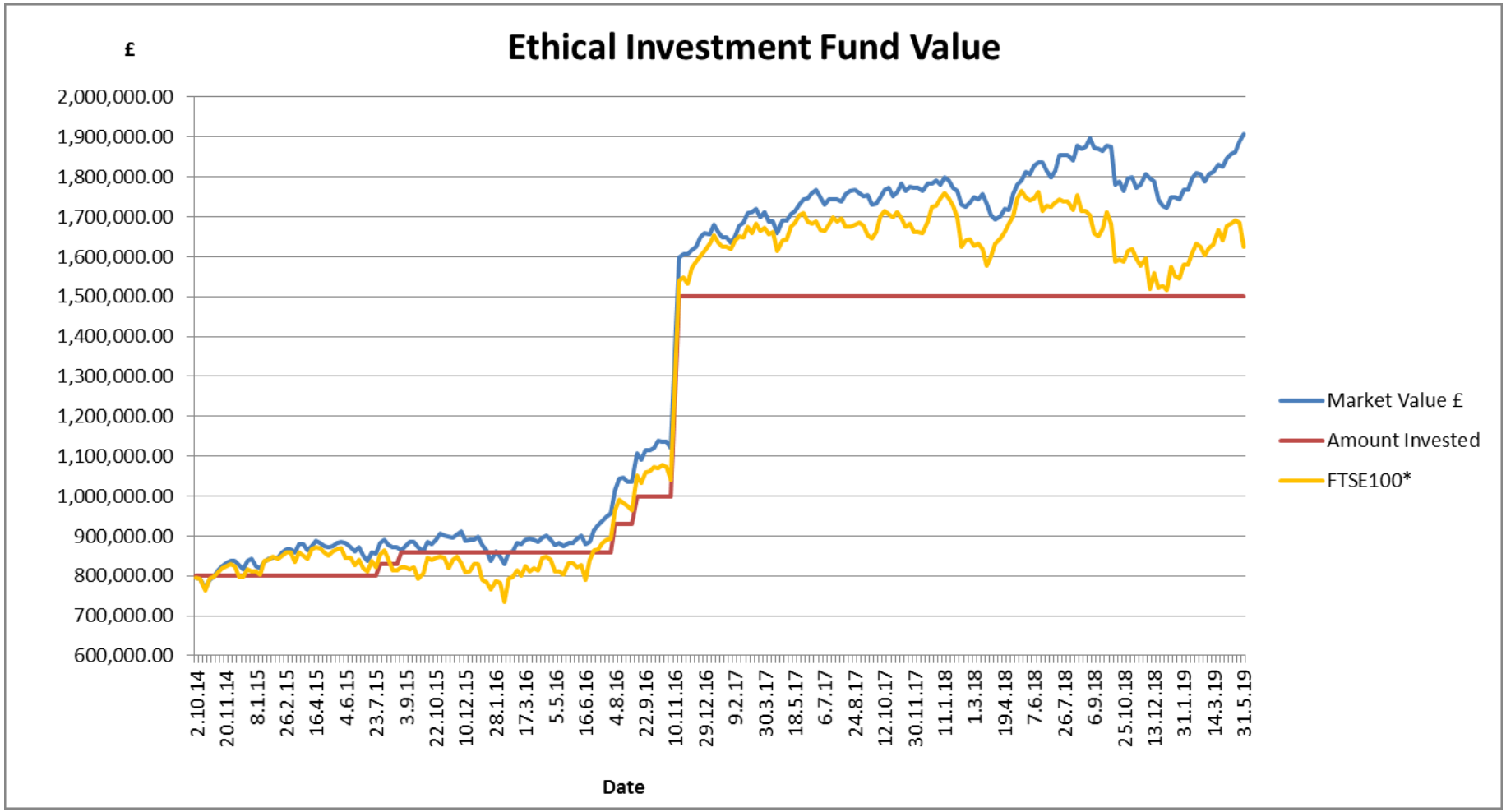
Summary of Funds and Transactions 01.04.19- 31.05.19

No of Funds 31.03.18	No of Funds 31.03.19	No of Funds 31.05.19		Balance 31.03.19 £	Adjustments £	£	Revised Balance £	Income Apr - May £	Expend Apr - May £	Balance 31.05.19 £
A			**By TYPE**							
10	10	80	General Purposes	435,706.25			435,706.25	1,015,503.50	(4,599.39)	1,446,610.36
62	58	60	Specific Purposes	1,168,822.99			1,168,822.99	54,223.44	(5,049.05)	1,217,997.38
5	5	5	Post Graduate Education	28,173.33			28,173.33	0.00	0.00	28,173.33
13	13	14	Research	226,328.74			226,328.74	4,879.08	(2,027.84)	229,179.98
90	**86**	**159**	**Total**	**1,859,031.31**	**0.00**	**0.00**	**1,859,031.31**	**1,074,606.02**	**(11,676.28)**	**2,921,961.05**
B			**By Location**							
32	31	31	RGH	276,415.36			276,415.36	1,393.31	(2,284.66)	275,524.01
15	15	15	PCH	364,109.46			364,109.46	5,648.00	(1,884.53)	367,872.93
0	0	73	POW	0.00	1,038,769.83		1,038,769.83	15,001.88	(1,137.95)	1,052,633.76
11	11	11	RGH/PCH Combined	500,474.93			500,474.93	8,100.91	(2,765.00)	505,810.84
6	6	6	YCR	26,818.61			26,818.61	699.00	(545.43)	26,972.18
6	6	6	YCC	311,065.98			311,065.98	4,353.23	(3,007.32)	312,411.89
1	1	1	Dewi Sant	597.22			597.22	0.00	0.00	597.22
1	1	1	Y Bwthyn	62,072.31			62,072.31	265.00	0.00	62,337.31
3	1	1	YGT	4,830.22			4,830.22	0.00	0.00	4,830.22
5	5	5	Mental Health Unit	13,191.93			13,191.93	0.00	(51.39)	13,140.54
1	1	1	CAMHS	10,527.20			10,527.20	0.00	0.00	10,527.20
4	3	3	Community	10,583.18			10,583.18	0.00	0.00	10,583.18
4	4	4	LHB Wide	278,344.91			278,344.91	374.86	0.00	278,719.77
1	1	1	Other	0.00			0.00	0.00	0.00	0.00
90	**86**	**159**		**1,859,031.31**	**1,038,769.83**	**0.00**	**2,897,801.14**	**35,836.19**	**(11,676.28)**	**2,921,961.05**

Low Value and Slow Moving Funds					APPENDIX B
A	Low Value Funds		Definition - fund balances below £1,000 as at 31.05.19		
Fund No	Fund Type	Location	Balance as at 31.05.19	Comments	
9304	General Purposes	POW	165.42	P.O.W	
9306	General Purposes	POW	720.57	P.O.W	
9313	General Purposes	POW	326.85	P.O.W	
9318	General Purposes	POW	199.99	P.O.W	
9322	General Purposes	POW	680.14	P.O.W	
9332	General Purposes	POW	589.26	P.O.W	
9335	General Purposes	POW	784.13	P.O.W	
9339	General Purposes	POW	788.10	P.O.W	
9350	General Purposes	POW	680.00	P.O.W	
9352	General Purposes	POW	693.24	P.O.W	
9353	General Purposes	POW	216.00	P.O.W	
9357	General Purposes	POW	806.59	P.O.W	
9360	General Purposes	POW	0.00	P.O.W	
9362	General Purposes	POW	322.27	P.O.W	
9363	General Purposes	POW	483.64	P.O.W	
9364	General Purposes	POW	265.97	P.O.W	
9366	General Purposes	POW	0.00	P.O.W	
9371	General Purposes	POW	402.75	P.O.W	
9422	Post graduate Education	Mental Health Unit	703.77	Expenditure received resulting in fund balance now below £1000	
9423	Post graduate Education	Mental Health Unit	519.94	Reminded fund holder-will be used to purchase books-fund agreed to be closed.	
9459	RESEARCH	RGH	871.23	Fund Manger requested to keep fund open.	
9465	RESEARCH	RGH	611.47	Fund to be used for course fees.	
9483	Specific Purposes	RGH	879.48	Endoscopy - Fund to be used for training day. Reminder has been sent	
9506	RESEARCH	RGH	209.81	Requested to keep fund open. Income expected for information packs.	
9507	RESEARCH	RGH	0.00	Requested to keep fund open.	
9516	Specific Purposes	RGH	4.54	Fund is used regularly.	
9519	Specific Purposes	RGH	911.05	Requested to keep fund open. New fund holder.	
9604	Specific Purposes	Dewi Sant	597.22	Dewi Sant Day Unit replaced by @home service. Fund will be closed.	
9680	Specific Purposes	YCR	712.64	Requested to keep fund open. Fund is used	
9775	Specific Purposes	Other	0.00	Fund to be kept open	
9824	Specific Purposes	RGH/PCH Combined	946.28	Expecting expenditure for furniture and some wall art for our patients' quiet room / bad news room .	
9826	RESEARCH	PCH	371.95	Chest Unit Fund- planned for closure. Meeting arranged to discuss.	
9850	Specific Purposes	LHB WIDE	305.35	Primary Care Fund. Requested to keep fund open.	
9874	Specific Purposes	YCC	305.79	Fund holder requested to keep fund open.	

B	Low Activity Funds		Definition - balance over £1k but no expenditure against fund in last 6 months (other than management charges)	
Fund No	Fund Type	Location	Balance as at 31.05.19	Comments
			£	
9450	General Purposes	RGH	42,223.94	Chief executive has been informed.
9453	Specific Purposes	RGH	1,304.73	Expenditure is expected.
9455	Specific Purposes	RGH	53,341.92	Expenditure expected - Trolleys for Medical wards
9456	Specific Purposes	RGH	1,414.60	RGH SCBU Fund -requested to keep this fund to be used & closed within 6 months
9460	Specific Purposes	RGH	15,093.25	Fund is used for annual subscriptions
9463	Specific Purposes	PCH	9,870.04	PCH SCBU Fund on hold waiting for unit to be completed.
9470	Specific Purposes	RGH	3,059.35	Possibility of merging fund. Meeting arranged.
9472	Specific Purposes	RGH	3,945.07	Fund holder is on temporary absence
9479	Specific Purposes	RGH	5,658.93	Fund will be closed - possibility of transferring to Giving To Pink Fund.
9481	Specific Purposes	RGH	4,955.64	Expenditure expected . To purchase chair/hoist//course etc.
9482	Specific Purposes	RGH	2,409.57	A&E Fund - will wait until changes to location have been implemented.
9485	Post graduate Education	RGH/PCH Combined	7,663.38	Fund holder to be contacted.
9486	Specific Purposes	RGH	3,092.48	Meeting was held and expenditure is expected. Reminder has been sent
9492	Specific Purposes	RGH	5,217.66	Expenditure has been received.
9494	RESEARCH	RGH	12,765.12	Meeting was held and expenditure is expected. Reminder has been sent
9497	Specific Purposes	RGH	5,989.46	Expenditure expected - Trolleys for Medical wards
9499	RESEARCH	RGH/PCH Combined	14,769.31	Meeting to be arranged to discuss.
9505	RESEARCH	RGH	4,387.38	Radiology - reminded fund holder the request for information.
9508	RESEARCH	RGH	27,199.80	Fund holder to be contacted.
9510	Specific Purposes	RGH	1,600.65	Fund Holder contacted.
9521	Specific Purposes	RGH	21,211.64	Fund holder to be contacted.
9600	General Purposes	Y Bwthyn	62,337.31	Will be used to purchase new items for the new palliative care unit once built.
9650	General Purposes	Community	2,435.11	Requested to keep fund open for future requests for aids for patient comforts.
9681	Specific Purposes	YCR	1,334.20	Requested to keep fund open.
9730	General Purposes	Community	6,744.73	Requested to keep fund open for future requests for aids for patient comforts.
9731	Specific Purposes	Community	1,403.34	Requested to keep fund open for future requests for aids for patient comforts.
9801	Specific Purposes	PCH	32,826.90	Meeting to be arranged to discuss.
9802	Specific Purposes	PCH	6,690.80	Meeting was held and expenditure is expected. Reminder has been sent
9803	Specific Purposes	PCH	5,503.23	Fund Holder contacted
9809	RESEARCH	PCH	11,136.12	Meeting to be arranged to discuss.
9827	Specific Purposes	PCH	7,472.32	Meeting was held and expenditure is expected. Reminder has been sent
9835	RESEARCH	PCH	67,291.31	Met with fund holder - spending plan to be agreed.
9885	General Purposes	UHB Wide	4,497.60	Chief executive has been informed.
9888	Specific Purposes	YCC	7,858.94	Fund holder requested to keep fund open.

APPENDIX C


Ethical Investment Fund Value
£
2,000,000.00
1,900,000.00
1,800,000.00
1,700,000.00
1,600,000.00
1,500,000.00
1,400,000.00
1,300,000.00
1,200,000.00
1,100,000.00
1,000,000.00
900,000.00
800,000.00
700,000.00
600,000.00
2.10.14
20.11.14
8.1.15
26.2.15
16.4.15
4.6.15
23.7.15
3.9.15
22.10.15
10.12.15
28.1.16
17.3.16
5.5.16
16.6.16
4.8.16
22.9.16
10.11.16
29.12.16
9.2.17
30.3.17
18.5.17
6.7.17
24.8.17
12.10.17
30.11.17
11.1.18
1.3.18
19.4.18
7.6.18
26.7.18
6.9.18
25.10.18
13.12.18
31.1.19
14.3.19
31.5.19
Date
Market Value £
Amount Invested
FTSE100*

ABMU Charitable Funds Analysis
as at 31.03.19

APPENDIX D

				Agreed Outcome				
Cost Centre	**Fund Purpose**	**Period Closing Balance (£) 31.03.19**	**Remain in SBU**	**Tfr to CTM**	**Query**	**To be split**	**Plans to close**	**Comment**
Y602-West Manual Handling	Equipment and Training	-226.22	✓					Old Swansea Trust Fund and service remaining in ABMU
Y606-West Resuscitation	Equipment and Training	-252.22	✓					Old Swansea Trust Fund and service remaining in ABMU
Y620-West Post Grad Dental	Training	-198.66	✓					Old Swansea Trust Fund and service remaining in ABMU
Y621-West Post Grad Hospitality	Training	-648.27	✓					Old Swansea Trust Fund and service remaining in ABMU
Y629-East Trust Medical Postgraduate	General	-1,080.35		✓				MPEC so POW and needs to transfer. Being run down no new monies
Y630-East GP Tutors Accounts	General	-3,130.66		✓				Old Bridgend Account so needs to transfer
Y633-East GP Tutors Accounts - Neath Port Talbot	General	-781.85	✓					Neath Port Talbot Account and service remaining
Y646-Morriston General Patients & Staff	General	-6,176.23	✓					Old Swansea Trust Fund and service remaining in ABMU
Y653-Singleton General Purpose	General	-84,235.87	✓					Old Swansea Trust Fund and service remaining in ABMU
Y654-Finance Admin	General	-1,559,710.23	✓					Contains the realised and unrealised gains & losses from the Investment Portfolio. Portfolio is old Swansea Trust portfolio and has never been added to so all gains and losses relate to Swansea services and remain in ABMU
Y660-ABM Spiritual Care Trust	General	-498.65	✓					Fund manager confirms only Swansea area funds in here - PoW monies in YP01
Y664-Charitable Funds Committee Fund	General	-236,046.55				✓		Fund built up from dividends and interest on the investment portfolio, realisation of £500k of gains from the portfolio and bank account interest. Investment portfolio covers only the Swansea element and so should remain with ABMU with the bank account interest being split. POW schemes have been supported from this fund since its creation, despite minimal income coming into the fund from POW funds. Fund will be split based on anlysis of transactions since fund was created using 72:28 unless income/expenditure is specific to one location
Y667-Africa Health Links	General	-24,335.45				✓		To be split based on whether staff contributing are transferring or remaining.Based on costs centre analysis of staff donating as at December, the share is 73% ABMU and 27% Cwm Taf.
Y668-West Gastroenterology/Nutrition Fund	General	-9,000.76	✓					Old Swansea Trust Fund and srvice remaining in ABMU
Y669-West Vascular Surgery Fund	Equipment, Research and Training	-13,293.43	✓					Old Swansea Trust Fund so remains in ABMU
Y670-Ward B2 Neath Port Talbot	Patient Care	-1,858.52	✓					NPTH - service remaining in ABMU
Y689-Neath Port Talbot General Purpose	General	-12,595.15	✓					NPTH - service remaining in ABMU
YA02-POW Intensive Care	General	-2,658.48		✓				Transfer
YA05-POW Theatres Fund	General	-165.42		✓				Transfer
YA09-Acute Pain Management Fund	General	-1,720.97		✓				POW based service- Transfer
YA10-Neath Port Talbot Day Surgery Unit	General	-254.96	✓					NPTH - service remaining in ABMU
YA11-POW Day Surgery	General	-720.57		✓				Transfer
YA12-East Opthalmology Day Surgery Fund	General	-2,356.80		✓				POW based service - Transfer
YA13-West Anaesthetics Education & Research	Training	-1,168.42	✓					Old Swansea Trust Fund and service remaining in ABMU
YA17-Chronic Pain Fund	Equipment, Patient Care and Training	-1,886.10	✓					Old Swansea Trust Fund and service remaining in ABMU
YA19-West ITU Consultants	Equipment and Training	-6,726.90	✓					Old Swansea Trust Fund and service remaining in ABMU
YA20-West ITU	General	-79,001.96	✓					Old Swansea Trust Fund and service remaining in ABMU
YA21-West HDU	General	-38,006.84	✓					Old Swansea Trust Fund and service remaining in ABMU
YA22-West Theatre Services	Equipment, Patient Care and Training	0.00	✓					Old Swansea Trust Fund and service remaining in ABMU
YA23-West Surgical M R Morgan	Equipment and Training	-6,789.85	✓					Old Swansea Trust Fund and service remaining in ABMU
YA24-Macs Childrens	Patient Care	-7,369.49	✓					Old Swansea Trust Fund and service remaining in ABMU
YB02-West Leukaemia	Patient Care, Research and Training	-32,290.18	✓					Old Swansea Trust Fund and service remaining in ABMU
YB04-Ty Olwen Day Centre	Equipment and Patient Care	-721.35	✓					Old Swansea Trust Fund and service remaining in ABMU
YB05-Ty Olwen Education	Training	-2,079.26	✓					Old Swansea Trust Fund and service remaining in ABMU
YB16-Kevin Blakeman	General	-52,267.76	✓					Old Swansea Trust Fund and service remaining in ABMU
YB17-West Bone Marrow Unit	Patient Care, Research and Training	-6,778.21	✓					Old Swansea Trust Fund and service remaining in ABMU
YB21-West Medical Genetics	Training	-2,981.43	✓					Old Swansea Trust Fund and service remaining in ABMU
YB24-West Haematology Patient Support	Training	-966.22	✓					Old Swansea Trust Fund and service remaining in ABMU
YB27-West Gynae Cancer & Oncology	General	-29,288.31	✓					Old Swansea Trust Fund and service remaining in ABMU
YB32-GWAED	Patient Care and Training	-15,907.03	✓					Old Swansea Trust Fund and service remaining in ABMU
YB34-Cancer Centre	General	-181,025.17	✓					Old Swansea Trust Fund and service remaining in ABMU
YB36-West Haematology Development	Research and Training	-1,747.80	✓					Old Swansea Trust Fund and service remaining in ABMU
YB39-West Traumatic Brain Injury Service	Equipment, Training and Patient Care	-6,171.83	✓					Old Swansea Trust Fund and service remaining in ABMU
YB40-POW Breast Cancer Fund	General	-14,285.03		✓				Transfer
YB41-Y Bwthyn Newydd	General	-172,020.35		✓				Transfer
YB42-Y Rhosyn Palliative care	General	-54,893.04	✓					Neath Port Talbot Account - service remaining in ABMU
YB44-Swansea Myeloma Fund	Research	-101,895.65	✓					Old Swansea Trust Fund and service remaining in ABMU
YB45-Tom's Trust Fund (Traumatic Brain Injury Service)	Patient Care	-14,450.14	✓					West Fund Traumatic Brain Injuries Service
YB46-Jill Rowe Neuro Ambulatory Unit Fund	Equipment, Patient Care and Training	-4,023.22	✓					Remain - Morriston Fund
YC01-West CCU Patients & Staff	Patient Care and Staff Benefit	-14,823.34	✓					Old Swansea Trust
YC02-West Cardiac Research	Equipment, Research and Training	-7,720.93	✓					Old Swansea Trust Fund so remains in ABMU - Cardiac

YC04-West Cardiac (K.Evans)	Equipment and Patient Care	-9,035.43	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC05-West Coronary Care	Equipment, Patient Care and Training	-13,508.00	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC06-West Cardiac Centre	Equipment, Patient Care and Training	-108,171.30	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC07-Dan Danino Ward Morriston	Equipment, Patient Care, Training and	-11,280.13	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC08-Cyril Evans Ward Morriston	Equipment, Patient Care, Training and	-2,450.27	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC09-Cardiac ITU Morriston	Equipment, Patient Care and Training	-5,080.63	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC10-West Cardiothoracic Surgery	Equipment, Research and Training	-38,491.66	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC11-West M Anderson Cardiology	General	-19,908.48	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC12-West Cardiac Research	Research, Training and Staff Benefit	-31,389.73	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC13-West Dr Jenkins Cardiology	Research and Training	-7,604.30	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC14-West Echo	Training	-1,358.82	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC15-West Cardiac Health team	General	-4,970.59	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC16-West ECG	Training, equipment , furniture	-2,121.70	✓			Old Swansea Trust Fund so remains in ABMU - Cardiac
YC17-East Cardiac Fund	General	-10,290.45		✓		Transfer
YC18-East Chest Fund	General	-5,980.57		✓		Part of POW cardio fund -so will need to transfer
YC19-East Cardiac Rehabilitation	General	-1,060.21	✓			Neath Port Talbot Team Remiains in ABMU
YC21-POW ECG Fund	General	-326.85		✓		Transfer
YC22-POW Cardiology Study Fund	Training	-31,646.44		✓		Transfer
YC23-POW Cardiac Rehabilitation Fund	General	-7,775.85		✓		Transfer
YC24-East Cardiac Catheter Laboratory	General	-1,228.49		✓		Transfer
YC25-Sarah Boulton Memorial GUCH Fund	Patient Care, Training, Staff Benefit an	-8,734.67		✓		This was set up as part of Cardio - Stands for Grown Up Congenital Heart Disease under Jonathan Goodfellow so transfers
YC26-Thoracic Surgery Fund	Patient Care and Staff Benefit	-87.20	✓			Morriston Fund
YD02-East Breast Radiology Fund	General	-322.27		✓		Dr Phillips confirmed it will transfer with the service
YD04-East Radiology/Endoscopy at social	General	-483.64		✓		Dr Phillips - Old Bridgend & District account - named after directorate - now just radiology which would it needs to transfer
YD05-POW Pharmacy	General	-199.99		✓		Transfer
YD06-East Pharmacy Development Fund	General	-531.94			✓	Covers Neath Port Talbot & Bridgend. Fund manager believes 50/50 split of fund is fair
YD08-West Gastroenterology	Equipment and Training	-3,193.41	✓			Old Swansea Trust Fund so remains in ABMU
YD10-West Endoscopy Education & Equipment Fund	Equipment and Training	-630.00	✓			Old Swansea Trust Fund so remains in ABMU
YD11-West Audiology	Equipment and Training	-10,763.67	✓			Old Swansea Trust Fund so remains in ABMU
YD12-West MPCE Cancer Research	Research	-22,722.22	✓			Old Swansea Trust Fund so remains in ABMU
YD13-West Medical Physics	Research and Training	-14,824.65	✓			Old Swansea Trust Fund so remains in ABMU
YD14-West Pharmacy	Equipment and Training	-815.11	✓			Old Swansea Trust Fund so remains in ABMU
YD15-CC Pharmacy	Equipment and Training	-292.95	✓			Old Swansea Trust Fund so remains in ABMU
YD17-West Radiology Dept	Equipment and Training	-302.20	✓			Old Swansea Trust Fund so remains in ABMU
YD19-West BP Imaging	Equipment, Patient Care and Training	-111.40	✓			Old Swansea Trust Fund so remains in ABMU
YE01-Ward G Morriston	Equipment, Patient Care and Staff Ben	-12,374.94	✓			Old Swansea Trust Fund so remains in ABMU
YE02-Ward H Morriston	Equipment	-132.87	✓			Old Swansea Trust Fund so remains in ABMU
YE03-Stuart Winsey Surgical Travel	Research and Training	-4,663.13	✓			Old Swansea Trust Fund so remains in ABMU
YE04-Breast of Friends - Singleton	Patient Care	-19,024.40	✓			Old Swansea Trust Fund so remains in ABMU
YE05-West Centre Digestion Disorders & Nutrition (CDI	Equipment, Research and Training	-19,747.36	✓			Old Swansea Trust Fund so remains in ABMU
YE06-MN Ward V Patients & Staff	General	-7,019.70	✓			Old Swansea Trust Fund so remains in ABMU
YE08-West GI Research	Research	-17,932.92	✓			Old Swansea Trust Fund so remains in ABMU
YE10-West Upper GI	Equipment and Training	-60,594.69	✓			Old Swansea Trust Fund so remains in ABMU
YE11-West Breast Care Centre	Patient Care and Training	-50,344.10	✓			Old Swansea Trust Fund so remains in ABMU
YE13-Morriston Ward R	Equipment, Patient Care and Training	-4,382.59	✓			Old Swansea Trust Fund so remains in ABMU
YE16-West UK Surgical Fund	Equipment, Staff Benefit and Training	-2,499.40	✓			Old Swansea Trust Fund so remains in ABMU
YE17-West Continence	Patient Care and Staff Benefit	-2,790.45	✓			Old Swansea Trust Fund so remains in ABMU
YE18-West Urology	Equipment, Patient Care, Research and	-48,573.70	✓			Old Swansea Trust Fund so remains in ABMU
YE20-West Prostate Cancer Research	Research and Training	-58,060.24	✓			Old Swansea Trust Fund so remains in ABMU
YE21-Singleton Paediatric Continence	Patient Care and Training	-2,348.07	✓			Old Swansea Trust Fund so remains in ABMU
YE22-West Higher Surgical Trainees	Patient Care and Training	-5,042.36	✓			Old Swansea Trust Fund so remains in ABMU
YE24-West Stoma Care	General	-4,655.75	✓			Old Swansea Trust Fund so remains in ABMU
YE25-West Breast Reconstruction	Training	-769.95	✓			Old Swansea Trust Fund so remains in ABMU
YE27-Neath Port Talbot General Surgery Fund	General	-10,313.89	✓			Fund manager confirmed no breast surgery donation in this fund. Purely NPT patients & should stay in ABMU
YE28-POW Ward 7 and Ward 8	General	-892.72		✓		Transfer
YE29-POW General Surgery Fund	General	-3,694.18		✓		Transfer
YE30-POW Urology	General	-1,304.58		✓		Transfer
YE34-POW Upper GI	General	-680.14		✓		Transfer
YF01-Morriston Clinical Decision Making Unit	Equipment, Patient Care and Training	-1,996.65	✓			Morriston Fund
YF02-Morriston Ward C	Equipment	-1,189.30	✓			Old Swansea Trust Fund so remains in ABMU
YF03-Morriston Ward D	Equipment, Patient Care and Training	-489.88	✓			Old Swansea Trust Fund so remains in ABMU
YF04-Morriston Gowers Ward	Equipment, Patient Care and Training	-186.82	✓			Old Swansea Trust Fund so remains in ABMU
YF05-Morriston Ward S	Equipment, Patient Care and Training	-5,642.83	✓			Old Swansea Trust Fund so remains in ABMU

YF06-West Chest	Equipment and Training	-24,426.30	✓			Old Swansea Trust Fund so remains in ABMU
YF08-West Respiratory Care	General	-9,767.62	✓			Old Swansea Trust Fund so remains in ABMU
YF09-West Medical Student Examination	Training	-465.76	✓			Old Swansea Trust Fund so remains in ABMU
YF10-Morriston A & E	General	-19,809.14	✓			Old Swansea Trust Fund so remains in ABMU
YF11-Morriston A & E Nurse Education	Training	-9,557.97	✓			Old Swansea Trust Fund so remains in ABMU
YF12-Singleton Hospital Diabetic Unit Fund	Equipment and Training	-1,698.55	✓			Old Swansea Trust Fund so remains in ABMU
YF13-West Diabetic Endocrine Research	Research and Training	-9,158.24	✓			Old Swansea Trust Fund so remains in ABMU
YF14-West Dermatology	Research and Training	-484.71	✓			Old Swansea Trust Fund so remains in ABMU
YF15-West Diabetic	Equipment	-10,789.27	✓			Old Swansea Trust Fund so remains in ABMU
YF16-West Endocrine Research	Equipment, Research and Training	-909.17	✓			Old Swansea Trust Fund so remains in ABMU
YF17-Singleton Ward 9 Patients & Staff	Equipment	-6,721.43	✓			Old Swansea Trust Fund so remains in ABMU
YF18-Singleton Ward 6 Patients & Staff	Patient Care and Training	-3,442.99	✓			Old Swansea Trust Fund so remains in ABMU
YF19-Singleton Ward 8 Patients & Staff	Patient Care and Training	-3,828.73	✓			Old Swansea Trust Fund so remains in ABMU
YF20-Singleton Ward 10 Patients & Staff	Patient Care and Training	-276.61	✓			Old Swansea Trust Fund so remains in ABMU
YF21-West GI Research	Research and Training	-1,060.32	✓			Old Swansea Trust Fund so remains in ABMU
YF22-West Endocrine Specialist Nurse	Patient Care and Training	-6,005.99	✓			Old Swansea Trust Fund so remains in ABMU
YF25-Singleton Medical Assessment Unit	Equipment, Patient Care and Training	-567.49	✓			Old Swansea Trust Fund so remains in ABMU
YF26-West Diabetes Unit Development	Equipment, Patient Care and Training	-16,593.85	✓			Old Swansea Trust Fund so remains in ABMU
YF27-West Renal Dialysis Research	Research	-2,074.74	✓			Old Swansea Trust Fund so remains in ABMU
YF28-West Renal Dialysis Unit	Patient Care	-90,301.36	✓			Old Swansea Trust Fund so remains in ABMU
YF29-West Renal Medical Ward	Equipment, Patient Care and Training	-11,649.04	✓			Old Swansea Trust Fund so remains in ABMU
YF30-West Renal Unit Education	Training	-799.32	✓			Old Swansea Trust Fund so remains in ABMU
YF31-West Neurology	Equipment and Training	-56,310.79	✓			Old Swansea Trust Fund so remains in ABMU
YF32-Neurology Education & Patient Equipment	Equipment and Training	-34,594.38	✓			Old Swansea Trust Fund so remains in ABMU
YF33-West Parkinson's Disease	Equipment, Patient Care and Training	-86,798.45	✓			Old Swansea Trust Fund so remains in ABMU
YF34-West Epilepsy Service	General	-110.10	✓			Old Swansea Trust Fund so remains in ABMU
YF35-West MS Specialist Team	Equipment, Patient Care and Training	-37,665.79	✓			Old Swansea Trust Fund so remains in ABMU
YF36-West Clinical Neurophysiology Charitable Fund	Equipment and Training	-19,143.61	✓			Old Swansea Trust Fund so remains in ABMU
YF37-Renal Dialysis UNIT Endowment	General	-20,948.60	✓			Old Swansea Trust Fund so remains in ABMU
YF38-Neath Port Talbot MIU Fund	General	-2,343.12	✓			Neath Port Talbot Account So will remain
YF39-POW A&E Fund	General	-7,010.90		✓		Transfer
YF40-Neath Port Talbot Diabetic Fund	General	-2,533.87	✓			Neath Port Talbot Account So will remain
YF41-NPTH Endoscopy Fund	Equipment and Training	-5,575.87	✓			Neath Port Talbot Account So will remain
YF42-NPTH Stroke Fund Ward B2	Patient Care	-1,241.03	✓			Neath Port Talbot Account So will remain
YF45-East Dermatology	Research	-2,329.08		✓		Transfer
YF46-POW Diabetic Adults	General	-269,593.95		✓		Transfer
YF47-POW Ward 5 and Ward 6	General	-9,568.60		✓		Transfer
YF48-POW Ward 2 and Ward 10	General	-7,325.67		✓		Transfer
YF49-POW Cardiac Care Unit Ward 4	General	-1,869.64		✓		Transfer
YF51-POW Gastroenterology	General	-17,075.07		✓		Transfer
YF56-East Respiratory Fund	General	-3,608.87		✓		Transfer
YF58-East Anticoagulation Fund	General	-15,046.34		✓		Transfer
YF59-East Fast Track Unit Fund	General	-339.26		✓		Transfer
YF60-Neath Port Talbot Wards	General	-17,926.34	✓			Neath Port Talbot Account So will remain
YF66-Melanoma and Skin Cancer	Equipment and Training	-26,365.39	✓			Singeton Fund So will Remain
YF68-SN Ward 4	Equipment, Patient Care, Training and	-3,283.67	✓			Singeton Fund So will Remain
YF69-GP Out of Hours Fund	General	-6,280.60	✓			Service to Remain in ABMU
YF70-Bevan Legacy Fund	Training	-158,459.10	✓			Specific Legacy for Neath Port Talbot Hospital so will remain
YF71-Renal Annexe	Equipment	-4,707.00	✓			Morriston Fund
YF75 - General Renal Medicine Fund	General	-944.00	✓			Morriston Fund
YG01-West Arthritis	Research and Training	-2,055.81	✓			Old Swansea Trust Fund so remains in ABMU
YG02-West Rheumatology	Research and Training	-3,033.59	✓			Old Swansea Trust Fund so remains in ABMU
YG03-West Orthopaedic	General	-336.98	✓			Old Swansea Trust Fund so remains in ABMU
YG05-Morriston Ward A	Equipment	-1,049.81	✓			Old Swansea Trust Fund so remains in ABMU
YG06-Morriston Ward J	Equipment	-745.32	✓			Old Swansea Trust Fund so remains in ABMU
YG07-West Trauma Unit	Equipment, Patient Care, Training and	-231.91	✓			Old Swansea Trust Fund so remains in ABMU
YG08-West Paediatric Ortho Develop	Equipment and Training	-5,121.89	✓			Old Swansea Trust Fund so remains in ABMU
YG09-Morriston Ward B Trauma & Ortho Surgery	Equipment and Staff Benefit	-1,002.89	✓			Old Swansea Trust Fund so remains in ABMU
YG12-West Arthroplasty Pre-admission Edu	Training	-1,571.70	✓			Old Swansea Trust Fund so remains in ABMU
YG17-POW Rheumatology Research	Equipment, Patient Care, Research and	-9,681.16	✓			Service Remaining in ABMU To be Provided under an SLA
YG18-Ward B2 Neath Port Talbot - Staff Fund	Staff Benefit	-2,521.27	✓			Neath Port Talbot Account So will remain
YG19-Arthroplasty Educational Support Fund	Training	-500.00	✓			Old Swansea Trust Fund so remains in ABMU
YH01-West Consultant Nurse & Midwife Cymru Confere	Training	-80.83	✓			Old Swansea Trust Fund so remains in ABMU
YH02-West Maternity	General	-15,158.91			✓	Fund has been used health board wide. Donations analysis is inconclusive so proposed split agreed with fund manager of 72:28 in accordance with the allocation split
YH04-West Mr Emery Gynaecology	Research and Training	-1,585.73	✓			Old Swansea Trust Fund so remains in ABMU

YH07-West Gynaecology	General	-4,856.31	✓		Old Swansea Trust Fund so remains in ABMU
YH08-West GUM Clinic	Patient Care, Training and Staff Benefit	-680.97	✓		Old Swansea Trust Fund so remains in ABMU
YH11-West Obs & Gynae Teaching	Equipment	-2,406.89	✓		Old Swansea Trust Fund so remains in ABMU
YH14-West TEDI	Patient Care and Training	-2,061.00	✓		Old Swansea Trust Fund so remains in ABMU
YH15-West Integrated Sexual Health	Training	-507.48	✓		Old Swansea Trust Fund so remains in ABMU
YH16-West Children's	Equipment and Training	-3,141.14	✓		Old Swansea Trust Fund so remains in ABMU
YH19-West NICU	Equipment and Training	-38,069.81	✓		Old Swansea Trust Fund so remains in ABMU
YH21-West Childrens Diabetes	Patient Care	-5,739.55	✓		Old Swansea Trust Fund so remains in ABMU
YH22-SN NICU Education Fund	Equipment and Training	-27,310.43	✓		Old Swansea Trust Fund so remains in ABMU
YH24-West NICU Staff Study	Training	-2,876.66	✓		Old Swansea Trust Fund so remains in ABMU
YH25-West Paediatric Nutrition	Equipment, Patient Care and Training	-2,768.86	✓		Old Swansea Trust Fund so remains in ABMU
YH26-West Paediatric Allergy	Equipment and Training	-309.06	✓		Old Swansea Trust Fund so remains in ABMU
YH28-West S.H.I.P.S.	Equipment and Patient Care	-27,221.87	✓		Old Swansea Trust Fund so remains in ABMU
YH29-West Childrens Cystic Fibrosis	Equipment and Training	-10,890.57	✓		Old Swansea Trust Fund so remains in ABMU
YH31-West Childrens Neurology	Equipment, Patient Care and Training	-11,968.57	✓		Old Swansea Trust Fund so remains in ABMU
YH32-West Cartref	Equipment, Patient Care and Training	-1,437.14	✓		Old Swansea Trust Fund so remains in ABMU
YH33-Scott McCrorie Nurses Study	Training	-865.13	✓		Old Swansea Trust Fund so remains in ABMU
YH35 - West Childrens Continuing Care	Patient Care	-2,800.00	✓		Old Swansea Trust Fund so remains in ABMU
YH36-West Health Visiting	Equipment, Patient Care and Training	-45.55	✓		Old Swansea Trust Fund so remains in ABMU
YH37-East Children's Ward	General	-1,778.19		✓	Transfer
YH39-East Obs & Gynae	General	-759.13		✓	Transfer
YH40-Port Talbot Gynae Fund	General	-290.08	✓		Neath Port Talbot Account So will remain
YH41-POW S C B U	General	-11,766.00		✓	Transfer
YH42-POW Paediatric	General	-79,155.44		✓	Transfer
YH43-East Infertility & Gynaecology	General	-643.64	✓		Neath Port Talbot Account So will remain
YH47-East Family Planning Fund	General	-25,988.23	✓		Service will be provided under an SLA from Swansea Bay for 2019/20 and therefore the fund needs to remain. Therefore 50:50 split agreed for whwn service transfers neds to happen in 2020/21
YH49-East OD & T Fund	General	-1,776.91		✓	Transfer
YH50-East Paediatric CF Fund	General	-788.10		✓	Transfer
YH53-Paediatric Endocrine Fund	General	-2,461.05		✓	Transfer
YH54-O&G STC Fund	Training	-24,088.63	✓		Singeton Fund So will Remain
YJ01-West Haematology & Leukaemia	Patient Care and Training	-13,925.29	✓		Old Swansea Trust Fund so remains in ABMU
YJ02-West Histo/Cytopathology	Research and Training	-828.04	✓		Old Swansea Trust Fund so remains in ABMU
YJ03-ABMU Pathology West General Purpose Fund	General	-1,742.35	✓		Old Swansea Trust Fund so remains in ABMU
YJ05-West Sanguine	Training	-571.36	✓		Old Swansea Trust Fund so remains in ABMU
YJ10-ABMU Pathology East General Purpose Fund	General	-698.35	✓		Service to Remain delivered by ABMU via SLA so will remain
YK02-West Mastectomy	Equipment, Patient Care and Training	-52,863.35	✓		Old Swansea Trust Fund so remains in ABMU
YK03-West ENT Support	Equipment, Patient Care and Training	-2,327.04	✓		Old Swansea Trust Fund so remains in ABMU
YK04-Singleton Ward 2 Patients & Staff	Equipment and Patient Care	-1,525.95	✓		Old Swansea Trust Fund so remains in ABMU
YK05-West ENT Fund	Patient Care	-2,218.97	✓		Old Swansea Trust Fund so remains in ABMU
YK06-West ENT Book	Training	-3,042.30	✓		Old Swansea Trust Fund so remains in ABMU
YK07-West Otolaryngology	General	-17,951.15	✓		Old Swansea Trust Fund so remains in ABMU
YK08-West ENT OPD	Equipment and Training	-832.52	✓		Old Swansea Trust Fund so remains in ABMU
YK09-West ENT Respiratory Symposium	Research and Training	-2,519.16	✓		Old Swansea Trust Fund so remains in ABMU
YK10-West ENT STB	Equipment and Training	-2,657.58	✓		Old Swansea Trust Fund so remains in ABMU
YK11-West Cleft & Lip Palate Team	General	-23,005.84	✓		Old Swansea Trust Fund so remains in ABMU
YK12-West Oral Surg Dental Research	General	-7,281.44	✓		Old Swansea Trust Fund so remains in ABMU
YK14-West Craniofacial Implant	General	-5,751.34	✓		Old Swansea Trust Fund so remains in ABMU
YK15-MN SLH Maxillofacial Research and General	Research and Training	-3,162.87	✓		Old Swansea Trust Fund so remains in ABMU
YK16-West Orthodontics	General	-1,387.75	✓		Old Swansea Trust Fund so remains in ABMU
YK17-West Max Facial Research No 2	Research and Training	-869.63	✓		Old Swansea Trust Fund so remains in ABMU
YK18-West Maxillofacial Ward	General	-446.62	✓		Old Swansea Trust Fund so remains in ABMU
YK19-West Lets Face It	Equipment and Training	-9,410.10	✓		Old Swansea Trust Fund so remains in ABMU
YK20-West Maxillofacial Res Sec	Research and Training	-12,405.53	✓		Old Swansea Trust Fund so remains in ABMU
YK23-West Maxillofacial Dept Educ & Equi	Equipment and Training	-8,043.90	✓		Old Swansea Trust Fund so remains in ABMU
YK24-West Clinical Implant Co-Ordinator	Research and Training	-18,050.20	✓		Old Swansea Trust Fund so remains in ABMU
YK25-West Restorative Dentistry - J Owen	Training	-11,761.38	✓		Old Swansea Trust Fund so remains in ABMU
YK26-West CARTIS	General	-3,405.22	✓		Old Swansea Trust Fund so remains in ABMU
YK27-West Ophthalmic Equipment	Equipment and Patient Care	-5,845.37	✓		Old Swansea Trust Fund so remains in ABMU
YK28-West Ophthalmic Education	Research and Training	-3,995.21	✓		Old Swansea Trust Fund so remains in ABMU
YK29-West Childrens Eye	Equipment, Research and Training	-2,968.99	✓		Old Swansea Trust Fund so remains in ABMU
YK30-West Ophthalmic General Purpose	Training	-7,139.27	✓		Old Swansea Trust Fund so remains in ABMU
YK31-West Eye T	Equipment and Training	-990.42	✓		Old Swansea Trust Fund so remains in ABMU
YK33-West Burns Unit	Equipment and Training	-6,454.27	✓		Old Swansea Trust Fund so remains in ABMU
YK34-B & P ITU Tempest Ward	General Purpose	-8,237.22	✓		Old Swansea Trust Fund so remains in ABMU
YK35-Morriston Pembroke Ward	Equipment, Patient Care, Training and	-7,452.42	✓		Old Swansea Trust Fund so remains in ABMU

YK37-Morriston Clydach Ward	Equipment and Training	-2,254.94	✓			Old Swansea Trust Fund so remains in ABMU
YK38-Morriston B & P OPD	Equipment and Patient Care	-1,564.11	✓			Old Swansea Trust Fund so remains in ABMU
YK39-Morriston Powys Ward	Equipment, Patient Care and Staff Ben	-4,206.38	✓			Old Swansea Trust Fund so remains in ABMU
YK40-Welsh Burns & Plastics Unit - Stickler Fund	Research and Training	-27,928.91	✓			Old Swansea Trust Fund so remains in ABMU
YK42-Morriston Dyfed Ward	Equipment, Patient Care and Training	-1,616.67	✓			Old Swansea Trust Fund so remains in ABMU
YK43-Welsh Dragon Burns Club	Equipment and Patient Care	-47,614.94	✓			Old Swansea Trust Fund so remains in ABMU
YK44-Artificial Limb & Appliance Centre	Patient Care	-2,658.74	✓			Old Swansea Trust Fund so remains in ABMU
YK47-Spinal Surgery Educational Fund	Equipment, Research and Training	-21,438.01	✓			Old Swansea Trust Fund so remains in ABMU
YK48-Debbie's Nurse Education	Training	-14,042.77	✓			Old Swansea Trust Fund so remains in ABMU
YK51-Neath Port Talbot Mastectomy Fund	General	-47,757.02		✓		Breast Care Services to Transfer to CT
YK52-POW ENT Fund	General	-3,683.98		✓		Transfer
YK54-POW Orthopaedic Ward	General	-1,689.77		✓		Transfer
YK55-POW Opthalmology Fund	General	-5,434.58		✓		Transfer
YK58-East Opthalmology Glaucoma Fund	General	-4,692.58		✓		Transfer
YK59-East Stroke & Vascular	General	-4,224.55			✓	Fund covers both Neath and Bridgend. Therefore 50:50 split proposed as source of donations is inconclusive.
YK60-East Health Psychology Tinnitus	General	-6,530.88		✓		Transfer
YK62-SDMU Fund	Patient Care, Training and Staff Benefit	-1,447.20	✓			Morriston Fund
YK63-SWW Motor Neurone Disease (MND) Fund	Equipment, Patient Care and Training	-735.00	✓			Morriston Fund
YK64-Anglesey Ward	General	-1,095.61	✓			Morriston Fund
YN01-Morriston Ward F	Equipment and Staff Benefit	-10,370.38	✓			Old Swansea Trust Fund so remains in ABMU
YN02-Singleton Ward 3 Patients & Staff	Equipment and Patient Care	-2,506.57	✓			Old Swansea Trust Fund so remains in ABMU
YN03-West Elderly Care Functions	Training, study leave, medical & office	-2,649.99	✓			Old Swansea Trust Fund so remains in ABMU
YN04-MN Stroke	Training, study leave, medical & office	-6,572.23	✓			Old Swansea Trust Fund so remains in ABMU
YN05-Henry Langen Peer Support Fund	General	-595.00	✓			Fund created in 2017 for neuromuscular services in Swansea
YN06-Gorseinon Pats Staff	Equipment, Patient Care, Training and	-27.84	✓			Old Swansea Trust Fund so remains in ABMU
YN08-Gorseinon West Ward	Equipment, Patient Care, Training and	-462.31	✓			Old Swansea Trust Fund so remains in ABMU
YN09-Singleton Ward 7 Patient & Staff	Equipment and Patient Care	0.00	✓			Old Swansea Trust Fund so remains in ABMU
YN10-West Elderly Care Research	Research and Training	-10,736.84	✓			Old Swansea Trust Fund so remains in ABMU
YN16-Rehab Day Unit (RDU)	Equipment, Patient Care, Training and	-1,754.00	✓			Neath Port Talbot Account So will remain
YN20-West Ward W	Patient Care and Training	-479.52	✓			Old Swansea Trust Fund so remains in ABMU
YN21-NPTH Neuro Rehab Patients & Staff Fund	Equipment, Patient Care and Training	-5,031.12	✓			Neath Port Talbot Account So will remain
YN22-West Asylum Seeker Health	Patient Care	-81.28	✓			Old Swansea Trust Fund so remains in ABMU
YN23-West District Nurse Training	Training	-644.99	✓			Old Swansea Trust Fund so remains in ABMU
YN24-West Spice Development	Patient Care	-17,047.79	✓			Old Swansea Trust Fund so remains in ABMU
YN25-Gorseinon District Nurse Comfort	Patient Care and Staff Benefit	-441.86	✓			Old Swansea Trust Fund so remains in ABMU
YN26 - West Occupational Therapy	Patient Care	-16,085.63	✓			Swansea Fund so remains in ABMu
YN30-West CREST	Equipment and Training	-529.91	✓			Old Swansea Trust Fund so remains in ABMU
YN31-West Dept of Nutrition & Dietetics	Training	-1,946.85	✓			Old Swansea Trust Fund so remains in ABMU
YN34-West Physiotherapy Fund	Equipment, Patient Care and Training	-12,564.91	✓			Old Swansea Trust Fund so remains in ABMU
YN36-West Lymphoedema Clinic	General	-11,741.07	✓			Old Swansea Trust Fund so remains in ABMU
YN41-POW Ewenny Ward	General	-1,570.18		✓		Transfer
YN42-POW Medical Day Unit	General	-1,426.06		✓		Transfer
YN43-Afan Nedd Day Unit	General	-47,296.18	✓			Neath Port Talbot Account So will remain
YN44-Neath Port Talbot Care of the Elderly	General	-6,663.91	✓			Neath Port Talbot Account So will remain
YN47-Wales Fertility Institute Staff Development Fund	General	-6,245.06	✓			Neath Port Talbot Account So will remain
YN50-Neath Dietetic Fund	General	-673.88	✓			Neath Port Talbot Account So will remain
YN51-Neath Physiotherapy Fund	General	-6,628.60	✓			Neath Port Talbot Account So will remain
YN53-Skewen District Nurses Fund	General	-3,376.97	✓			Neath Port Talbot Account So will remain
YN55-East CHS Speech Therapy Fund	General	-1,087.57		✓		Transfer
YN56-Paediatric Physiotherapy	General	-16,369.08			✓	Fund has been used as a health board wide fund and so needs to be split. Analysis of the source of donations shows a 92% share for Swansea and Neath Port Talbot and 8% share for POW. It is therefore proposed to split the fund on this basis.
YN57-POW Physiotherapy Dept	General	-680.00		✓		Transfer
YN58-East Occupational Therapy	General	-2,069.51		✓		Transfer
YN59-East Community General Purposes	General	-5,645.36			✓	Fund has been used health board wide. Donations analysis is inconclusive so proposed split agreed with fund manager of 72:28 in accordance with the allocation split
YN61-Maesteg General Purposes	General	-197,486.90		✓		Transfer
YN64-East Palliative Care	General	-693.24		✓		Transfer
YN66-Neath COPD Fund	General	-6,764.91	✓			Neath Port Talbot Account So will remain
YN67-East Startwell	General	-805.49			✓	Fund covers Neath and Bridgend. Donations analysis is inconclusive so proposed 50:50 split
YN68-Pontardawe District Nurses Fund	Equipment	-616.00	✓			Remain
YN69-Bridgend District Nursing Patient Fund	General	-216.00		✓		Transfer
YN70-Shickle Fund	Equipment	-675.00	✓			Find set up in 2016 for Cymmer Health Centre So Remain

YN71-Pulmonary Rehabilitation	Equipment and Training	-1,280.00	✓		Service Being Provided under SLA
YN72-Palliative Care OT Therapuetic Activities Fund (YBI	General	-4,532.74		✓	Transfer with YBN
YP01-POW Chapel	General	-1,589.09		✓	Transfer
YP03-POW General Purpose	General	-9,877.58		✓	Transfer
YP10-League of Friends Neath	Equipment	195.58	✓		Neath Port Talbot Account So will remain
YP11-League of Friends Port Talbot	Equipment	1,564.14	✓		Neath Port Talbot Account So will remain
YP12-League of Friends MN	Patient Care and Staff Benefit	9,662.47	✓		Old Swansea Trust Fund so remains in ABMU
YP13-Friends of SN Hospital	Patient Care and Staff Benefit	0.00	✓		Old Swansea Trust Fund so remains in ABMU
YP20-West Catering	Equipment and Training	-71.97	✓		Old Swansea Trust Fund so remains in ABMU
YP21-Arts in Health	Patient Care	-46,401.11	✓		Source of income is grants for schemes and sale of art at Morriston and Singleton as POW sales go into POW General Purpose Fund. Grants provided to date are for ongoing projects which cover areas of Bridgend and which will continue post 01.04.19 and be paid by ABMU from the grant until the scheme ends. No new grants will be bid for until 01.04.19 so nothing will transfer
YP23-Morriston Ward T	Equipment, Patient Care and Training	-467.52	✓		Old Swansea Trust Fund so remains in ABMU
YR01-West Neuropsychology Fund	Equipment and Training	-1,811.88	✓		Old Swansea Trust Fund so remains in ABMU
YR02-West Community Drugs Team	Equipment and Training	-1,364.36	✓		Service Remains with ABMU
YR03-Cefn Coed Rehab Servs	Patient Care	-378.24	✓		Service Remains with ABMU
YR08-West All Wales Eating Dis Sp Int Gr	Research and Training	-562.84	✓		Service Remains with ABMU
YR11-Ty Einon	Patient Care and Training	-219.74	✓		Service Remains with ABMU
YR12-Cefn Coed EMI (D)	Patient Care	-9,338.97	✓		Service Remains with ABMU
YR13-Cefn Coed Ward 1 Staff Develop	Patient Care and Training	-783.41	✓		Service Remains with ABMU
YR14-Garngoch Pat / Staff	Patient Care	-17,298.80	✓		Service Remains with ABMU
YR15-Garngoch EMI Research	Training	-1,317.54	✓		Service Remains with ABMU
YR17-Cefn Coed Pat / Staff	General	-8,727.64	✓		Service Remains with ABMU
YR18-West Patients Council	General	-32,248.42	✓		Service Remains with ABMU
YR19-Tonna EMI Fund	General	-367.64	✓		Service Remains with ABMU
YR20-Tonna EMI Day Hospital Fund	General	-3,235.53	✓		Service Remains with ABMU
YR21-Tonna David Blight Legacy	Equipment and Research	-16,911.12	✓		Service Remains with ABMU
YR23-Coity Clinic Adult General Endowment	General	-8,128.91		✓	Service Transfers to Cwm Taf
YR26-Glanrhyd Dr R Colgate Research	General	-806.59		✓	Service Transfers to Cwm Taf
YR28-Glanrhyd General Purpose	General	-4,749.62		✓	Service Transfers to Cwm Taf
YR29-Older Peoples Services Coity Clinic	General	-7,638.16		✓	Service Transfers to Cwm Taf
YR31-East Psychology Fund	General	0.00		✓	Balance transferred into Glanrhyd General Purpose which transfers to Cwm Taf.
YR34-Glanrhyd CDAT Fund	General	-2,422.65		✓	Service Transfers to Cwm Taf
YR35-Port Talbot & Afan Valley Forge Cen	General	-1,146.82	✓		Service Remains with ABMU
YR37-Ward F (Adult) Mental Health NPTH	General	-155.30	✓		Service Remains with ABMU
YR38-Ward G (Elderly) Mental Health NPTH	General	-984.07	✓		Service Remains with ABMU
YR39-Glanrhyd Angelton Clinic Fund	General	-3,755.24		✓	Service Transfers to Cwm Taf
YR40-Glanrhyd Caswell Clinic	General	-1,735.46	✓		Service Remains with ABMU
YR41-Cefn Yr Afon	-	-2,500.00		✓	Service Transfers to Cwm Taf
YR42-Psychological Medicine - Liaison	General	-51.96	✓		Service Remains with ABMU
YR44-Chronic Conditions Management	Equipment and Training	-28.87	✓		Service Remains with ABMU
YT02-Speech Therapy Cleft	General	-1,837.05	✓		Old Swansea Trust Fund so remains in ABMU
YT03-West Speech Therapy	Equipment and Training	-10,943.53	✓		Old Swansea Trust Fund so remains in ABMU
YT04-Learning Disabilities Patient Fund	General	-76.70	✓		Service Remains with ABMU
YT05-Learning Disabilities Directorate Fund	General	-232.67	✓		Service Remains with ABMU
YT08-East Llwyneryr Unit	General	-5,250.90	✓		Service Remains with ABMU
YT10-Cardiff Medical Fund	General	-1,233.51	✓		Service Remains with ABMU
YT11-Laurels and Briary Patient Fund	Patients Activities & Welfare	-409.65	✓		Service Remains with ABMU
Total	-	**-5,996,889.43**			

Summary of Fund balances as at 31st March		
To Remain with ABMU		-4,668,801.58
Transfer to Cwm Taf		-1,024,970.52
To be Split		-303,117.33
To be Resolved		0.00
Total		**-5,996,889.43**

Current Split Analysis	ABMU	Cwm Taf	Total	
Y664-Charitable Funds Committee Fund	-235,906.92	-139.63	-236,046.55	See CFC Fund analysis tab
Y667-Africa Health Links	-20,451.86	-3,883.59	-24,335.45	See Africa Tab
YD06-East Pharmacy Development Fund	-265.97	-265.97	-531.94	

YH02-West Maternity	-10,914.42	-4,244.49	-15,158.91
YK59-East Stroke & Vascular	-2,112.27	-2,112.28	-4,224.54
YN56-Paediatric Physiotherapy	-15,059.55	-1,309.53	-16,369.08
YN59-East Community General Purposes	-4,064.66	-1,580.70	-5,645.36
YN67-East Startwell	-402.75	-402.75	-805.49
Total	**-289,178.39**	-13,938.93	**-303,117.32**

Total value of Funds to Transfer to Cwm Taf Morgannwg UHB as at 31st March 2019	**-1,038,909.45**

APPENDIX E

THIS SUPPLEMENTAL DEED OF DECLARATION is made on the ….. July 2019 by Cwm Taf Morgannwg University Health Board

WHEREAS:

A. The Trust holds charitable monies pursuant to an Original Declaration of Trust of the charity called Cwm Taf Morgannwg NHS General Charitable Fund (registered under charity registration number 1049765)

B. The Trust wishes to amend the said Original Declaration and the Charity Commission has provided prior written approval to the amendments specified in this supplemental deed.

NOW IT IS HEREBY AGREED as follows:

1. **Interpretation**

1.1 Words and phrases defined in the Original Declaration shall, where used in this Supplemental Deed and except as amended in this Supplemental Deed or unless the context otherwise requires, have the same meaning in this Supplemental Deed.

1.2 Except as set out in this Supplemental Deed the provisions of the Original Declaration shall remain in force and effect and in the event of any conflict between the provisions of the Original Declaration of Trust and this Supplemental Deed the provisions of this Supplemental Deed shall prevail.

1.3 Clause headings are for convenience only and shall not affect the construction of this Supplemental Deed and unless otherwise specified, all reference to Clauses are to Clauses of this Supplemental Deed.

1.4 References to “this Supplemental Deed” and/or any other document are to be construed as references to this Supplemental Deed and/or such other document as amended, supplemented, or otherwise amended from time to time.

2. **Amendment of Original Declaration**

2.1 With effect from the date of the Supplemental Deed the Original Declaration(s) shall be amended, to the extent required in the respective declarations, as follows:

Clause C (Objects) shall be amended by deleting "*Cwm Taf UHB*" and replacing it with "*Cwm Taf Morgannwg UHB and for any other Health Services for which specific monies have been donated for use within the UK or overseas*"

IN WITNESS whereof this Deed has been duly executed on the date first mentioned above.

THE COMMON SEAL OF THE CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD WAS HEREUNTO AFFIXED IN THE PRESENCE OF

……..
Professor Marcus Longley, Chairman,
Cwm Taf Morgannwg University Health Board

……
Dr Sharon Hopkins, Interim Chief Executive,
Cwm Taf Morgannwg University Health Board

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

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Cwm Taf Morgannwg University Health Board

INTERNAL AUDIT PROGRESS REPORT

Audit Committee - July 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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2. Outcomes from completed audit reviews 1
3. Delivery of the 2019/20 Internal Audit plan 2
4. Performance monitoring 2

Appendix A:

Table 1: Status of assignments

Table 2: 2019/20 reviews already reported

Please note:

This audit progress report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction

1.1. This progress report provides the Audit Committee (the 'committee') with the current position regarding the work undertaken by Internal Audit since papers for the last ordinary Audit Committee were submitted on 7 May 2019.

1.2. The report includes details of the progress made to date against individual assignments along with details regarding the delivery of the outstanding reports from 2018/19, and 2019/20.

2. Outcomes from completed audit reviews

2.1 Since the May meeting of the committee eight assignments have been finalised, and two reports are in draft. The finalised reports along with the allocated assurance rating are set out in the table below. The full versions of these reports are included in the committee's papers as separate items.

Assignments reported in 2018/19 annual report	Assurance rating
Health and Care standards	Reasonable
Surgery – Compliance	Reasonable
Surgery – Management arrangements	See Table 1 for individual ratings
Water safety	Reasonable

Assignments	Assurance rating
Prince Charles Hospital project	Substantial
Radiology - Compliance	Reasonable
Radiology – Management arrangements	See Table 1 for individual ratings
Freedom of Information	Substantial

3. Delivery of 2019/20 Internal Audit plan

3.1 Our plan for the 2019/20 programme of work was approved at the Audit Committee on 1 April 2019. We have set out the progress against the plan in Table 1 of Appendix A. In the table we also list the three reviews from the previous year that, due to timing, will be included in the 2019/20 Annual Report.

3.2 The schedule includes the timing of the audits. These dates may be subject to change as the audit work progresses, and any alterations will be communicated to the committee via future progress reports.

3.3 In Table 2 of Appendix A we list the reports already presented to the committee.

4. Performance monitoring

4.1 In the table below we set out the current position of performance against the agreed measures for the 2019/20 programme of work.

Performance measure*	Reviews	Notes
Report turnaround: Time from fieldwork completion to draft reporting (10 working days) Target:80%	7/7 (100%)	-
Report turnaround: Time taken for management response to draft report (15 working days) Target:80%	3/5 (60%)	Reviews > 15 days: • Radiology - compliance • Radiology – management arrangements
Report turnaround: Time from management response to issue of final report (10 working days) Target:80%	5/5 (100%)	-

**Information for core Internal Audit team*

4.2 In addition, after each audit review is finalised we issue a performance questionnaire. The questionnaire covers areas such as the professional conduct of the auditor, the opportunity to discuss findings, and overall satisfaction.

4.3 We report the number of performance questionnaires issued and the response rate to date for the 2019/20 work programme:

- Number of questionnaires issued: 3
- Number of responses received: 3 (100%)

Note: The response rate is affected by the timing of the issue of the questionnaire and the completion of this progress report.

Table 1: Status of assignments to be reported in July Audit Committee or later, excluding Q3 and Q4 reviews

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
Directorate reviews – Radiology - Management arrangements	30	Final	Risk and governance – Reasonable Performance and planning – Reasonable Workforce - Reasonable	-	-
Directorate reviews – Radiology - Compliance	15	Final	Reasonable	-	-
Data quality review	15	Draft	Limited	-	Draft report issued 28.06.19
Freedom of Information	13	Final	Substantial	Q1	-
Retention of staff - follow up	5	Draft	Limited	Q1	Draft report issued 24.06.19
Prince Charles redevelopment - follow up	-	Final	Substantial	Q1	-

Appendix A

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
Raising concerns – follow up	5	WIP	-	Q1	Fieldwork on going
Directorate review – Pathology – management arrangements	30	WIP	-	Q1	Fieldwork on going
Directorate review – Pathology - compliance	15	WIP	-	Q1	Fieldwork on going
WHSSC - Directorate review of Cardiac	15	WIP	-	Q1	Fieldwork on going
Carbon reduction commitment	-	WIP	-	-	Was not included in original plan – Undertaken by SSU
Planned preventative maintenance	20	WIP	-	Q2	Fieldwork on going - SSU
Consultant job planning	20	WIP	-	Q1	Fieldwork started 08.07.19
Primary care cluster plans	15	Planned	-	Q1	Fieldwork to start 15.07.19

Appendix A

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
Governance arrangements – QS&R committee review	15	Planning	-	Q1	Terms of reference issued 19.06.19. However, review to be paused as WAO and HiW undertaking review
Medical equipment review – including follow up	20	-	-	Q2	Was in plan for Q1, but management action dates later so moved
Management of major capital	25	Planning	-	Q1	Ongoing discussions regarding focus. Fire system at PoW/ Neo - SSU
Health & Safety	20	Planning	-	Q2	-
Digitisation	15	Planned	-	Q2	ToR issued. Fieldwork planned for July
Information governance – Medical records management	15	Planning	-	Q2	-
WHSSC – Information governance	15	Planning	-	Q2	Scoping meeting with Board Secretary 17.07.19
Outpatients	17	-	-	Q2	-

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
Nurse Staffing Levels Act (Wales) 2016	20	-	-	Q2	-
IMTP/Efficiency Board	25	-	-	Q2	-

Table 2: 2019/20 reviews already reported

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
Sustainability reporting	10	Final	Reasonable	Q1	-
Annual Quality Statement	5	Final	Reasonable	Q1	-

Water Safety

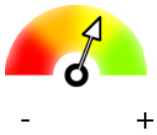
Final Internal Audit Report

2018/19

Cwm Taf Morgannwg University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance


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Appendix A Management action plan
Appendix B Audit evidence
Appendix C Audit assurance rating

Review reference:	SSU CTU 1819 02
Report status:	Final
Fieldwork commencement:	18th February 2019
Draft report issued:	19th April 2019
Draft report meeting:	7th May 2019
Updated report issued:	14th May 2019
Further management responses:	23rd May and 14th June 2019
Final report issued:	17th June 2019
Auditor/s:	NWSSP: Audit & Assurance - Specialist Services Unit
Executive sign off:	Ruth Treharne, Director of Planning & Performance
Distribution:	Tim Burns, Assistant Director of Capital and Estates Alan Martin, Head of Operational Estates
Committee:	Audit Committee

ACKNOWLEDGEMENT

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The Water Safety audit was commissioned in order to evaluate the associated processes and procedures that support its management and control. The audit assessed compliance with the requirements of Welsh Health Technical Memorandum (WHTM) 04-01, Safe Water in Healthcare Premises.

The audit formed a part of the approved 2018/19 internal audit plan.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the UHB, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The audit evaluated the systems and controls in place within the UHB with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas covered were appropriately managed.

Accordingly, the scope and remit of the audit was directed to the following areas:

- **Governance -** The Health Board had adequate arrangements in place to support the implementation of the approved code of practice. Also, that an appropriate policy was in place to address water safety issues, there were defined allocation of responsibilities, clear lines of communication and reporting and approval processes.
- **Monitoring and Reporting -** To ensure that the estate was appropriately monitored. To ensure that the Health Board had effective monitoring procedures in place e.g. the establishment of appropriate Water Safety Groups (WSGs). Assurance that there was appropriate record retention and dissemination of information through to the Executive team and Board.
- **Procedures -** To ensure that management were implementing applicable procedures – both internal and external requirements.
- **Management -** Assurance that relevant staff have received appropriate training, and appropriate resources are allocated. Assurance that and an appropriate inspection / detection regime is operated.
- **Risk Management -** Assurance that the Health Board has performed a suitable and sufficient assessment of risks. Risks were appropriately managed.

3. Associated Risks

The potential risks considered in the review were as follows:

- Patient Safety;
- Prosecution / criminal negligence;
- Adverse publicity;
- Breach of regulations / Approved Code of Practice;
- Fines and defence costs;
- Ineffective / inappropriate governance arrangements;
- Ineffective / ill-informed management; and
- Ineffective risk control.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The audit identified a number of areas for improvement, against the requirements of the WHTM 04-01 and the HSE Approved Code of Practice, primarily:

- HSE guidance emphasises the importance of having a current policy and plan; both required updating to reflect current risk assessments, high priority issues and current working practices; and
- Improved compliance with water safety PPMs (planned preventative maintenance schedules), in respect of calorifiers, and flushing requirements, was needed.

It is acknowledged that the University Health Board has recently approved additional staff resource to be allocated to this area. Further, key areas noted above, had already been identified by management and work had commenced to address these areas at the time of the audit.

The latest Authorising Engineer report recognised some improvements had been made from the position reported in the prior year; however, the report nevertheless raised a number of recommendations (in line with those identified in this audit report), and further noted that actions remain outstanding from the prior 2017 reports.

Noting the investment to date and subsequent progress made to address issues, **reasonable assurance** has been determined. However, noting the marginal nature of this positive assurance (see table on page 6 for further assessment), this is subject to the agreement of further follow up during

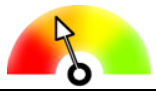
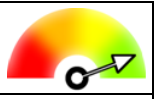
2019/20. The follow up should affirm whether the intended action has been taken in a timely manner and whether it has been effective as evidenced at a new sample of wards / sites to those considered at this audit.

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

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

5. Assurance Summary

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

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

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

Design of Systems/Controls

The findings from the review have highlighted **three** issues that were classified as weaknesses in the system control/design for water safety.

Operation of System/Controls

The findings from the review have highlighted **eight** issues that were classified as weaknesses in the operation of the designed system/control for water safety.

6. Summary of Audit Findings

The key findings are reported within the Management Action Plan (**Appendix A**).

Governance



To ensure there is an appropriate policy in place to address water safety issues, there is defined allocation of responsibilities, clear lines of communication and reporting and approval processes.

A clear reporting line was noted for water safety issues, with the Water Safety Group (WSG) providing reports to the Infection Prevention and Control Committee (IPC), being formally accountable to the Capital and Estates Board and the Risk Committee with line of sight into the main Board.

The internal monitoring and reporting of water safety was the responsibility of the Estates Department, with oversight and monitoring with the Head of Estates as Appointed Person. The use of risk registers and a Balanced Scorecard to highlight any areas of concern/non-compliance etc. was co-ordinated between the Appointed Person and the Compliance Department.

The Health Board had additionally appointed an external adviser (NWSSP: SES) to provide guidance and assurance on safe water management activities.

Responsible Persons (RP) had been formally appointed at the key sites, however Deputy Responsible Persons had not yet been formally trained and appointed. Accordingly, the RPs may not have been sufficiently supported in operational water management practices by suitably qualified individuals. Suitable individuals had been identified for the roles, and training scheduled for April 2019 (**recommendation 1**).

Whilst noting the issues raised, **reasonable assurance** has otherwise been determined in respect of Governance arrangements.

Procedures



To ensure that management were implementing applicable procedures.

The requirement for an up to date policy and plan are key to compliance with the HSE guidance on managing Health & Safety and WHTM 04-01 (Part B).

The UHB's Water Policy was combined with the Water Safety Plan at the time of the audit, and required updating (**recommendation 2**).

The appointed Authorising Engineer had also recognised this and had assessed the Water Safety Plan as 'ineffective'.

A Water Safety Plan (WSP) was in place at the UHB, however, this was last updated in 2014, and did not therefore adequately reflect the latest guidance, including revisions to the Welsh Health Technical Memorandum (WHTM) 04-01 in 2015 and 2016 (**recommendation 3**).

Management confirmed that the WSP is currently undergoing a full review.

As the policy and plan are key documents to demonstrate the effective management of water safety, and were no longer reflective of current working practices, **limited assurance** has been determined for this area.



Monitoring & Reporting

To ensure that the Health Board has effective monitoring procedures in place e.g. the establishment of appropriate Water Safety Groups (WSGs). Assurance that there is appropriate record retention and dissemination of information through to the Executive team and Board.

The UHB operated a Water Safety Group (WSG), in line with WHTM 04-01 (Part B), which is centrally responsible for monitoring the management of water safety within the Health Board. The Group had an appropriate membership and was found to meet on a regular basis in line with the terms of reference. However, for the period reviewed, attendance from a number of key parties was found to be poor (**recommendation 4**). This may reduce the effectiveness of the Group in terms of informed decision making and information sharing.

The WSG provided reports to the Infection Prevention and Control Committee, which meets quarterly. Attendance from Estates representatives was not recorded in the minutes of any of the 2018 meetings and no reports were recorded as having been presented in relation to water management in the period reviewed (2018). This appears to be a matter of record keeping, with management confirming that Estates had regularly attended (**recommendation 5**).

Records were found to be generally retained in line with the requirements of WHTM 04-01, excepting a small sample of temperature check logbooks at Prince Charles Hospital, where 14 of the 21 sampled logs could not be located during the audit (see **recommendation 8** and **Appendix B**).

Noting the above a **reasonable assurance** has been determined.



Management

Assurance that relevant staff have received appropriate training, and appropriate resources are allocated. Assurance that an appropriate inspection / detection regime is operated.

Responsible Persons had been identified, as above, and had received appropriate training. Wider training was also evidenced for individuals with involvement in water management activities, with only the newly identified Deputy Responsible Persons requiring completion of relevant training, which was scheduled for April 2019 (see **recommendation 1**).

To ensure that the Health Board had appropriate monitoring and testing arrangements in place, a sample of PPM (planned preventative maintenance) activities were reviewed at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH).

The following was observed:

- Log books were the identified method of recording arrangements on-site and were retained in relation to the estates activities tested.
- A full set of records were retained regarding the routine temperature checking at the RGH site, however fourteen of twenty-one log books sampled in relation to 6-monthly thermostatic mixing valve (TMV) checks at PCH could not be located during the audit.

  In the absence of on-site records, the electronic system utilised to manage remedial works was not able to verify the status of outstanding elements (e.g. to identify if there is any issue with timeliness of addressing remedial jobs), due to the way the electronic system flags an "overdue" PPM. The issue identified related specifically to the 6-monthly TMV checks, but may also extend to other PPMs within the system. Audit findings in relation to the above testing are additionally noted at **Appendix B**.
- Each area sampled had adopted the flushing recording procedure, including sign-off of flushing sheets by wards / housekeeping at RGH. There was one instance, from ten tested, whereby the flushing had not been completed at the required level of frequency.
- Shower heads were replaced and recycled to mitigate the need for regular cleaning – improving water safety and freeing-up Estates resource to be directed to other compliance task.
- Calorifiers at both sites sampled had not been stripped/drained with sufficient frequency. Work has progressed to address these issues.

(See **recommendations 6-9**).

As there are certain important areas for improvement, **limited assurance** has been determined for this area.

Subsequent to the conclusion of audit fieldwork, the logbooks were identified as having been on site with operatives. They have been returned to the central storage location and arrangements improved with regard the control of these documents.

Risk Management



Assurance that the Health Board has performed a suitable and sufficient assessment of risks, and that risks are appropriately managed.

In accordance with the HSE Approved Code of Practice (ACoP) for Water Safety management, corporate and operational risk registers should be adequately maintained. Procedures were reviewed for the two key sites within the scope of this review.

Risk registers were managed by the Compliance Manager, in co-ordination with the Head of Estates, and were reported to the Water Safety Group and the Health and Safety Committee.

Risk assessments are also required as per WHTM 04.01 section 2.8.

Risk assessments have been periodically undertaken at the UHB for all sites over a number of years and all were updated in 2017. The external company appointed to refresh the assessments in 2017 did not deliver sufficiently detailed and accurate assessments to comply with the WHTM requirements – requiring significant interpretation, risk assessment and prioritisation by internal staff. The additional input from internal staff allowed management to focus efforts on the high risk areas identified.

The Authorising Engineer also recognised this point as a key factor in reducing the compliance rating at his latest annual report, evaluating the risk assessments as 'ineffective'.

However, subsequently, a replacement contractor had recently completed risk assessments of two of the acute sites (PCH & RGH). Management advised that the findings of the updated assessments aligned with those of the original assessments and confirmed that they are low risk systems. Appropriate remedial action is forecast to begin from April 2019 onward.

The implementation of newly completed risk assessments should be utilised to prioritise any necessary remedial actions (**recommendation 10**).

Noting the concerns identified, **reasonable assurance** has been determined to reflect the action ongoing and proposals to address concerns. It is suggested that further audit work would provide assurance that the proposed action has been implemented as intended and has been effective.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	2	7	1	**10**
Actioned since audit fieldwork	1	1	1	**3**

Governance

Finding 1: Appointed Persons	Risk
The HSE Approved Code of Practice (L8) states that: *"The duty-holder should specifically appoint a competent person or persons to take day-to-day responsibility for controlling any identified risk from legionella bacteria, known as the 'responsible person'. It is important for the appointed responsible person to have sufficient authority, competence and knowledge of the installation to ensure that all operational procedures are carried out effectively and in a timely way."* (ref 51). *"Appropriate arrangements should be made to ensure that the responsible person, or an authorised deputy, can be contacted at all times."* The UHB had formally appointed a number of Responsible Persons (RPs), to provide this key role across its estate, working within the wider structure including Executive Lead, independent Authorising Engineer, and trained and experienced operational staff. However, no Deputy Responsible Persons (DRPs) had yet been formally appointed. Individuals had been nominated and were scheduled to attend training in April 2019. Formal appointment would follow completion of the training. Whilst formal appointment was to be completed, enhancing assurance in this area, management was satisfied that appropriate technical, trained staff were in post undertaking water safety duties.	Governance arrangements may not be sufficient to facilitate effective oversight and control of legionella. Staff may not be appropriately trained to identify potential hazards or issues and/or resources are not sufficient to provide efficient oversight and control of water safety.

Recommendation 1	Priority level
Deputy Responsible Persons should be formally appointed to provide sufficient operational support to the Responsible Persons (O).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. Significant work has been carried out over the last year to secure additional funding to recruit 4 additional Band 6 Estates officers. This was approved by the Director of Finance in 3rd quarter of 2018. These posts have now been appointed to, consequently 2 officers will undergo AP water training on 2nd April and will be appointed in the very near future, and a further 2 are due to attend on the next available course following that. This will then give the HB 6 RP's / DRP's. It should be noted that all have received the general water training.	Head of Operational Estates August 2019

Procedures

Finding 2: Policy	Risk
The Health Board did not have a high level Water Safety Policy in place at the time of the audit. Whilst a Water Safety Plan (WSP) was in place, incorporating some of the required elements of a higher level policy, this was out of date and required review and updating (see **finding 5**). Key aspects of the policy, including responsibilities and accountability, were not detailed in the current WSP, and it was unclear what the reporting structure should be. Management advised they were in the process of reviewing the existing Water Safety Plan and creating a separate Policy and Plan, appropriate to the purpose of each document.	The UHB's approach to safe water management may not be appropriately documented and approved. Key responsibilities and procedures may not be adequately defined.
Recommendation 2	**Priority level**
A Water Safety Policy should be prepared and appropriately approved (D).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. A draft water safety policy has been prepared and is currently being circulated to members of the Water Safety Group and will be ratified at its meeting at the beginning of April. It is acknowledged that the existing water safety plan is out of	Head of Operational Estates July 2019

date, however the WSG has agreed that the existing plan will remain in use until the revised plan is adopted. The plan is in draft and is being finalised. All comments have been received and are currently being considered. Once complete this will be circulated and adopted by the WSG. It will then be ratified by the Corporate Risk Committee.	

Finding 3: Water Safety Plan	Risk
WHTM04-01 (Part B) identifies the Water Safety Plan (WSP) as a key document in the safe water management process: *"To assist with understanding and mitigating risks associated with waterborne hazards in distribution and supply systems and associated equipment, healthcare organisations should develop a WSP, which provides a risk-management approach to the safety of water and establishes good practices in local water usage, distribution and supply."* (6.16) *"The WSP is a living document. It should be kept under continual review and ensure the adequate assessment and control of the risks from a wide range of waterborne pathogens."* (6.18) Whilst the UHB had a Water Safety Plan in place, the document was out of date (dated September 2014) and did not therefore adequately reflect the latest guidance (published in 2016). Areas identified as needing to be updated included, for example, the updates to WHTM in July 2015, May 2016 and April 2017; procedures in practice were not reflected; section 3.C.1 on PPM frequency; operational monitoring of control measures and record-keeping methodology; supporting programmes, including communication, training and competency checks; flushing procedures; and, shower clean procedures. The appointed Authorising Engineer also recognises these points and has assessed the Water Safety Plan as 'ineffective'. Management confirmed that the Water Safety Group was aware of this issue and the WSP was under review at the time of the audit.	The UHB's implemented policy and procedures may not sufficiently address legislative compliance requirements.

Management's view is acknowledged that the existing WSP has been approved for continued use by the WSG until the updated Plan is completed. However, the absence of an up to date and regularly reviewed WSP, is a point of non-compliance with the requirements of the WHTM and is therefore rated accordingly.	
Recommendation 3	**Priority level**
a) The Water Safety Plan should be reviewed and updated in line with current guidance, and approved by the Water Safety Group. b) The Water Safety Plan should be subject to continual review and updating as necessary from now on (D).	**High**
Management Response	**Responsible Officer/ Deadline**
Agreed. A draft water safety policy has been prepared and is currently being circulated to members of the Water Safety Group and will be ratified at its meeting at the beginning of April. It is acknowledged that the existing water safety plan is out of date, however the WSG has agreed that the existing plan remains relevant and will remain continue to be adopted until a revised plan is developed. The plan is in draft and is being finalised. Once complete this will be circulated and adopted by the WSG. It is acknowledged that once adopted the WSP is a live document and will be subject to continual review by the WSG.	Head of Operational Estates July 2019

Monitoring & Reporting

Findings 4 & 5: Water Safety Group & Infection Prevention & Control Committee	Risk
The WHTM 04.01 (Part B) states, in respect of the Water Safety Group (WSG): *"The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation and review of the WSP* [Water Safety Plan]*. The aim of the WSG is to ensure the safety of all water used by patients/residents, staff and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring it identifies water-related hazards, assesses risks, identifies and monitors control measures and develops incident protocols."* (6.3). The UHB has implemented a Water Safety Group, as required above. The defined Terms of Reference (dated 2018) specifies a quorum of five members, to include the Chair, one operational manager along with "*senior nursing representation and Facilities manager."* Minutes and attendances for the Water Safety Group across the last year were reviewed, to ensure they were sufficient to enable the Group to adequately discharge its function (as above). Meetings were found to have been held on a bi-monthly basis, in line with the agreed frequency set out in the terms of reference. However, not all required staff were seen to be in regular attendance, including Clinical Board representatives, infection control nurses and nursing staff.	Governance arrangements may not be sufficient to facilitate effective oversight and control of safe water management. Best practice and policy requirements may not be adequately shared across key parties. Decisions may not be sufficiently informed.

Further, the microbiologist assigned to water safety had not attended since April 2018. Management confirmed that a new microbiologist has recently been appointed, which should improve this aspect. The WSG provides reports to the Infection Prevention & Control Committee, which meets on a quarterly basis. A review of minutes found that there had been no representation from Estates evident in the recorded minutes during 2018, with no reports presented with relevance to Water Safety. Whilst management advised Estates representation is sent to each meeting, this was not reflected in the minutes provided.	
Recommendations 4 & 5	**Priority level**
4) Attendances of the Water Safety Group should be reviewed (in particular the assigned microbiologist), to ensure arrangements are appropriate to facilitate the effective discussion of safe water management (O).	**Medium**
5) Minutes of the Infection Prevention & Control Committee should accurately reflect attendances and items reported and discussed (O).	**Low**
Management Response	**Responsible Officer/ Deadline**
4) Actioned since fieldwork.	N/A

Attendance at the WSG is generally good, with the quorum always being present as stipulated in the Terms of reference. The attendances are regularly reviewed in the TOR annually. Following additional recruitment, the microbiologist has confirmed their availability and commitment to attending the WSG. 5) Actioned since fieldwork. Representatives from the Estates department regularly attend the IPCC meetings. In the last 4 meetings attendance was missed on one occasion which was the December meeting. In general, one of the SOM (RP) attend the meeting. We have asked the IP&CC to note all attendees from now on – recognising in particular where deputies attend the meetings.	N/A

Management

Findings 6-8: Water Safety PPMs	Risk

According to the Water Safety Plan and WHTM 04.01 section 10/Appendix D, legionella sampling should be undertaken quarterly and pseudomonas sampling semi-annually. In addition, the Estates department carry out monthly temperature monitoring, shower checks, calorifier monthly checks and quarterly draining, water tank inspections and thermostatic mixing valve (TMV) testing.
 	
The audit included site visits to Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) to review the documentation available in relation to routine Estates checks.
 	
A sample of 10 checks was undertaken at each site. The following was noted from the testing undertaken:
 	
RGH
 	
• All log books were available for review.
• The review of log books confirmed that:
  ○ monthly temperature checks had been undertaken as scheduled;
  ○ shower heads were replaced on a quarterly basis; and
  ○ Calorifiers should be stripped annually in accordance with WHTM 04-01 7.3.4. At RGH, management were unable to advise when the three calorifiers at this site had last been stripped. This issue was known and a contractor had recently been appointed to undertake this task and provide a report on the internal condition of the equipment; to inform frequency of future drainage schedules.
	The legionella risk may not be effectively prioritised and managed within Estates.

PCH • From the log books available for review: ○ Fourteen of twenty-one log books in relation to 6-monthly thermostatic mixing valve (TMV) temperature checks was incomplete or not available for review. It was confirmed that the electronic maintenance system (TABS) was unable to produce information to confirm whether this work had been completed. Management acknowledge the limitations with the current TABs system, and are actively seeking alternative options to improve functionality. It is recognised that this will take some time to fully replace the system therefore this will not be resolved in the short term. Whilst Balanced Scorecard reports are produced by management each month identifying any missed jobs from the previous month, this system allows TMV checks to go 6 months past their due dates before being flagged (see **Appendix B**). ○ shower heads were replaced on a quarterly basis; and ○ The calorifier in Oncology was being drained annually, not quarterly, and therefore was not compliant with WHTM 04-01 7.34 (noting that no assessment and approval was noted that earlier quarterly drainage activities were deemed sufficient and could now move to an annual programme).	

Recommendations 6-8	Priority level
6) All testing, sampling and monitoring should be undertaken in accordance with frequency set out by Water Safety Group, the Water Safety Plan and WHTM 04.01 (O).	**Medium**
7) Action reports should be produced to ensure that all remedial work is up to date and complete (O).	**Medium**
8) Management should attempt to locate the missing log books at PCH. If documentation remains unlocated, the situation should be reported to the Water Safety Group (O).	**High**
Management Response	**Responsible Officer/ Deadline**
6) & 7) • Calorifiers at RGH – the contractor is now stripping them down annually, cleaning internally and providing a detailed report on their condition to aid future PPM frequency. 8) Actioned since audit fieldwork. It was noted that log books were all in place at PCH, but that some were actively being used at the time of the audit for live works. A full check has been carried out and all log books are in place. They are now being kept in the Estates Officers compliance area and are controlled via a sign-in/ sign-out process.	Head of Operational Estates July 2019 N/A

Finding 9: Flushing	Risk
In respect of flushing requirements, WHTM 04.01 (6.42) states: *"HSG274 Part 2 recommends that generally, for infrequently used outlets, flushing is carried out once a week but that in healthcare facilities the risk assessment, as agreed by the WSG, may indicate a higher frequency, and water draw-off should form part of the daily cleaning process. The procedure for such practice should be fully documented and covered by written instructions."* It was confirmed that flushing was required on all wards that have identified unused assets to ensure that stagnant water does not build up with a high count of bacteria, which may then be passed to a patient or staff member. The audit sampled 10 wards at RGH and PCH to review the flushing records in place (full testing details are included at **Appendix B**): Flushing was undertaken at ward level and records retained in housekeeping rooms. Monthly checking was undertaken by Housekeeping to ensure flushing was being carried out. Of the sample of 10 general wards, flushing was undertaken and appropriate records maintained in all except one instance. The Children's Ward had flushing records, but had not been undertaken three times a week in accordance with the Water Safety Plan for the records reviewed.	Required procedures may be undertaken incorrectly / may not be undertaken at all. Risk to patient / staff health. Potential non-compliance with ACOP / WHTM 04-01.

Recommendation 9	Priority level
Flushing should be undertaken, and documented, in accordance with the requirements of the Water Safety Plan (O).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. Children's Ward RGH – flushing had occurred, but not at the prescribed frequency, this has been picked up with housekeeping. Additionally, the audit sample included areas that had not been identified as 'infrequently used outlets', but were being monitored by management to ensure that they were being flushed with sufficient frequency.	Head of Operational Estates July 2019

Risk Management

Finding 10: Risk Assessments	Risk
WHTM 04.01 section 2.8 states: *"A risk assessment forms an integral component of the WSP and is a legal requirement to identify potential hazards (which may be microbial, chemical or physical) in the system, risks of infection to patients, staff and visitors, and other indicators of water quality (for example, taste, odour, flavour and appearance if intended for drinking)."* And *"Once potential hazards and hazardous events have been identified, the severity of risk needs to be assessed so that priorities for risk management can be established."* (6.24). The Health Board has arranged for risk assessments to be undertaken at regular intervals across all of the sites, with significant investment directed towards addressing the risks identified at prior assessments. On refresh of the risk assessments in 2017 by an appointed external contractor, it was identified that the format/ presentation of information was not as desired by the UHB – requiring significant management interpretation to identify the high risks. Nonetheless, whilst causing an inconvenience, management was able to utilise the information to identify and prioritise works. The Authorising Engineer recognised this point as a key factor in reducing the compliance rating at his latest annual report, evaluating the risk assessments as 'ineffective'.	Identified risks may not be effectively prioritised and addressed, risking non-compliance with legislative requirements.

Accordingly, more recently, new risk assessments were commissioned from a different contractor at two acute sites. Management advise that the outcome of the updated assessments confirmed that they are low risk system and identified remedial action was forecast to begin from April 2019 onward.	
Recommendation 10	**Priority level**
The newly completed risk assessments should be utilised to prioritise any necessary remedial action (O).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. Risk assessments are now available for all sites, and all high risks relating to the physical infrastructure have been actioned. The re-commissioned risk assessments are now being utilised to prioritise remedial actions and identified the both RGH and PCH are low risk systems.	Head of Operational Estates May 2019

Appendix B: Supporting Evidence

PPM testing: TMV Temperature Checks

(The table details the log books reviewed on site at PCH. Highlighting indicates where logs could not be located to confirm whether the PPM had been undertaken)

Area	Date last undertaken (A)	Previous date undertaken (B)	Month should have been undertaken (B + 6 months)	No. of months between checks (A - B)	No. of months since last check (February 2019 - A)	Comments
Ward 2 & Link	Jan-19	Dec-17	Jun-18	13	1	PPM job PM1425408 start date 7th September 2017, completed on 9th December 2017. Paperwork missing until August 2018 and then HD423044 raised in January 2019. Should be Sept, March, August, February as it's six monthly.
Ward 3	Aug-18	Nov-17	May-18	9	6	Should be May 2018 & November 2018
Ward 4	Aug-18	Nov-17	May-18	9	6	Should be May 2018
Ward 5	Aug-18	Dec-17	Jun-18	8	6	Should be June 2018 & December 2018
Ward 6	Aug-18	Nov-17	May-18	9	6	Should be May 2018
Ward 7	Aug-18	Jan-18	Jul-18	7	6	Should be July 2019
Ward 8	Aug-18	Jan-18	Jul-18	7	6	Should be July 2019
Ward 9	Feb-19	Sep-18	Mar-19	5	0	
Ward 10	Feb-19	Sep-18	Mar-19	5	0	
Ward 11	Feb-19	Sep-18	Mar-19	5	0	
Ward 19	Feb-19	Oct-18	Apr-19	4	0	Not required until April 2019 but done in February 2019
Ward 30	Mar-18		Sep-18		11	Should be one in September 2018
Ward 31	Apr-18		Oct-18		10	Should be one in October 2018

Area	Date last undertaken (A)	Previous date undertaken (B)	Month should have been undertaken (B + 6 months)	No. of months between checks (A - B)	No. of months since last check (February 2019 - A)	Comments
Ward 34	Oct-18	Apr-18	Oct-18	6	4	
Ward 35	Oct-18	Apr-18	Oct-18	6	4	
Post Grad	Aug-18		Feb-19		6	
Day Unit	Apr-18		Oct-18		10	Should be one in October 2018
ITU	Apr-18		Oct-18		10	Should be one in October 2018 - relates to example PM325002 (in report). New job raised in October 2018 (PM325003) as per frequency with a 6-month completion date. Not done at time of testing. TABS issue.
Antenatal	Apr-18		Oct-18		10	Should be one in October 2018
Dental	Feb-18		Aug-18		12	Should be one in August 2018
Cardiac	Apr-18		Oct-18		10	Should be one in October 2018

Flushing testing

Flushing at RGH

Ward	Flushing records held	Flushing undertaken
Children's Ward	Y	N – last noted to be undertaken on 21/01 & 12/02
Maternity	Y	Y
Intensive Care	Y	Y
Endoscopy	Y	Y
X Ray	Y	Y
A&E	Y	Y
Antenatal	Y	Y
Ward 10	Y	Y
Post Natal	Y	Y
HSDU	Y	Y

Flushing at PCH – all flushing undertaken appropriately

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Health & Care Standards review

Internal Audit Report

2018/19

Cwm Taf University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Executive sign off:	Greg Dix - Director of Nursing, Midwifery and Patient Care
Distribution:	Alison Davies Assistant Director Quality and Patient Experience Allison Thomas Business Manager, Quality & Safety, Patient Care and Safety Directorate Rebecca Thomas Senior Nurse, Professional Standards & Quality Improvement
Committee:	Audit Committee

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Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party

1. Introduction and Background

The audit review of the Health & Care Standards (the 'standards') has been completed in line with the 2018/19 Internal Audit Plan for Cwm Taf University Health Board (the 'Health Board').

The Standards set out the Welsh Government's common framework of standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings. They set out what the people of Wales can expect when they access health services and what part they themselves can play in promoting their own health and wellbeing. They set out the expectations for services and organisations, whether they provide or commission services for their local citizens.

The Standards came into force from 1 April 2015 and incorporate a revision of the 'Doing Well, Doing Better: Standards for Health Services in Wales (2010)' and 'Fundamentals of Care Standards (2003). The Standards provide a consistent framework that enables health services to look across the range of their services in an integrated way to ensure that all that they do is of the highest quality and that they are doing the right thing, in the right way, in the right place at the right time and with the right staff.

The Health Board uses and electronic system called the Health and Care Monitoring System (HCMS), to capture and assess its compliance against the standards.

Previous audit work has been undertaken to ensure that appropriate plans were in place for the effective implementation of the standards across the Health Board. More recent audit work has focussed on ensuring effective completion of self-assessments and the subsequent monitoring.

The relevant lead for the assignment is the Director of Nursing, Midwifery and Patient Care.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Standards. The review has sought to provide assurance to the Health Board's Audit Committee that risks material the achievement of the systems' objectives are managed appropriately.

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

- Suitable oversight of the Health and Care Standards throughout the Health Board is in place, with regular reporting of performance against the standards at relevant committees.

- A documented process, including a timetable of key dates, is in place for the preparation and completion of the self-assessments. Training is provided where necessary.
- Self-assessments are completed in line with the Health Board's prescribed timescales, are subject to formal sign off at a ward level and central review for ensuring consistency.
- Appropriate narrative, evidence and scoring is in place to support the self-assessments.
- Action plans are developed at a ward / department level following identification of issues with a central review of action plans to identify common issues across the Health Board.

3. Associated Risks

The potential risks considered in this review were as follows:

- Insufficient governance and oversight of Health and Care Standards throughout the Health Board.
- Non-adherence to the relevant requirements of the Health and Care Standards.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Health and Care Standard 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 Health and Care Monitoring System (HCMS) is the electronic system which houses the Health and Care Standards. For the three areas tested (District Nursing, Surgical Ward at RGH, Older Persons Mental Health Ward at Ysbyty Cwm Cynon), all had completed their self-assessments within the prescribed audit window, though not all could demonstrate there had been a review of the data by a Senior Nurse

A sound process was seen to be in place centrally to inform all relevant staff of the need to complete their self-assessments, offer support if necessary and monitor and remind those who had not yet completed them.

Whilst guidance and training on use of the HCMS and the Health and Care Standards has been provided in the past, there has been no recent updates. Whilst users can request refresher training at any time, uptake is low. However testing undertaken during this audit review has highlighted some areas where training and guidance may assist. For example, a number of questions in the self-assessments are based around staff selecting a sample

of five patient files. When we tried to reconcile self-assessment scores back to files we could not as staff had no recording of which patient files they had selected. Some had selected a different five files for each question or section within the standards. It was therefore felt that guidance is needed on the process staff should following when selecting a sample of files and on keeping an audit trail of those files to support any outcomes.

At the time of the audit, the annual Health & Care Standard Report was currently being developed and yet to be finalised. It is intended to be completed by the end of May 2019 and planned to be presented at the next Quality Safety & Risk Committee taking place in June 2019.

5. Assurance Summary

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

Assurance Summary					
1	Oversight of process				✓
2	Process planning and training			✓	
3	Timeliness and review of self-assessments			✓	
4	Appropriateness of self-assessments		✓		
5	Action plans				✓

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

Design of Systems/Controls

The findings from the review have not highlighted any issues that are classified as weakness in the system control/design for Health and Care Standards.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weakness in the operation of the designed system/control for Health and Care Standards.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A)

Objective 1: Suitable oversight of the Health and Care Standards throughout the Health Board is in place, with regular reporting of performance against the standards at relevant committees.

We note the following areas of good practice:

- Each report presented to Board and its sub-committees makes reference to the Health and Care Standards and their links to that report.
- An annual report is presented to the Quality, Safety and Risk Committee summarising the outcomes of the self-assessment work.

We did not identify any findings under this objective.

Objective 2: A documented process, including a timetable of key dates, is in place for the preparation and completion of the self-assessments. Training is provided where necessary.

We note the following areas of good practice:

- Overview guidance was issued to all relevant staff a month ahead of the of the self-assessment audit period. This gave clear guidance on the timeframe for completing the assessment and the deadline for reviewing. Staff were also informed that support was available and that refresher training could be provided if necessary. Staff in the three areas tested confirmed that the central always provided the necessary support they required.
- There was a timetable in place documenting the stages of the process which was updated as each stage was completed.

We identified the following finding:

- Training and guidance documentation has been provided in the past to support the use of the HCMS database, and the interpretation of the questions in Health and Care Standards module, however this has not been refreshed in recent years

Objective 3: Self-assessments are completed in line with the Health Board's prescribed timescales, are subject to formal sign off at a ward level and central review for ensuring consistency.

We note the following area of good practice:

- Monitoring of completed self-assessments took place during the two month assessment period and reminder emails were sent to the

teams who had not yet submitted their return, offering support if needed.

We identified the following finding:

- Whilst all three selected areas submitted their self-assessment before the expected end date, not all had been signed off as reviewed by the Senior Nurse as required. In addition, in one instance the same person had signed off the self-assessment and input the information.

Objective 4: Appropriate narrative, evidence and scoring is in place to support the self-assessments.

We identified the following finding:

- We were unable to confirm the appropriateness of the scores in the completed self-assessments in the three selected areas, as in all cases no records were retained of which patient files were sampled and supporting narrative was not always input on the system.

Objective 5: Action plans are developed at a ward / department level following identification of issues with a central review of action plans to identify common issues across the Health Board.

We note the following areas of good practice:

- Following recommendations made in previous year's internal audit report a method for capturing issues arising from the self-assessments has been developed. The Patient Care and Safety team provide support to managers in the completion of their action plans. Plans were in place for the three areas that we tested.
- An action plan 'drop in' session was organised by the Health Board to inform and educate staff on the process of preparing an action plan.

We did not identify any findings under this objective.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**1**	**1**	**3**

Finding 1: Self-assessment review (Operating effectiveness)	Risk
For the three wards and areas that we sampled we reviewed their self-assessment submission to ensure there was appropriate narrative and evidence in place to support the scoring that had been attributed. In all cases the applicable sections of self-assessments had been completed. However, we identified the following: • **Evidence -** A number of the questions within the self-assessment are based on the information within a sample of five patient files. All three staff involved with the compilation of the self- assessment exercise had not kept a record of which patient files had sampled. In some cases different files had been used for different questions or standards. As such, we were unable to verify the self-assessment scores. Similarly, the Senior Nurse would not have been able to undertake any checks prior to signing off the self-assessment. • **Narration -** Most findings did not have any narration to support them. The HCMS does not require a narrative and as such the self-assessments can be completed with or without narratives. This is left at the discretion of the staff inputting and reviewing. In some cases, where questions are open to interpretation, we felt that a brief narration would have assisted in getting a better understanding on why particular score had been attributed, especially where the resulting score is amber or red rated. This may also help when completing the action plans being used for monitoring.	Non-adherence to the relevant requirements of the Health and Care Standards.

• **Scoring-** Scoring of the self-assessments appears to be subjective, as there is no guidance in relation to scoring. As such, it is difficult to understand how the standards had been measured, and there could be inconsistencies across wards or areas.	
Recommendation 1	**Priority level**
1. Details should be retained of those files that have been sampled when completing self-assessments, to allow the re-performing of scoring calculations by the Senior Nurse or anyone else undertaking consistency checks. 2. Where questions are open to interpretation, narrative explanations should be included within HCMS, especially for those questions resulting in a red or amber score.	**High**
Management Response	**Responsible Officer/ Deadline**
1. We will add a space on the self-assessment form for staff to record the hospital number of the patient's records they have audited. 2. Explore the possibility of automating the input of some supporting narrative within the HCMS. Continue to encourage staff to provide supportive narrative – this can be achieved during training and highlighted in any guidance documents.	Senior Nurse Professional Standards and Quality Improvement – end of June 2019 Senior Nurse Professional Standards and Quality Improvement – end of June 2019

	– need to link in with Head of Clinical Audit & Quality Informatics with regards to the functionality.

Finding 2: Training and guidance (Operating effectiveness)	Risk
Training Following the completion of the self-assessments, action plans will be produced for wards / departments to implement. The Patient Care and Safety team arranged two 'drop in' training sessions to inform staff about the action plans. We were informed by the Senior Nurse for Professional Standards and Quality that the first session was cancelled as no one attended, and while the second session took place the attendance was very low. While no specific training was offered in relation to the completion of the self-assessments, staff were aware and had been informed via email from the Patient Care and Safety team to contact them for support if required. **Guidance** A 'HCS Audit process guidance' and timetable, which gave an overview of the self-assessment work was issued to all relevant staff. This included the action plan training dates, and the availability of support if needed. However, there is no detailed guidance which encapsulates the whole process including the system (HCMS) in use from the point of commencement to the actual completion of the H&C standards self-assessment and thereafter. During our review, we identified some matters that could be avoided with a refresh of training and guidance. These were: • The same officer inputting and 'signing off' a wards self-assessment.	Non-adherence to the relevant requirements of the Health and Care Standards.

• Staff are not always aware of the 'n/a' (not applicable) button within the self-assessment. We were informed by the Senior Nurse that the confusion could have been due to 'n/a' also denoting not answered within the patient survey questionnaire which is also embedded within the HCMS. This was evident during our review of information within the District Nursing team. As a result some questions were marked with a score of zero instead of using the 'n/a' function, which affected the ward / department overall score as it suggests they were non-compliant in that area. • Evidence or audit trails not retained to allow identification of the sample of files used. • Staff completing the return monthly instead of annually. • Ambiguity on the need to include narrative to support the scores input.	
Recommendation 2	**Priority level**
Guidance documentation should be in place and made available to all relevant staff on the completion of the self-assessments within the Health Care Management System. Guidance should include a step by step guide to completing the assessment, but also cover areas that have been identified as issues, such as the retention of records to show which samples were used and how samples should be selected (a consistent sample or different one for each question). Additional training should be considered to support the guidance issued.	**Medium**

Management Response	Responsible Officer/ Deadline
We will review the current guidance and amend to ensure we include a more detailed guide to completing the self-assessment. This will be further supported with a week of dedicated walking the wards/areas and speaking to staff.	Senior Nurse Professional Standards and Quality Improvement – end of September 2019
We will explore the opportunity for creating a video to guide staff through the self-assessment process and storing the necessary supporting documents on a SharePoint page.	Senior Nurse Professional Standards and Quality Improvement – end of September 2019

Finding 3: Review and sign off (Operating effectiveness)	Risk
At the point where the self-assessments has been input on the Health Care Management System (HCMS), an email is sent to the Ward Manager, as the first reviewer, where they are prompted to sign off the data that has been input. Subsequently, the Senior Nurse is prompted to undertake a second review, and sign off the review within the system. Our testing of the review and sign off in the three wards and departments that we sampled identified: • Ward 7 Mental Health – both the initial sign off and review sign off had been completed by the same person, which was also after the Health Board's timetabled deadline. • District Nursing (Hirwaun Park team) - although the data was submitted on time, at the time of our fieldwork it was yet to be signed off by the Senior Nurse. We note that this did not have an impact on the data being included for the overall Health and Care Standards report. We note that in other health organisations a form or peer review is undertaken prior to the completed standards being submitted for inclusion in any corporate report. While we acknowledge that a level of independent checking is carried out by the Patient Care and Safety team, this is not at a detailed level. Cross checking across wards and departments would allow for inconsistencies in scoring and interpretation of the questions to be resolved, and give teams the opportunity to learn from each other.	Non-adherence to the relevant requirements of the Health and Care Standards.

Recommendation 3	Priority level
Staff should be reminded of the need for the data input into the HCMS to be reviewed and signed off in a timely manner. The review should be undertaken by a Senior Nurse and be someone different to who input the data in the first instance. Consideration should be given to introducing a system of peer reviews amount wards / departments to allow the identification of inconsistencies and sharing of best practice.	**Low**
Management Response	**Responsible Officer/ Deadline**
We will explore the opportunity for automated notification reminders for staff to sign off their data in line with the expected deadlines. Continue to encourage staff to sign off their data within the timescales identified – this can be achieved during training and highlighted in any guidance documents. We will introduce a programme of peer review for undertaking the 2019 audit. This will take place after the 31st November so that comparisons can be made.	Senior Nurse Professional Standards and Quality Improvement – end of September 2019 - need to link in with Head of Clinical Audit & Quality Informatics with regards to the Health Care Monitoring System functionality. Senior Nurse Professional Standards and Quality Informatics – end of 2019.

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

Prince Charles Redevelopment
Follow-up of Previously Agreed Recommendations

FINAL INTERNAL AUDIT REPORT
2019/20

Cwm Taf Morgannwg University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Opinion and key findings

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Appendix A Management Action Plan

Appendix B Audit Assurance Ratings

Review reference:	SSu_CTM_1920_05.1
Report status:	Final
Fieldwork commencement:	25th April 2019
Fieldwork completion:	24th June 2019
Draft Report issued:	26th June 2019
Management Response received:	28th June 2019
Final Report issued:	3rd July 2019
Auditor/s:	NWSSP: Audit & Assurance Specialist Services Unit
Executive sign off	Ruth Treharne Director of Planning & Performance (Senior Responsible Officer)
Distribution	Iain Worby (Deputy SRO)
Committee	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The audit originated from the 2019/20 PCH Redevelopment audit plan agreed with management and presented to the April 2019 Audit Committee.

The audit sought to determine the current status of previous audit recommendations contained within the PCH Redevelopment Audit Report, issued in March 2019 and assessed as providing ***Limited*** assurance.

The review included 13 high and 8 medium recommendations in the following key areas:

- Cost Management;
- Programme Management;
- Programme Governance; and
- Appointments and Contracts.

2. Scope and Objectives

An objective of the audit was to deliver assurance to the Audit Committee that timely and appropriate management action had been applied to address risks identified and reported at the PCH Redevelopment Audit Report (March 2019).

3. Associated Risks

The potential risks considered in the review were:

- Management control frameworks continue to exhibit weaknesses;
- Management did not have processes in place to review and action agreed audit recommendations; and
- Management did not have adequate recording systems to inform whether requisite actions have been undertaken, and are therefore unable to evidence actions.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The system of internal control in place to manage the risks associated with implementing agreed recommendations has been assessed as providing **Substantial Assurance**.

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

5. Summary of Audit Findings

The status of agreed management actions can be summarised as follows:

Audit	Closed	Partially implemented	Outstanding	Total
High	13	-	-	**13**
Medium	8	-	-	**8**
Low	0	-	-	**0**
Total	**21**	**-**	**-**	**21**

Each of the agreed actions had been fully implemented at the time of this review.

6. Audit Conclusion

Agreed actions from the prior review have been **fully implemented**.

Further audit work will be conducted as part of the 2019/20 agreed Audit Plan to determine and appraise the **ongoing effectiveness** of the action taken by management in due course.

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Previously Agreed Management Recommendations

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Updated Status
3	The Project Board should ensure mechanisms are in place to allow it to effectively discharge its responsibility to confirm that the Programme delivers appropriate value for money	Deputy SRO By 13th April 2019	**High**	Closed. Noting the implementation of recommendations 9,10 & 11.
4	The Programme Business Case should be prioritised for completion and submission to the Welsh Government	Deputy SRO By 13th April 2019	**High**	Closed. The Programme Business Case was submitted to the Welsh Government (WG) on the 28th February 2019.
8	The UHB should also determine alternative courses of action, if it becomes clear that the Supply Chain Manager will not agree to significantly revise its cost estimates for Phase 2 or provide alternative solutions to deliver the Programme in accordance with approvals	Deputy SRO By 13th April 2019	**High**	Closed. Alternative courses of action were considered by the Project Board (and defined at the business cases) in the event that target cost agreement could not be achieved. However, the External Cost Adviser reduced the variance between their own assessment and that of the Supply Chain Manager, allowing them to recommend acceptance of the target cost.
9	The up-lift and indexing methodology (to assess inflationary costs) should be tested and either accepted/rejected (£59,835m) *(O)*.	Deputy SRO By 13th April 2019	**High**	Closed. The variation outlined was scrutinised and validated as part of the determination of the Business Cases for Phase 1b, Phase 2 and overall Programme Business Case – as submitted to WG.

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Updated Status
10	The unapproved additions should be analysed and either accepted/rejected (£59.708m) *(O).*	Deputy SRO By 13th April 2019	**High**	Closed. The variation outlined was scrutinised and validated as part of the determination of the Business Cases for Phase 1b, Phase 2 and overall Programme Business Case – as submitted to WG.
11	The variance between the External Cost Adviser and Supply Chain Partner assessments should similarly be resolved (£24m) *(O).*	Deputy SRO By 13th April 2019	**High**	Closed. The variation outlined was scrutinised and validated as part of the determination of the Business Cases for Phase 1b, Phase 2 and overall Programme Business Case – as submitted to WG.
12	Professional advice should be received on the VAT recovery assumptions for agreement with HMRC, and appropriately acted upon	Deputy SRO By 13th April 2019	**High**	Closed. The appointed VAT advisers have provided advice on the VAT recovery assumptions and cost reporting has been updated accordingly.
14	The Project Board should receive copies of the monthly Welsh Government 'Dashboard Reports' submissions for information and to enhance internal monitoring *(O).*	Deputy SRO By 3rd May 2019	**Medium**	Closed. The Project Board now receives copies of Welsh Government dashboards reports.
15	The internal requirements for 'Dashboard Reporting' should be extended to cover all phases of the Programme and provide additional financial information prior to the approval of relevant OBC/FBC/BJCs	Deputy SRO By 3rd May 2019	**Medium**	Closed. Confirmation has been received that WG dashboards are not required for unapproved elements. However, the Project Board now receives all-encompassing cost reports – including forecast costs for all elements of the

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Updated Status
	for internal reporting/control purposes *(O).*			programme, including unapproved elements. This compensatory arrangements adequately addresses the identified risk.
16	A full activity based resource plan should be developed for current and future internal resource requirements (including fully dedicated operational leadership) – see also **recommendation 23**	Deputy SRO By 3rd May 2019	**High**	Closed. An initial assessment has been made to determine the requirement for the current stage of the programme (Phase 1b) – with key appointments made e.g. Deputy SRO, Commissioning Officer and Administration Officer. Further assessments have been concluded on the additional resource requirement to deliver Phase 2 – based on the phasing of programme options currently being considered.
17	The UHB should supplement existing arrangements with checkpoint stages to effect enhanced monitoring of the performance of the external advisers	Deputy SRO By 3rd May 2019	**High**	Closed. Key Performance Indicators have recently been completed for the advisers, Supply Chain Manager and UHB. Further, a meeting was held with the External Project Manager/ External Cost Adviser to discuss performance to date and specific actions agreed to address each UHB concern. Further review meetings have been programmed to monitor and evaluate adviser performance.
18.1	The monitoring of the financial stability of the Supply Chain Manager should be the responsibility of the Director of Finance, so he provides	Head of Finance 30th April 2019	**High**	Closed. The Director of Finance is now included on the circulation of Financial Vetting Reports and Cabinet Office updates

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Updated Status
	ongoing advice to the Project Board in relation to the same *(D).*			from NWSSP: SES. The same was presented to the recent Project Board.
18.2	The Director of Finance should determine whether similar arrangements should be required for other relevant parties in the supply chain *(D).*	Head of Finance 30th April 2019		Closed. Whilst the UHB stated "the supply chain is the responsibility of the Supply Chain Partner", NWSSP: SES has been requested to provide regular reports on the Mechanical & Electrical Supply Chain Member.
18.3	The Director of Finance should determine whether similar arrangements should be required for any of the external advisers *(D).*	Head of Finance 30th April 2019		Closed. This has been assessed as lower risk but similar regular reports have been requested from NWSSP: SES.
19	The risk provisions for the insolvency of key parties at each phase should be reviewed for adequacy*(D).*	Head of Finance 30th April 2019	**High**	Closed. The risk of potential delay arising from insolvency has now been fully quantified as T149b within the risk register.
20	Project Management Tools will be regularly reviewed at key checkpoints to ensure they remain effective	Deputy SRO By 3rd May 2019	**Medium**	Closed. Key management tools have been updated for consideration by the Project Board. The same have been programmed for regular review going forward.
21 a) & b)	The risk register should include details of: a) the individual(s) responsible for mitigation actions	Deputy SRO By 3rd May 2019	**High**	Closed. a) Risks have now been allocated between the Deputy SRO and the relevant service lead, based on which is best placed to oversee implementation.

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Updated Status
	b) quantify the financial value of the identified risks (see recommendation 21). (O).			b) The risk register is not fully costed and reported to the Project Board.
22	Work stream leads will be accountable to the Project Team/Board on performance to achieve outcomes/ products *(D).*	Deputy SRO By 3rd May 2019	**Medium**	Closed. In response to the Gateway review, the technical and service aspects are now led by different individuals, with supporting work streams. Each feeds, independently on their areas of responsibility, into the Project Board.
23	The resource/ activity plan will give due consideration to the required work streams (D).	Deputy SRO By 3rd May 2019	**Medium**	Closed. The resource requirement has considered the requirement of each officer, including attendance of key meetings and work stream input.
24	Opportunities should be explored to implement efficiencies through increased collaboration between the Supply Chain Manager, external advisers and the UHB	Deputy SRO By 3rd May 2019	**Medium**	Closed. The advisers' resource is now site based and co-located with the Supply Chain Manager. Further opportunity for collaboration will be considered at the regular performance reviews.
25	Contracts should be signed in a timely manner	Deputy SRO By 13th April 2019	**High**	Closed. Letters of intent were not utilised at Phase 1b.

Ref	Recommendation	Responsibility & Timescale	Priority Rating	Updated Status
Recommendations from Prior Audit (fieldwork progressed during September and December 2016)				
4	Time-bound deliverables and outputs will be established for each element of the business case as soon as possible and submitted to the Project Board for agreement. Business case delivery progress will be monitored by the Project Board in the form of dashboard reporting against the same.	Assistant Director of Planning (Capital & Estates) Deputy SRO. To be agreed by Audit Committee and NWSSP-AA	**Medium**	Closed. This relates to the business case process for potential future phases beyond Phase 2. The same will be incorporated within the audit plan for future phases.
5	An appropriate IAAP will be developed to recognise the various assurance providers. Funding of costs of assurance providers, including internal audit will be recognised within the business case project costs.	Deputy SRO CTUHB will provide evidence to NWSSP-AA by 13th April in order for this recommendation to be formally closed.	**Medium**	Closed. The Audit Plan for 2019/20 was agreed at the April 2019 Audit Committee.

Handover of Care at Emergency Departments Follow-up Health Board Related Recommendations

Internal Audit Update Paper

2018/19

Welsh Ambulance Services NHS Trust

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix A Original Findings and Recommendations with Current Findings and Considerations Going Forward
Appendix B Prioritisation of Recommendations
Appendix C Responsibility Statement

Review reference:	WAST1819-20
Fieldwork commencement:	26 March 2019
Fieldwork completion:	23 May 2019
Report issued:	21 June 2019
Auditors:	Helen Higgs, Head of Internal Audit Osian Lloyd, Deputy Head of Internal Audit Johanna Butt, Principal Auditor Philip Lewis-Davies, Principal Auditor

Distribution: Board Secretary

ACKNOWLEDGEMENT

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

Please note:

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1. Introduction and Background

The follow up review of the Handover of Care at Emergency Departments was completed in line with the Welsh Ambulance Services NHS Trust ('WAST') 2018/19 Internal Audit Plan. The review sought to provide all six health boards that have Emergency Departments, with assurance that operational procedure is compliant with Welsh Health Circulars issued by Welsh Government.

The purpose of the review was to assess whether health boards have taken appropriate action in response to the findings raised following the Handover of Care at Emergency Departments review in 2017/18 where we gave an opinion of 'limited assurance'. While the review was included in the WAST Internal Audit Plan, all six health boards that have Emergency Departments were engaged in the fieldwork of the review and the draft report was issued to the six health boards for response to relevant recommendations in January 2018. Note that Powys THB was excluded from the review, as it does not manage any Emergency Departments.

The statement of intent section of the Welsh Health Circular titled 'NHS Wales Hospital Handover Guidance' (reference WHC/2016/029) states:

'The safety, effectiveness and dignity of care of patients must be at the forefront of systems of emergency care. The best care is provided to patients in the correct care environment. When ambulance crews take a patient to hospital it is essential that they are released swiftly so they can continue to provide a safe and efficient service to the local community.

Health boards are responsible for ensuring the safe emergency transport, and timely treatment, of citizens in their local area. When a patient is conveyed to a hospital by ambulance care must be handed over to the hospital team within 15 minutes, and health boards are responsible for ensuring that this happens reliably. All members of the health board Executive team have a special responsibility to communicate the importance of handover.

Patients and their carers are important partners in the process of handover and admission. Their involvement should be a key part of planning emergency care, and when delays occur they should be kept fully informed of the reasons and the progress being made in resolving them.

Staffing arrangements in hospitals should ensure the safe care and treatment of patients. Hospital sites should have effective Escalation Plans in place to ensure ambulances can be offloaded at times of peak pressure. Senior clinical decision makers should be present routinely at the hospital front door and their presence strengthened as part of the escalation plan when pressures build in the system.

The planning of Unscheduled Care must be given a high priority by health boards. Delays in hospital handover is frequently associated with blockages to patient flow further upstream, and work across the whole pathway of health and social care is necessary to address this properly.

Key actions to support hospital handover have been highlighted and summarised. They are intended for implementation by the health boards and Trusts in the NHS across Wales in local policies and protocols, and should be incorporated into local site Escalation Plans as they are revised in line with the latest Welsh Government advice.'

2. Scope and Objectives

The scope of this follow up review does not aim to provide assurance against the full review scope and objective of the original audit. The follow-up review does not provide an assurance level against the action taken by health boards in response to the original report findings raised.

The follow up review engaged all six health boards included in the scope of the 2017/18 audit with the exception of Cardiff & Vale University Health Board, where permission to engage was not received. Note that this follow up review was performed prior to the restructure of Cwm Taf and Abertawe Bro Morgannwg University Health Boards and their renaming as Cwm Taf Morgannwg and Swansea Bay University Health Boards respectively.

The 2017/18 report included the following caveat:

'*A draft version of this report was presented to the WAST Audit Committee in March 2018. While management responses to our recommendations have been received from WAST, responses are still awaited from health boards on the seven out of eight recommendations that apply to both WAST and health boards.*

We have received assurances from WAST that it will continue to work with health boards to encourage management responses and work to implement these joint responsibility recommendations.'

The 2017/18 review assessed compliance with the following key actions highlighted within the Welsh Health Circular to support hospital handover:

- planning for emergency care should involve patients with recent experience of care and must be clearly visible in the IMTP;
- ambulance conveyance should be actively managed by health boards and WAST;
- pathways for emergency care that bypass the Emergency Department should be in place;

- safe, sustainable, staffing levels for emergency care, able to flex to meet demand, must be in place, with appropriate levels of supervision;
- health boards and WAST should meet weekly to manage emergency care flow. These meetings should ensure that care pathways that reflect the five step ambulance model used to commission ambulance services in Wales are in place;
- health board executives must visibly and repeatedly communicate the importance of ambulance handover to staff;
- hospital clinical staff must ensure that any patient waiting more than 30 minutes has been assessed and moved immediately into hospital is there is a risk to patient safety; and
- wards must increase their ability to pull patients safely from Emergency Departments at times of peak demand. If significant ambulance delays occur, health boards must ensure that effective site escalation arrangements allow ambulances to be released promptly.

In addition we also reviewed the training provided to paramedics and Emergency Departments to support effective hospital handover.

3. Associated Risks

The overall risk to be considered in the follow up review was poor governance arrangements leading to failure to implement agreed audit recommendations and therefore continued:

- Non-compliance with Welsh Government guidance resulting in patients coming to harm; and
- Failure to achieve the most efficient and effective use of resources.

4. Audit Findings

The findings and recommendations raised from the 2017/2018 audit are set out in Appendix A, together with current findings, including health board comments. This report should be read in conjunction with the separate follow up Internal Audit report (ref WAST 1819-20).

The current review considers all recommendations made (high, medium or low priority). This report **does not** provide assurance against the full review scope and objective of the original audit.

During the course of the review we attended meetings with health board nominated key contacts at five health boards, with the exception of Cardiff

& Vale University Health Board (C&VUHB), where permission to engage was not received. We discussed actions and progress made to address the relevant findings and recommendations. Documentary evidence in support of comments has not been received in all instances and as such may not be reflected in the report.

Whilst all health boards received a copy of the original internal audit report, management responses to it varied. Two of the health boards, Betsi Cadwaladr University Health Board (BCUHB) and Swansea Bay University Health Board (SBUHB), formerly Abertawe and Bro Morgannwg University Health Board managed relevant findings and recommendations raised in the report via their respective Audit Committees, reporting on specific actions taken and progress made. The remaining health boards did not manage these findings and recommendations in such a formal manner but were able to comment on actions already in hand or that the specific issues were not considered relevant to their Emergency Department operations, for example where their Ambulance Quality Indicators (AQIs) already evidenced good performance.

There have been continued developments of processes and practices in all health boards, many in conjunction with WAST to improve handover of care and aimed at reducing delayed handover times whilst maintaining or improving patient care and experience. WAST and health boards have engaged in a number of pilot/trials in this regard.

In respect of the recommendations made in the initial report, many of the actions taken either did not commence until late in the final quarter of 2018/19 or, in the case of certain health boards, were not primarily implemented in response to the original report. As such, these actions are either not fully implemented, or have not had enough time to embed to enable us to see the impact on handover delays or an improvement in the AQIs.

	2018-19											
	QTR 1			QTR 2			QTR 3			QTR 4		
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Percentage of notification to handover within 15 minutes of arrival at hospital (AQI20 i)	51.70%	57.00%	58.60%	54.80%	54.80%	52.80%	52.40%	56.20%	53.60%	48.00%	51.80%	51.20%
Number of notification to handover within 15 minutes (AQI20 i)	9,804	11,521	11,398	11,042	10,733	10,144	10,568	11,105	11,309	9,752	9,406	10,297
Total Number of handovers (AQI20 i)	18,974	20,213	19,449	20,149	19,593	19,223	20,155	19,768	21,090	20,324	18,156	21,127
Number of lost hours following notification to handover over 15 minutes (AQI21)	6,134	4,137	3,777	4,562	4,669	5,253	6,020	4,707	6,038	8,781	5,610	6,833
Total lost hours in the quarter		14,048			14,484			16,765			21,224	

We acknowledge that some of the actions to be taken are long-term and also require support and cooperation between health boards and WAST, and as such will take some time to be fully implemented and embedded.

5. Assurance Summary

The following table summarises the extent to which the original recommendations have been implemented and provides classification of current risks:

	Area	Priority 2017/18 audit	Direction of travel	Priority 2018/19 audit
1	Patient Care during handover delays.	Low	Progress made. Further work is required to reduce the risk.	Low
2	Conveyance to ED.	High	Progress made. Further work is required to reduce the risk.	Medium
3	Pathways to bypass ED.	High	Progress made. Further work is required to reduce the risk.	Medium
4	HALO Role.	Medium	This recommendation was prmarily for WAST to implement.	Low
5	Strategic forums.	Medium	This recommendation was prmarily for WAST to implement.	Medium
6	Patient flow initiatives.	Medium	Progress made. Further work is required to reduce the risk.	Medium
7	Delayed handover clinical triage.	High	This recommendation was specifically for Cardiff and Vale University Health Board. The health board did not engage in the audit.	High
8	HAS data.	Medium	Limited progress made. Further work is required to reduce the risk.	Medium

Recommendations 4 and 5 are primarily the responsibility of WAST and have been included in the WAST Handover of Care at Emergency Departments follow up report WAST1819-20.

Regarding recommendation 4, WAST confirmed that Swansea Bay University Health Board was the only health board that recognised the benefit of having a Hospital Ambulance Liaison Officer (HALO) at their hospitals and agreed to part fund a Clinical Team Leader (CTL) as a 'Patient

Flow Co-ordinator' to attend the hospitals whenever WAST experienced delays.

Regarding recommendation 5, WAST confirmed that they had recently undertaken a review of the governance arrangements between WAST and the health boards. Structured interviews were held at each health board. This exercise will form the basis of a stakeholder engagement map.

6 Summary of Audit Findings

Actions Implemented in Full / Superseded	Actions Implemented in Part	Actions Not Implemented
0	**5**	**1**

The prior year report identified three **high priority** findings, two of which are now considered to be partially implemented and the priority ratings reduced to reflect the progress made and positive impact on risk. One remains at high priority as the finding commented on Cardiff and Vale University Health Board procedures. This health board did not engage in the audit and we are not able to provide an updated rating.

- **Conveyance to ED (previous finding 2)**

Our original review identified that both health boards and WAST raised the issue regarding the impact on conveyance and peaks in attendance to Emergency Departments that result in handover delays. In particular, GP referrals are unscheduled and occur between GP hours which can contribute to bottlenecks outside hospitals. Ambulance crews were often unable to convey GP referrals to hospital within the relevant department's opening hours. It was generally recognised that improvements could be made by having scheduled conveyance for GP referrals where appropriate.

Our current review found that WAST had undertaken a number of initiatives in conjunction with specific health boards in an attempt to positively impact conveyance of GP referral to the ED, these included:

- WAST carried out a two-day trial in October 2018 in collaboration with Aneurin Bevan Heath Board (ABUHB), to assess the impact of Health Care Professional (HCP) calls being handled by a clinician. This resulted in a reduction in the number of patients being conveyed to hospital by a Welsh Ambulance Service resource.

- Enhancing on the above, Betsi Cadwaladr University Health Board (BCUHB) implemented a Single Integrated Clinical Assessment and Triage service (SICAT) which went live in November 2018. This service sits co-terminus within the WAST's Clinical Contact Centre (CCC) in

North Wales. It is currently manned by an experienced General Practitioner (GP) working alongside an APP. The service focuses on Health Care Practitioner (HCP) demand – though this is not exclusive, where calls of higher acuity are identified, to avoid ambulance deployment or patient conveyance. As at March 2019, the service had managed almost 200 calls. Analysis of these calls shows an improvement in reducing the deployment of WAST crews and the avoidance of conveyance to Emergency Departments. The scheme also saw an increase of ambulance conveyances to Minor Injuries Units.

- WAST in collaboration with ABUHB undertook a GP transport pilot. The purpose of the pilot was to reduce the delays with transporting patients referred into acute hospitals from GP's, and to diarise suitable patients to improve flow through the assessment units. The initial pilot ran for 6 weeks during February and March 2018. The trial had mixed success due to a number of reasons including no dedicated coordinator, the crew being diverted to emergency calls and shifts not being covered, although it did show a general reduction in the time from booking to arrival at assessment units. It was proposed that the trial be run for six months from October 2018 to April 2019, however, the decision was taken to defer due to significant pressures.

- ABUHB was involved in a Falls Response pilot in conjunction with WAST to reduce the number of patients who have fallen, which represents one of the 'Big 5' unscheduled care demands, being transferred to the ED. This pathway has been rolled out to several health boards and many of the health boards reviewed confirmed that they have taken part in the Falls Response vehicle scheme commissioned by WAST from December 2018.

- Swansea Bay University Health Board (SBUHB) have undertaken work to reduce unnecessary conveyance to ED from Care Homes. This has included successfully rolling out training on 'I Fell Down' to the Neath Port Talbot (NPT) Local Authority area with plans to roll out to the Swansea Local Authority homes at the time of our review. The health board had also agreed to participate in the National Collaborative Commissioning Unit's (NCCU) 'National Early Warning Score (NEWS) project' to ensure the use of regular NEW scoring in two or three nursing homes in the Swansea Bay area to support conveyance and discharge decisions.

- SBUHB was also involved in a Bevan exemplar project on the 'Integrated Response Model' with the aim of redirecting appropriate 999 emergency calls where the patient would be better suited to receiving community based care from the Acute Clinical Team. The project summarised that "*The Integrated Response Model is an innovative new approach, aligned to the principles of prudent healthcare, to reduce the burden of*

emergency 999 calls and A&E attendances by offering an alternative pathway of care that was only limited by the resources needed to deliver it. The project reduced the number of patients needing transport by the ambulance service and admission to hospital, and it is recommended that it is adopted and spread more widely across Wales".

- The Delivery Unit (DU) undertook a progress review in 2019 of Ambulatory Emergency Care (AEC) in Wales at SBUHB and stated that Singleton hospital is emerging as one of its national exemplars. The DU highlighted the following for the hospital, that whilst there is '*no AECU there is a clear ambulatory ethos across the whole front door footprint'*. It highlighted the hospital's Acute GP Unit (AGPU) and the multiple pathways within AGPU which is open between 8.00am – 8.00 pm with 48% of patients discharged from AGPU with calls taken by GPs who also provide clinical advice.

- Some health boards commented that it has been perceived by front line teams, that a higher number of acutely unwell patients are self-presenting at the ED. This is in the context that whilst overall ambulance conveyances have reduced, attendances at ED / MIU / SAU have increased. This may be as a consequence of the pilots to reduce the number of patients being conveyed by a WAST vehicle.

We acknowledge that the response to this finding is also reliant on health boards, in conjunction with WAST, evaluating the results of the trails in reducing conveyancing to Emergency Departments. Where successful, and appropriate, extending across Wales and health boards working with their primary care services to ensure that patients are being referred appropriately and in line with the health board's demand and capacity.

This finding is now considered **partially implemented** with priority reducing to **medium**.

- **Pathways to bypass ED (previous finding 3)**

Previously, we were unable to reconcile the schedule of pathways managed through the WAST Clinical Pathways Approval & Appraisal Group (CPAG) to the list of pathways for each of the health boards. Paramedics had not always been able to follow a pathway and this was not well recorded. We were informed that tablet devices had recently been allocated to paramedics which would provide WAST an opportunity, with software development, to provide an electronic tool of all the available pathways for paramedics that could increase their ability to utilise a pathway and bypass conveyance to ED where appropriate.

During the current review we were informed that the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) is best known for the production of clinical guidelines for pre-hospital care, often referred to as just the

'JRCALC guidelines'. The WAST's CPAG group looks at national pathways and works to ensure compliance with JRCALC guidelines. These guidelines will outline whether a patient should be taken to Emergency Departments or elsewhere. Where it is elsewhere, the exact location is agreed at a local level with the health board. WAST and the health boards are represented on the bi-monthly Unscheduled Care Professional Advisory Group (NPUCPAG), of which all Emergency Departments in Wales are invited to attend. The agenda for this meeting includes changes in pathways linked to developments in medicine / Welsh Government major service redesign.

We were informed that a directory of pathways for every clinical condition across each health board areas does not exist within WAST and that this does not exist elsewhere in the UK. Local engagement between WAST and each health board regarding the sharing of pathway developments and changes, varies across Wales. Work is in hand at several health boards to actively review whether correct pathways are being applied in all instances. At one health board where there is considerable regional variation in pathways, WAST has been engaged to monitor all activity and to identify any incorrect pathways so that both WAST and the health board can clarify and avoiding confusion and repeat errors.

We were informed that where cross border transport occurs, either within Wales or from England to Wales, there is a heightened risk of uncertainty in applicable pathways. In these instances the WAST CCC is key in confirming or directing pathways to be applied. Several health boards are monitoring pathways in such cross border situations to identify any incorrect pathways, and to share details of any instances with WAST.

This finding is considered **partially implemented** with priority reducing to **medium priority**.

- **Delayed handover clinical triage (previous finding 7)**

Previously we were informed that The Welsh Government health circular clearly states that *"WAST crews should not routinely be responsible for monitoring patients over prolonged periods outside A&E, and hospital clinicians should be responsible for overseeing the assessment of patients."*

The University Hospital of Wales (UHW) was the only hospital of the 6 visited that did not undertake a face to face assessment of the patient before admission to the hospital. In all other cases the clinician carried out an initial patient assessment in the back of the waiting ambulance as required.

During our current review we were not able to engage Cardiff & Vale University Health Board as permission was not provided. We understand

that the Emergency Unit has seen a change in management team who will review their decision around this.

This finding is considered **not implemented** with priority remaining at **high priority** as the procedures adopted at CVUHB remain non-compliant with the Welsh Health Circular.

Our prior year report identified four **medium priority** findings. Two findings are considered partially implemented with priority remaining at **medium priority** to reflect the progress to be made. The remaining two findings were primarily the responsibility of WAST and our follow-up work at WAST has determined the progress made against these findings.

- **Patient flow initiatives (previous finding 6)**

During the original audit we reviewed Board meeting minutes for each health board and found that delayed handovers are included in performance reports. It was clear that all health board executives are aware of the problem of handover delays and set targets and actions to reduce them. We also reviewed the IMTP's for the six health boards and found that emergency care is included with reference to developing joined-up health and social care services. Whilst this is noted as a priority by all health boards, the AQI's showed little improvement in performance on handover delays. The only health boards that were near the 15-minute handover target of 100% are Cwm Taf Morgannwg University Health Board (CTUHB) achieving almost 90% each month and Hywel Dda University Health Board (HDUHB) achieving circa 80%.

We noted that it was surprising, given the transparency of this performance information over the past 3 years with each health board receiving the quarterly AQIs showing health board comparative data, that those lower performing health boards have not done more to emulate models of the higher performers, notably, CTUHB.

Our current review found that health boards with poorer AQI handover performance have engaged with other health organisations in Wales and England to identify processes and practices that could be adopted to aid delivery of improved handover performance. A review of CTUHB practices by other health boards has resulted in adoption of some processes that have not always delivered the expected improvements. It was commented that one solution does not fit all; rather it has been found that a range of initiatives gleaned from a number of health boards have been implemented by health boards with poorer AQI handover performance.

Processes and practices have been adjusted within health boards in the light of internal reviews performed and have thought to have contributed to improvement in the performance recognised. There is inevitably a delay between implementing processes and practices and then being able to see

the impact in performance via published AQIs. In many instances changes that have been implemented are yet to feed into published AQIs.

This finding is considered **partially implemented** with priority remaining at **medium priority**.

- **Hospital Arrival Screen (HAS) data (previous finding 8)**

Previously, we found some contradiction over the responsibility for completing and at what point the HAS handover entries should be completed. It was apparent that the data was not as accurate as it would be if there was clear guidance and understanding on HAS roles and responsibilities and a consistent approach at all hospitals over exactly what point the paramedics or clinicians update the HAS. Additionally, the late reason was not always recorded where delays of over 15 minutes had occurred, which could provide both WAST and health boards with information to assist in reducing delays.

Our current review found that the HAS Guidance has not been re-circulated to WAST staff, and onward to health boards, as it was felt that the guidance around roles and responsibilities needed to be strengthened. We understand that the process may change following the introduction of the dual pin system which will require WAST and health board staff to complete the HAS together. WAST wrote to the Welsh Government (WG) in February 2019 asking that they consider updating the current HAS guidance and clarifying roles and responsibilities.

We obtained a HAS Report showing all handovers with delays over 15 minutes for the period February 2018 - March 2019. Review of the report confirmed that for 44% of the delays the reason code had not been completed. The percentage rate of 'NULL' entry rate across hospitals sites ranged from 22% in Morriston Hospital to 92% in Maelor General Hospital Wrexham. In the case of Maelor General Hospital the high NULL entry rate is partially explained by the poor physical locations of HAS screens. We understand that WAST has recently relocated a number of HAS screens within several Emergency Departments, including Maelor General Hospital and this should aid reduced NULL entries by allowing Emergency Department staff to access HAS screens efficiently.

WAST's Health Informatics Team developed a self-serve report in February 2019. The report shows, by hospital site, the reasons and time of day for each handover delay. The intention is to use this information to inform discussions with health board colleagues and develop operating models. The value of this exercise to health boards may be limited by the specific late reason options set on HAS. However, as this report was not available until February 2019, we were unable to confirm that this is being undertaken at this early stage of implementation.

This finding is considered **partially implemented** with priority remaining at **medium priority**.

Our prior year report identified one **low priority** finding. The finding is considered partially implemented with priority remaining at **low priority** to reflect the progress to be made.

- **Patient Care during Handover Delays (previous finding 1)**

Previously we noted that one of the key feedback improvement themes identified by the WAST Quality, Safety and Patient Experience team is in regards to the provision of nutrition, hydration and continence when a patient experiences a significant delay and is held outside the Emergency Department. Although the majority of patients conveyed to Emergency Departments are admitted within 60 minutes there are over 1,300 patients each month that wait in an ambulance for long periods.

During our site visits at Emergency Departments we observed instances where WAST staff were providing food and drink to patients in ambulances from stock cupboards held at hospitals. We noted that although handover delays should not occur, where they do, health boards should maintain a formal record of continence, nutrition and hydration offered and declined or accepted by the patient to evidence that adequate care in these areas was provided at reasonable times.

Our current review has identified that health boards engaged in the follow up review considered this issue a high priority as patient care and patient experience was considered of utmost importance. With regard to procedures implemented by the health boards, they confirmed that responsibility for monitoring of the patient whilst in the ambulance lies with the health board once triage has been actioned by Emergency Department staff in the ambulance.

Standard Operating Procedures in respect of handover were issued at each health board, however these did not specifically refer to nutrition, hydration and continence. Hywel Dda University Health Board (HDUHB) has recently developed a flow chart which details the care priorities for patients in ambulance offload delays, for inclusion in the next iteration of their ambulance off-load policy. All health boards have provided an update to WAST on the arrangements in place to provide patients with dignified care if patients are delayed on ambulances whilst awaiting handover of care at emergency departments.

This finding is considered **partially implemented** with priority remaining at **low priority**.

The priority ratings of the open findings is summarised in the table below:

	2017/18	2018/19
High priority	3	1
Medium priority	2	4
Low priority	1	1
Total	**6**	**6**

The findings of our current review are detailed in Appendix A, together with the original recommendations and considerations going forward.

Previous Finding 1 Patient care during handover delays

Original Finding (Original Priority Rating: LOW)

One of the key feedback improvement themes that has been identified by the WAST Quality, Safety and Patient Experience team is in regards to the provision of nutrition, hydration and continence when a patient experiences a significant delay and is held outside the ED. Although the majority of patients conveyed to ED are admitted within 60 minutes there are over 1,300 patients each month that wait in an ambulance for long periods.

In order to address continence concerns WAST now participates with the All Wales Continence Bundle to ensure that pre-hospital patient care is included in their monitoring. The approach regarding the appropriate provision of continence, nutrition and hydration is currently informal and there are no standard operating procedures. Arrangements vary and it would assist ambulance crews if health boards had a clearer process in place, particularly at those hospitals that typically experience handover delays in excess of 60 minutes. During our site visits at EDs we observed instances where WAST staff were providing food and drink to patients from stock cupboards held at hospitals. In addition to nutrition, hydration and continence considerations, significant handover delays can lead to patients requiring pressure sore area care.

Original Recommendations

1. Health boards undertake a review of the arrangements in place for the provision of continence, nutrition and hydration at each hospital to ensure safe and dignified care is provided to patients during handover delays.
2. Although handover delays should not occur, where they do health boards should maintain a formal record of continence, nutrition and hydration offered and declined or accepted by the patient to evidence that adequate care in these areas was provided at reasonable times.

Current Findings	
Whilst the rating of the finding was rated low, the health boards engaged in this review considered this a high priority as patient care and patient experience was considered of utmost importance. With regard to procedures implemented by the health boards, they have confirmed that responsibility for monitoring of the patient whilst in the ambulance lies with the health board once triage has been actioned by Emergency Department staff in the ambulance. Delays in handover will extend the time from triage to physical transfer in to the Emergency Department. The health boards noted that the applicability of the finding to their individual operations varied depending upon the timeliness with which patients were being handed over from the ambulance to their respective Emergency Departments. Where the vast majority of patients were transferred from the ambulance within the 15 minutes target time, the applicability of the finding was less relevant. They also commented that patients were assessed and processed based on acuity and need so those patients that remained in an ambulance over the 15 minutes target time were less acute and were more likely to be mobile, limiting issues regarding bed sore management and continence concerns. Standard Operating Procedures in respect of handover were in place at each health board, however these did not specifically refer to nutrition, hydration and continence. All health boards have provided an update to WAST on the arrangements in place to provide patients with dignified care if patients are delayed on ambulances whilst awaiting handover of care at emergency departments.. One health board, Hywel Dda University Health Board (HDUHB) has developed a flow chart which details the care priorities for patients in ambulance offload delays, for inclusion in the next iteration of their ambulance off-load policy. This finding is considered **PARTIALLY IMPLEMENTED** to reflect that Standard Operating Procedures need to be updated in some instances. Standard Operating Procedures need to be updated to reflect reality, the finding remains **OPEN**. The priority level remains **LOW**.	
Considerations Going Forward	**Priority Level**

1. All health boards should ensure that their Emergency Department Standard Operating Procedures are current and reflect actual practices regarding the provision and recording of nutrition, hydration and continence needs of those patients in the period between being triaged in the ambulance and being handed over. 2. All health boards should undertake compliance checks to confirm that Emergency Department staff are acting in accordance with Standard Operating Procedures regarding the provision and recording of nutrition, hydration and continence needs of those patients in the period between being triaged in the ambulance and being handed over.	**Low**

Previous Finding 2 Conveyance to ED

Original Finding (Original WAST Priority Rating: HIGH)

There are a number of AQIs that relate to conveyance including the '*number of incidents that resulted in non-conveyance to hospital*' under '*Step 4: Give Me Treatment*' and the '*number of 999 patients conveyed to hospital*', including analysis by type and also those conveyed to hospital outside of the local health board area, under '*Step 5: Take me to Hospital'*.

The Wales Audit Office Review of Emergency Ambulance Services Commissioning Arrangements dated July 2017 highlighted improvement areas for the AQIs. There is recognition that these indicators are still developing and require further refining to ensure they demonstrate key data in a clear way. There are also opportunities to improve the presentation of some indicators so that they become more accessible and understandable to readers and make them more meaningful in understanding patient outcomes and patient experiences. Additionally, the report highlighted that EASC members are not yet fully recognising and making the most of the potential that this information holds to inform decisions for improving the quality of ambulance services for patients across Wales.

It is recognised that it would not be appropriate to set a 'target' of reduced conveyance following 'See and Treat' as this could incentivise decision making to the detriment of the patient. However, there could be improved usage of the conveyance data that would enable analysis that should improve handover delays and reduce the cost of lost hours. For example, improved analysis of patients who were seen by the hospital clinician and released without requiring treatment, highlighting that the conveyance was not necessary or identifying patients that were conveyed to ED where an alternative pathway was more appropriate, also known as 'missed opportunities'. Further analysis would also identify if paramedics require training and development and ensure that all crews have the guidance and understanding to reduce conveyance to ED.

GP Referrals

During this audit there was a particular point raised by all of the health boards and by WAST regarding the impact on conveyance and peaks in attendance to ED that result in handover delays. GP referrals are unscheduled and occur between GP hours, typically 10am to 6pm which can contribute to bottlenecks outside hospitals. Furthermore, we were informed that the time lost during hospital handover delays, coupled with the way the WAST clinical model is designed to prioritise calls in line with their red, amber, green rating, mean that ambulance crews are often unable convey GP referrals to hospital within the relevant department's opening hours. This is due to GP referrals typically being classified as green priority and results in the patient not receiving timely and appropriate care. It was generally recognised that improvements could be made by having scheduled conveyance for GP referrals where appropriate.

Original Recommendations

1. WAST, in conjunction with EASC, evaluates how it records, analyses and reports on conveyance and how this information is used to gain assurance that conveyance to ED is restricted to those cases where the presenting condition determines that the ED is the appropriate pathway for the patient. WAST should develop ways of identifying missed opportunities, for example, through undertaking sample audits across a range of indexed conditions and comparing conveyance rates across health boards.

2. WAST and health boards undertake a project to investigate whether GP referrals could be scheduled, where the patient condition allows, so that the time of arrival at the ED is more likely to improve the patient experience by being aligned to the demand and capacity models of the hospital.

Current Findings

GP Referrals

WAST has undertaken a number of initiatives in conjunction with health boards in an attempt to positively impact conveyance to the Emergency Department.

WAST performed a two-day trial in October 2018 with Aneurin Bevan University Health Board (ABUHB), to assess the impact of Health Care Professional (HCP) calls being handled by a clinician. This resulted in a reduction in the number of patients being conveyed to hospital.

Enhancing on the above, Betsi Cadwaladr University Health Board (BCUHB) has also implemented a Single Integrated Clinical Assessment and Triage service (SICAT) which went live on 12th November 2018. This service sits co-terminus within WAST's CCC in North Wales. It is currently manned by an experienced General Practitioner (GP) working alongside an APP. The service focuses on Health Care Practitioner (HCP) demand – though this is not exclusive, where calls of higher acuity are identified, to avoid ambulance deployment or patient conveyance. As at March 2019, the service had managed almost 200 calls. Analysis of these calls identified that the initiative had delivered an 80% stand down for deployment of WAST crews and 65% avoidance of conveyance to ED – of these almost 50% have been returned to their GP for routine follow up and 20% had been given self-help advice. The scheme also saw a 25% increase of ambulance conveyances to the health board's Minor Injuries Units (MIU) through the month of November 2018 and this continued into December. The service recruited an additional four GPs to work within the service, and is currently training an Advanced Pharmacist who will soon support both SICAT and GP Out of Hours (OOH). This is a joint venture with WAST working through advanced risk sharing arrangements.

We were also provided with a highlight report for the GP transport pilot which was undertaken within ABUHB. The purpose of the pilot was to reduce the delays incurred when transporting patients referred into acute hospitals from GP's, and to diarise suitable patients to improve flow through the assessment units. The intention was for ABUHB to take over the allocation and management of GP transport crews during the busiest times (Monday-Friday, 8am-8pm) to ensure that patients are transported to an acute assessment unit in a timely manner following a referral and to diarise suitable patients to support effective flow. The transport crews would also support discharges from assessment units in order to create capacity to offload new patients arriving. The initial pilot ran for 6 weeks during February and March 2018 but had mixed success due to a number of reasons, including no dedicated coordinator (a paramedic on light duties covered 8.00 – 4.00 for 4 weeks), the crew being pulled to do emergency jobs and not every shift being covered. The highlight report detailed that data analysis of the initial pilot was not statistically significant, but did show a general reduction in the time from booking to arrival at assessment units.

The highlights report proposed that the trial be run for 6 months from October 2018 to April 2019, the decision was taken to defer due to significant pressures. We acknowledge that this work is also reliant on the health boards working with their primary care services to ensure that patients are being referred in line with the health board's demand and capacity.

ABUHB was involved in a Falls Response pilot in conjunction with WAST to reduce the number of patients who have fallen, which represents one of the 'Big 5' unscheduled care demands, being transferred to the ED. This pathway has been rolled out to several health boards and many of the health boards reviewed confirmed that they have taken part in the Falls Response vehicle scheme commissioned by WAST from December 2018.

SBUHB has undertaken a lot of work to reduce unnecessary conveyance from care homes. This has included providing training on the 'I Fell Down' tool to four care homes in the NPT Local Authority area, which at the time of our review, was in the process of being rolled out to Swansea Local Authority homes, with the aim of reducing conveyance from care homes to ED for patients who have fallen. The health board had also agreed to participate in the National Collaborative Commissioning Unit's (NCCU) 'National Early Warning Score (NEWS) project' to ensure the use of regular NEW scoring in two or three nursing homes in the Swansea Bay area to support conveyance and discharge decisions. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

SBUHB was also involved in a Bevan Exemplar project of the 'Integrated Response Model' during 2017/18, with the Bevan Commission evaluation report being published in 2018. Bevan Exemplars are NHS professionals who are supported to trial and test out their innovative ideas to improve resource efficiency, patient experiences and health outcomes. The project involved the Acute Clinical Team (ACT) in Neath Port Talbot Hospital alongside WAST colleagues piloting a scheme to redirecting appropriate 999 emergency calls where the patient would be better suited to receiving community based care from the Acute Clinical Team. The project took place

between October 2017 and March 2018 and included a sample of 40 patients who were either referred into, or proactively brought into the care of the ACT by WAST. The average length of stay with the ACT was 5.4 days. 87.5% of patients were safely cared for in the community rather than admitted into an acute hospital. The report recognised the cost saving per patient and the patient / carer / staff satisfaction and the increased autonomy for the Acute Clinical Team and nursing home staff. The report concluded that the project "*reduced the number of patients needing transport by the ambulance service and admission to hospital, and it is recommended that it is adopted and spread more widely across Wales*".

The Delivery Unit (DU) undertook a progress review in 2019 of Ambulatory Emergency Care (AEC) in Wales at SBUHB and stated that Singleton hospital is emerging as one of its national exemplars. The DU highlighted the following for the hospital, that whilst there is 'no AECU there is a clear ambulatory ethos across the whole front door footprint'. The DU's review noted that Singleton Hospital has an Acute GP Unit (AGPU), Singleton Assessment Unit and Medical Day Unit with multiple pathways in AGPU, which is open 8am – 8pm, calls are taken by GPs, who also provide clinical advice. It noted that 48% of patients are discharged from AGPU. Singleton Assessment Unit (SAU) has 20% of patients treated and discharged the same day, with on-call consultants currently undertaking SAU work. Approximately 25 – 35 patients per day are seen in SAU. There is specialty input, with Gastroenterology in-reach and there a keenness to develop more Cardiology/Diabetes input.

Some health boards commented that it has been perceived by front line teams, that a higher number of acutely unwell patients are self-presenting at the ED and are being taken directly to resuscitation area in ED from reception. This is in the context that whilst overall ambulance conveyances have reduced, attendances at ED / MIU / SAU have increased. This may be as a consequence of the pilots to reduce the number of patients being conveyed by a WAST vehicle.

This finding is considered **PARTIALLY IMPLEMENTED** and remains **OPEN.** The priority level has been reduced to **MEDIUM** to reflect the progress made regarding avoiding conveyance to ED.

Considerations Going Forward	Priority Level
1. Health boards, in conjunction with WAST, should evaluate the results of the trials in ultimately reducing conveyance to Emergency Departments, and where found successful, extend the trails across Wales, where appropriate. 2. Health boards should work closely with primary care service providers to ensure that patients are being referred appropriately and in line with the health boards' demand and capacity.	**Medium**

3. The health boards in collaboration with WAST should assess the impact of any pilot to reduce the number of patients being conveyed to the ED by a WAST vehicle on the demand and capacity of the hospital.	

Previous Finding 3 Pathways to bypass ED

Original Finding (Original WAST Priority Rating: HIGH)

As part of the audit we were provided with a schedule of pathways managed through the Clinical Pathways Approval & Appraisal Group (CPAG). We were also provided with a list of pathways by each of the six health boards. We were unable to reconcile these and were therefore unable to verify that:

- There is a clear and consistent process for WAST and health boards to formally approve each pathway;
- Where a pathway is approved, there is a clear flowchart that has been made available and understood by WAST staff, including the crews and staff within the Clinical Contact Centres;
- Each pathway is underpinned by detailed methodology to enable evaluation and monitoring of its success in reducing conveyance to ED; and
- There is a process in place to review and identify pathways that are effective and should be considered for implementation at other health boards.

We were informed by the WAST Operations staff interviewed, that paramedics have not always been able to follow a pathway as the alternative location did not have capacity or resource to receive and treat the patient at the time. This is currently not well recorded and as such we could not audit this in any detail.

We also noted during our visits that the WAST crews have a pathways folder in the ambulance that should enable them to identify and follow the appropriate pathway. Again, we were unable to reconcile that all of the pathways were in the folder and overall we could not be confident that all staff were fully aware of them. In particular, if a crew conveyed across border to another health board Area it is unlikely that they would be aware of the local pathways. We were informed that tablet devices have recently been allocated to paramedics. This provides WAST with an opportunity, with software development, to provide an electronic tool of all the available pathways for paramedic's that could increase their ability to utilise a pathway and bypass conveyance to ED where appropriate.

Original Recommendation

1. WAST and health boards undertake a review of the governance arrangements for the identification and approval of all pathways, together with a consistent process for recording, disseminating and measuring outcomes.
2. WAST ensures that any blocks or breaks that prevent the use of a conveyance pathway to bypass ED are recorded and management action is taken to address any issues.

3. WAST investigates the opportunity of developing an electronic pathways tool to assist paramedics in following pathways to bypass conveyance to ED.

Current Findings

Governance of Identification and Approval of Pathways

The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) is best known for the production of clinical guidelines for pre-hospital care, often referred to as just the 'JRCALC guidelines'. The WAST's CPAG group looks at national pathways and works to ensure compliance with JRCALC guidelines. These guidelines will outline whether a patient should be taken to Emergency Departments or elsewhere. Where it is elsewhere, the exact location is agreed at a local level with the health board.

WAST and the health boards are represented on the bi-monthly National Programme for Unscheduled Care Professional Advisory Group (NPUCPAG), of which all Emergency Departments in Wales are invited to attend. The agenda for this meeting includes changes in pathways linked to developments in medicine / Welsh Government major service redesign.

We were informed that a directory of pathways for every clinical condition across each health board area does not exist within WAST and that this does not exist elsewhere in the UK. Local engagement between WAST and each health board regarding the sharing of pathway developments and changes varies across Wales, examples include:

- WAST are being informed of changes in pathways through the health board's Unscheduled Care Board. Where major changes to existing pathways or development of a new pathway occurs, communications are in place to engage WAST with membership of Project Boards for each development and access to Task and Finish Groups;
- Where pathways are complex with regional variation present, WAST regional representatives are being engaged by the health board to share pathway developments;
- Development of new pathways are being shared with WAST at local operations meetings and are linked to a current major service model restructuring at the health board; and

- A bespoke operation is in progress to review all pathways with WAST, social care and community teams, together with reporting to Welsh Government on the effectiveness of clinical pathways, as experienced in the busy winter months.

In addition, Betsi Cadwaladr University Health Board has asked WAST to perform an audit of activity to identity where and when incorrect pathways have been used and why, to aid improvement in correct pathway usage across the health board by WAST resources.

Regarding out of area transfers within Wales, one Health Board with significant transfer volumes, commented that such transfers are monitored, pathways reviewed, and WAST informed, if and when the correct pathway is not implemented.

With regard to English ambulance transfers into Welsh health boards it was confirmed by another health board that the ambulance crew will not have access to pathway information and will be reliant on WAST CCC being aware of the correct pathway to apply and to instruct English crew accordingly.

This finding is considered **PARTIALLY IMPLEMENTED** and remains **OPEN.** The priority level has been reduced to **MEDIUM** to reflect the progress made regarding continued communication of pathway developments and changes to WAST.

Considerations Going Forward	Priority Level
1. Each health board, in conjunction with WAST, should proactively assess whether pathways are being correctly applied. 2. Where the application of an incorrect pathways is identified, the reasons should be investigated and corrective action taken to ensure that such errors are not repeated and that WAST are always provided with up to date pathway documentation.	**Medium**

Previous Finding 6 Patient flow initiatives

Original Finding (Original WAST Priority Rating: MEDIUM)

We reviewed Board meeting minutes for each health board and found that delayed handovers are included in performance reports. It was clear that all health board executives are aware of the problem of handover delays and set targets and actions to reduce them. As noted in Action 1 above, we have also reviewed the IMTP's for the six health boards and found that emergency care is included with reference to developing joined-up health and social care services. Whilst this is noted as a priority by all health boards, the AQI's over the past 12 months have shown little improvement in performance on handover delays. The only health boards that are near the 15-minute handover target of 100% are Cwm Taf University Health Board, now Cwm Taf Morgannwg University Health board (CTMUHB), achieving almost 90% each month and Hywel Dda University Health Board (HDUHB) achieving circa 80%.

CTMUHB's performance may be attributed to its project to reduce delays and improve the flow of patients across hospital, GP and community services. The 'Focus on Flow' project won the NHS Wales Improving Patient Safety Award 2014. It should be acknowledged that all of the Wales NHS health boards have undertaken projects and initiatives to improve unscheduled care and address patient flow. Many of these are currently in operation. What is clear from the AQI's is that the initiatives applied by CTMUHB have been very effective in respect of the impact on WAST and lost ambulance hours as a result of handover delays.

It is surprising, given the transparency of this performance information over the past 3 years with each health board receiving the quarterly AQIs showing health board comparative data, that those lower performing health boards have not done more to emulate models of the higher performers, notably, CTMUHB.

Original Recommendation

1. WAST and health boards evaluate the key factors adopted by CTMUHB that resulted in their handover performance improving from circa 50% to 90% since 2013 and work together to drive similar improvement.

Current Findings

We were informed that health boards with poorer AQI handover performance have engaged with health organisations in Wales and in England to identify processes and practices that could be adopted to aid delivery of improved handover performance.

A review of CTMUHB practices by other health boards has resulted in adoption of some processes that have not always delivered the expected improvements. It was commented that one solution does not fit all; rather it has been found that a range of initiatives gleaned from a number of health boards have been implemented across the health boards in Wales.

Processes and practices have been adjusted within health boards in the light of internal reviews performed and have thought to have contributed to improvement in the performance recognised. There is inevitably a delay between implementing processes and practices and then being able to see the impact in performance via published AQIs. In many instances changes that have been implemented are yet to feed into published AQIs. Consequently health boards consider that improvements in performance have been supported by a number of factors but are not able to necessarily prove causation, for example:

- Embedding of a Single Integrated Clinical Assessment and Triage service (SICAT) within WAST control centre;
- Development of alternative pathways;
- Proactive triage processes on arrival with prompt action taken;
- Fit to sit assessment;
- Corridor waiting (where physical configuration of Emergency Department allows the use of a non-public thoroughfare);
- Maximise patient flow through Emergency Department and into hospital;
- Improvement in discharge from hospital practices, adoption of SAFER patient flow model, investment in local authority initiatives;
- Additional resources for winter period; and
- Effective application of standard escalation process.

Other opportunities to further improve performance have been identified by health boards, for example, the creation of focussed observation / assessment areas, away from main Emergency Department acute treatment areas, allowing dedicated staff to manage treatment and through flow of patients more efficiently.

This finding is considered **PARTIALLY IMPLEMENTED** and remains **OPEN.** The priority level remains **MEDIUM** to reflect the fact that the various projects and actions implemented to improve performance are yet to be evidenced in published AQIs.

Considerations Going Forward	Priority Level
1. Health boards should continue to review their handover performance via published AQIs and evaluate how changes in performance achieved over time are a direct result of individual changes in processes and practices implemented. 2. Health boards should support and develop successful processes and practices, whilst those deemed unsuccessful should be reviewed and reversed where appropriate.	**Medium**

Previous Finding 7 Delayed handover clinical triage

Original Finding (Original WAST Priority Rating: HIGH)

The Welsh Government health circular clearly states that *"WAST crews should not routinely be responsible for monitoring patients over prolonged periods outside A&E, and hospital clinicians should be responsible for overseeing the assessment of patients."*

The University Hospital of Wales (UHW) was the only hospital of the 6 visited that did not undertake a face to face assessment of the patient before admission to the hospital. In all other cases the clinician carried out an initial patient assessment in the back of the waiting ambulance as required.

We were informed by staff at UHW that that the ambulance triage by ED clinicians is not one supported by the Royal College of Emergency Medicine and that whilst nurses do not enter the ambulance, the risk to patients is managed through the protocols and processes in place; a clinical assessment by the Majors Assessment Nurse (MAN) through communication with the paramedic.

The current practice at the UHW is contrary to Point 3 of the Welsh Government guidance above. This is a conscious decision by the hospital, as outlined above, and results in greater responsibility on the paramedics to assess the patient condition and monitor that condition for over 30 minutes and sometimes several hours. There is also a missed opportunity for the ED clinician to undertake an assessment at an earlier stage that could have resulted in the patient being redirected, avoiding an unnecessary wait for the patient and lost hours to WAST.

Original Recommendation

1. WAST seeks confirmation from Welsh Government regarding responsibility for undertaking a clinical assessment of patients prior to admittance to the ED.

Current Findings

This recommendation relates to Cardiff & Vale University Health Board (CVUHB) as the issue raised refers to the UHW site only. During our current review we were not able to engage CVUHB as permission was not provided. We understand that the Emergency Unit has seen a change in management team who will review their decision around this.

However, we have noted the following comments made by CVUHB to the Assistant Director of Nursing, WAST in a letter dated 21 January 2019.

Findings 7 — Delayed handover clinical triage

Cardiff and Vale UHB are appreciative that they were the only UHB that did not provide a face-to-face assessment of the patients if delayed outside the Emergency Unit department and rely on the professional handover from the WAST crew. The relationship and interaction between the Assessment Nurse and WAST crew is imperative to ensuring effective and efficient patient assessment. The UHB is committed to improving patient flow throughout the hospital to minimise the WAST delay and subsequent assessment in the back of an ambulance. The UHB is currently experiencing greater improved performance in WAST delays than other UHBs across Wales. As previously mentioned, the Emergency Unit has seen a change in management team who will review their decision around this.

This finding is considered **NOT IMPLEMENTED** and remains **OPEN.** The priority level remains **HIGH** to reflect the lack of any progress made to comply with Welsh Health Circular WHC/2016/029.

Considerations Going Forward	Priority Level
1. In line with the response above, the CVUHB Emergency Unit should formally review the current practice of not undertaking a face to face assessment of the patient before admission to the hospital.	**High**

Previous Finding 8 HAS data

Original Finding (Original WAST Priority Rating: MEDIUM)

Through discussion with paramedics and hospital clinicians (i.e. Nurse in Charge) we found some contradiction over the responsibility for completing the HAS handover entries. Some thought it was the responsibility of the other party, particularly when the entry had not been completed. Others felt it was the responsibility of both parties which had on occasions resulted in the paramedic finding the entry had already been made by the hospital. It was also found during observation at site visits that the point at which the paramedic updated the HAS varied. Some 'notified' as soon as they entered the ED and then notified the Nurse in Charge, others the other way around. Whilst this finding is mainly anecdotal it was apparent that the data is not as accurate as it would be if there was clear guidance and understanding on HAS roles and responsibilities and a consistent approach at all hospitals over exactly what point the paramedics or clinicians update the HAS.

We analysed HAS data covering a sample of 7 days (Mon-Sun) over 7 weeks in September and October 2017. The analysis highlighted that the late reason is not completed over 25% of the time. If this data was complete and accurate it would provide both WAST and health boards with information to assist in reducing delays.

Original Recommendation

1. WAST and health boards ensure that the roles and responsibilities for recording data on the HAS are clearly understood. This should be supported by clear guidelines and protocols to ensure that the data can be relied upon as fair and accurate with consistent application of the time recording for the notification and handover.
2. The health boards and WAST undertake an assessment over the use of the 'late reason' data and where and how it provides management information that can assist in managing handover delays, e.g. addressing issues such as a lack of beds.

Current Findings

Our current review found that the HAS Guidance has not been re-circulated by the Welsh Government to WAST staff as it was felt that the guidance around roles and responsibilities needed to be strengthened. We understand that the process may change following the introduction of the dual pin system which will require WAST and health board staff to complete the HAS together. WAST wrote to

the Welsh Government in February 2019 asking that they consider updating the current HAS guidance and clarifying roles and responsibilities.

It was evident from discussions with the health boards that there is a need for WAST to refresh learning on the operational use of HAS given the variation in operational views provided and the adverse impact on quality and consistency of HAS data.

We obtained a HAS Report for all handovers with delays over 15 minutes for the period February 2018 - March 2019. This included 'NULL' entries, i.e. where no reason code had been entered for the delay. Review of the report confirmed that out of 105,178 handovers with delays over 15 minutes - 46,664 (44%) of these had 'NULL' entries which indicates that the reason code is still not routinely completed. The 46,664 'NULL' entries were split as follows - 22,143 (approx 48%) between 15 - 30 minutes delay, 13,611 (approx 29%) between 30 - 60 minutes delay and 10,910 (approx 23%) over 60 minutes delays.

The percentage rate of 'NULL' entry rate across hospitals sites ranged from 22% in Morriston Hospital to 92% in Maelor General Hospital Wrexham. The latter's poor data completion has been partly explained by the poor physical location of HAS screens in the Emergency Department. Relocation of the HAS screen has now occurred and should improve data completion. In addition, we acknowledge that the proposed introduction of dual-PIN may further improve these figures.

WAST confirmed that a review of delayed handover reasons in December showed that the majority of the reason codes completed related to 'no beds available', which they feel did not give the depth of analysis needed to review causation. WAST's Health Informatics Team produced a self-serve report in February 2019. The report shows, by hospital site, the reasons and time of day for each handover delay. The intention is to use this information to inform discussions with health board colleagues and develop operating models. However, as this report was not available until February 2019, we were unable to confirm that this being undertaken at this early stage of implementation.

Swansea Bay University Health Board commented on the missed opportunity for improved use of the data recorded on HAS and is to provide refresher training on the handover process to deliver consistent practice across all sites. However other health boards have commented that the pre-determined reasons on the HAS screen are too general and do not provide the health boards with sufficiently detailed reasons. The process was not thought to capture sufficiently detailed reasons, limiting the usefulness of any management information forthcoming from the HAS system.

This finding is considered **PARTIALLY IMPLEMENTED** to reflect that some actions have started and remains **OPEN**. The priority level remains **MEDIUM** due to the lack of reinforcement of HAS user guidance by WAST as linked to the impending implementation of the dual PIN process, the need to further consider the usefulness of the pre-determined reasons on HAS for late handover and

ensure any developments are consistently applied, and the self-serve report being made available only recently to inform discussions between WAST and health board staff, preventing assessment of how effective it is in addressing handover delays.

Considerations Going Forward	Priority Level
1. Health boards should ensure that all Emergency Department staff are provided with consistent and updated HAS operational documentation and learning by WAST, including any proposed dual pin role out. 2. Health boards should ensure that delayed handover reasons are always entered on HAS and are used to inform discussions with WAST colleagues and develop operating models. 3. Health boards should consider whether the current option of pre-listed delayed handover reasons on HAS are able to usefully inform health boards' management decision making processes.	**Medium**

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 Trust. 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:

Audit and Assurance
Cwmbran House (First Floor)
Mamhilad Park Estate
Pontypool, Gwent
NP4 0XS

Contact details

Helen Higgs –Head of Internal Audit – 01495 300846
Osian Lloyd – Deputy Head of Internal Audit – 01495 300843
Johanna Butt – Principal Auditor
Philip Lewis-Davies – Principal Auditor

Cwm Taf University Health Board

Directorate review – Surgery - Management Arrangements

Internal Audit Report

2018/19

July 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix B Assurance opinion and action plan risk rating
Appendix C Detailed scope and objectives

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Distribution:	Paula Pearce, Directorate Manager
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Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

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1. Introduction and Background

The review of the Surgery directorate's management arrangements was completed in line with the 2018/19 Internal Audit plan for Cwm Taf University Health Board (the 'Health Board' or the 'organisation').

As part of the 2018/19 programme of work, we reviewed the management arrangements for a number of directorates and it is anticipated that all directorates will be audited over a three year period.

In addition to this review of management arrangements within the Surgery directorate, a separate piece of audit work was undertaken within the directorate to establish the level of compliance within the Scheme of Delegation and a number of the most relevant/highest risk Financial Control Procedures applicable to the Surgery Directorate.

As such we will produce two reports, one focussing on compliance with financial governance arrangements, and one focussing on management arrangements.

As part of our audit planning we spoke with members of the finance team, the Deputy Director of Finance, the Directorate Manager and the Directorate's business partners.

The areas sampled for testing within the Surgery Directorate included two surgical wards namely Ward 7 at Royal Glamorgan Hospital (RGH) and Ward 8 at Prince Charles Hospital (PCH).

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

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the management arrangements, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievements of system's objectives are managed appropriately.

The areas we sought to provide assurance on were:

- Governance arrangements
- Risk management
- Workforce management & service delivery
- Planning and performance
- Standards of conduct
- Directorate specific objective

Our detailed scope and objectives are set out in Appendix C.

3. Associated Risks

The potential risks considered in the review were as follows:

- The directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
- Services are not effectively planned.
- Risks materialise as they have not been identified and / or addressed.
- Reduced service provision / additional costs due to inappropriate or unauthorised absence.
- Staff performance is not effectively assessed and addressed.
- Directorate objectives are not achieved as a result of demand and capacity data failing to be properly used and monitored.

OPINIONS AND KEY FINDINGS

4. Assurance Opinions

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. This review, focussing on management arrangements, covers risk management and governance (which includes the objectives for standards of conduct and directorate specific), performance and planning, and workforce, giving three separate opinions relating to the relevant domain areas.

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

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

Risk management and governance

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with risk management and governance 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.

Governance Arrangements

The Directorate holds an up to date organisational chart that reflects the current governance structure and the committees and groups in place that are served by clear reporting and information lines. The two key groups within the Directorate are the Clinical Business Meeting (CBM) and the Quality, Safety and Risk Group (QS&R). In some instances the agendas, reports, minutes and action logs for these meetings, were not provided despite our requests for them. As such, this made it difficult to evidence discussions and decisions on key points.

The Directorates appears to have good working relationships with its business partners which was evidenced through its CBMs and the support provided during the IMTP development process. However, we note that a number of key officers within the Directorate, such as the Heads of Nursing and Clinical Director, do not routinely attend the CBM, despite this being a requirement of the CBM terms of reference.

We also note good practice in the Directorate's development and ongoing use of a RAG rated IMTP monitoring report and detailed action plan, which is discussed during its directorate business meetings.

Risk Management

The Directorate uses the Datix Risk Management database to record, monitor and update its risks. Our review of the risk register on Datix showed that 17/18 risks had passed their review date. Whilst there may have been a review of these risks, there was no evidence of this recorded within Datix. We also identified that eight risks had a risk handler attributed to them who was no longer an employee of the Health Board.

Our review of the CBM meetings from July 2018 to March 2019 identified that only one out of three 'Non-Patient Safety Incidents, Risk and Claims'

reports were presented over this period, though in one quarter, the report had not been produced by the central team.

Standards of Conduct

We understand through discussions with the Directorate Manager they have not been made aware of Declarations of Interest (DoI) returns. As such, declarations and personal interests may not be taken into consideration.

At the present time, not all staff within the Directorate had made a DoI or 'nil return' despite reminders to do so. As such, we have raised a finding to reflect this.

Performance and planning

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with performance and planning 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 Directorate has used the Health Board's Local Planning Framework to develop its 2019-22 IMTP and all draft submissions were made to the planning department in accordance with the Health Board's timetable. Additionally, we saw evidence of both stakeholder engagement and engagement with the relevant business partners. We also note that feedback sessions took place within the directorate to address issues that were identified by the planning department following their review of the first draft.

Monitoring of the overall financial position and non-financial performance measures takes place during the CBM and the Senior Management Team (SMT) meetings. The CBM monitoring is usually at a directorate wide level and not broken down by department or ward. However, due to there being no minutes available for the SMT group, we cannot confirm the level of monitoring that is taking place.

On a quarterly basis a Directorate Manager's report is taken to the CBM that is in effect an IMTP monitoring report and covers the Directorate's key priorities, demand and capacity planning, Referral to Treatment (RTT) target, and workforce performance. The monthly finance pack to the CBM allows budgets and CRES targets to be monitored monthly.

Workforce

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with workforce 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.

We analysed the absence rates, mandatory training, and PDR compliance rates for the Directorate and focused our detailed testing onward 7 at Royal Glamorgan Hospital (RGH), and ward 8 at Prince Charles Hospital (PCH).

Our workforce testing was split into seven key areas; annual leave, flexi-time and Time of in Lieu (TOIL), sickness management, PDRs, mandatory training, staff rosters, and consultant job plans. We identified examples in both wards where the monitoring and management was not in accordance with the Health Board's policies.

Our key concerns as a result of our testing relates to the errors at both wards in the calculation of annual leave entitlements, and reconciliations to ESR. We identified errors in the completion of sickness records, and instances where sickness meetings were not being carried out.

At ward 8 in PCH mandatory training compliance rates were low (38%). By comparison ward 7 at RGH had a compliance rate of 92%. Furthermore, the sign off of consultant job plans was low.

In the minutes of the CBMs that we reviewed we saw evidence of sickness levels, PDR, and mandatory training rates being reported. In addition, *ad hoc* reports were provided on the status of job plans. The Directorate needs to ensure that the monitoring undertaken at CBM meetings, and the underlying issues are appropriately communicated to wards.

5. Assurance Summary

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

Assurance Summary					
1	Governance arrangements			✓	
2	Risk Management		✓		
3	Workforce management & service delivery			✓	
4	Planning and performance			✓	
5	Standards of Conduct			✓	

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

Design of Systems/Controls

The findings from the review highlighted no issues that are classified as a weakness in the system control/design of management arrangements within the surgery directorate.

Operation of System/Controls

The findings from the review have highlighted eleven issues that are classified as weaknesses in the operation of the designed system/control of management arrangements within the surgery directorate.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Governance Arrangements

We note the following areas of good practice:

- The Directorate has a clear governance structure in place that outlines who the senior team are, the business partners, and the operational team that are in place. There is also a committee structure chart, which maps out the flow of information at a high level between the various groups.
- The governance structure shows a clear line of communication from the CBM to the Senior Management Team and the Quality, Safety and Risk Group meeting. The SMT communicate with the Vacancy Panel, monthly HR meeting and finance meeting.
- The Directorate Manager appears to have a good working relationship with the business partners and has regular one to one meetings with the workforce business partners and monthly meetings with finance. Both business partners attended all of the CBM meetings that we reviewed.
- There are systems in place to ensure new legislative and regulatory information received within the Directorate is disseminated and actioned on a timely basis.

We identified the following findings:

- The main groups that oversee governance issues are the QS&R Group meeting, the CBM and the SMT. The Directorate were unable to provide us with a TOR for the SMT meeting and the TOR for the QS&R Group meeting had not been reviewed in line with its review date. The TOR for the CBM is in a draft format.
- There is no key point of contact within the directorate who maintains the agendas, reports and minutes for the key Directorate meetings The Directorate could only provide action notes for the CBM so we were unable to confirm what reports were presented. No minutes or action logs could be provided for the QS&R Group.
- The TOR for CBM lists the key staff who should be in attendance at meetings. For the five meetings that we sampled, the Heads of Nursing and Clinical Director only attended one meeting each.

Objective 2: Risk Management

We identified the following findings:

- The Directorate has 17/18 risks within Datix that have passed their review date.
- Eight risks (45%) on the risk register have 'handlers' who no longer work for the Health Board.
- Risks do not have actions identified against them in Datix.
- Our review of the Quality, Safety and Risk Group meetings established that the risk register is not discussed at every meeting.
- Our review of the CBM meetings identified that the risk data report was taken only once during over a period of nine months. This quarterly report focusses on the directorate's high scoring risks, but does not contain information such as when these risks were first created or last reviewed.

Objective 3 - Workforce & Service Delivery

We note the following areas of good practice:

Annual leave

- The annual leave planning process within both wards that we visited is well managed. We note that staff are required to request annual leave months in advance, and it appears to be allocated fairly within the wards.
- The day to day management of annual leave was found to be well controlled in RGH Ward 7.

PDRs

- As an additional reminder and prompt both ward managers keep a calendar of when PDRs are due.
- Our testing of a sample PDRs at ward 7 RGH identified that all had been completed on time, had meaningful objectives, and had been signed by both the employee and manager.

Mandatory Training

- Training compliance rates was seen to be high at 92% in RGH ward 7. The Ward Manager was seen to maintain spreadsheets of all staff, training expiry dates and time is set aside to allow staff to complete their training.

Rosters

- At both wards that we visited thee-rostering policy and the timetable for roster completion were held in locations available for staff to reference if needed.

Consultant Job Plans

- The status of Consultant Job plans are reported to the CBM for monitoring.

References

- In all cases where reference were required, evidence could be seen of them being obtained prior to the person starting in post.

We identified the following findings:

Annual leave

- Both wards had calculated the annual leave entitlement based on the incorrect number of bank holidays, therefore attributing staff too much leave. Furthermore at PCH other leave entitlement differences were identified, highlighting the lack of reconciliations at that start of the year between ESR and the Health Roster system.
- At both wards we identified differences between the leave recorded on ESR, Health Roster and paper records, meaning that it was not clear which gave the accurate balance and again highlighting that reconciliations are not taking place between the systems at points during the year.

Sickness

- We identified errors in relation to completing self-certification and Return to Work (RTW) forms in both wards we reviewed. We also identified a number of occasions when medical certificates were not always obtained when required.
- Sickness episodes were not always correctly input on ESR or not input in a timely manner especially for staff that remain off long term.
- Long term sickness meetings were not always taking place in line with the All Wales Managing Attendance Policy.
- We noted instances whereby sickness triggers had been met and staff had not received the appropriate return to work / trigger interview according to the sickness policy.

PDRs

- At ward 8 PCH PDR documentation was not always fully completed. There were examples whereby the documentation was not signed by the manager or the employee.
- There were a number of cases were there time gap between PDRs was a number of years.
- Not all PDRs had been input onto ESR as having been completed.

Mandatory Training

- Across the 11 core modules PCH ward 8 was reporting an average compliance rate of 38%. None of the staff had completed the Ward /

Department Fire Safety Training and as such no staff members were 100% compliant with their training.

Rosters

- At both wards, current establishment levels meant that between one and three shifts per day shift and per night shift had to be covered by bank or agency staff in order to achieve the staffing level set out in the roster template.
- The nurse in charge was not always identifiable from reviewing the worked rosters.

Consultant Job Plans

- Our testing identified three out five job plans sampled were not in date, with one being over a year out of date. We noted that in four of the plans reviewed, the plans were signed off after the plan start date, in some cases seven months after.

Objective 4: Planning and Performance

We note the following areas of good practice:

- The IMTP was developed in line with the timetable set out in the Local Planning framework and was produced with the full involvement of all business partners including finance, information, planning and workforce. The Directorate Manager and Deputy Directorate Manager had a series of meetings with the business partners to develop the IMTP. Feedback sessions took place to address any issues that had been identified by the planning department in the first draft and we could see that discussions had taken place with the relevant staff to address these issues.
- Budget and CRES monitoring takes place at the CBM where the finance pack is a standard agenda item and is presented and discussed. In addition, the Finance Business Partner meets monthly with the budget holders to ensure that the monthly position and the staff in post are accurate.
- We saw evidence of monitoring the shortfall in achieving the 2018/19 CRES target. The Directorate had to attend several Executive director level review meetings to monitor and forecast the CRES outcome for 2018/19.
- The Directorate reviews non-financial performance measures and key performance indicators during the monthly CBM. The Directorate Manager's report, which in effect is an IMTP monitoring report, is presented on a quarterly basis and looks at the performance dashboard that highlights the main KPIs. RTT targets and the main risks that face each department within the Directorate is also included as is the Health Board wide workforce KPIs. Quality, safety and risk issues also feature in this report.

- In addition, the Workforce Business Partner presents workforce reports on a monthly basis at the CBM, which looks at sickness absence, PDR compliance and Core Mandatory training. We can also see from the Surgical Senior Team agenda that PDR, mandatory training compliance and sickness rates are discussed in preparation for the CBM.
- The Demand and Capacity plans form part of the performance dashboard which is presented at the CBM on a quarterly basis.

We identified the following finding:

- Due to the absence of agendas or minutes for the Senior Management Team, we could not evidence some workforce data being discussed at a ward or departmental level, in order for potential problem areas to be addressed.

Objective 5: Standards of Conduct

We identified the following areas of good practice:

- The Health Board has updated its Standards of Behaviour Policy to formally incorporate the need for all staff Band 8a or equivalent and above to complete a declaration of interest or 'nil' return.
- The Health Board undertakes an annual process that requires relevant staff to complete a declaration of interest. Outcomes are reported to the Audit Committee.

We identified the following findings:

- The Directorate Manager was not aware of the declarations that had been made by staff within the Directorate and therefore was not considering that information when managing the Directorate.
- Half of relevant directorate staff failed to submit a DOI or Nil Return despite reminders being sent by management within the Directorate.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Risk and governance	2	2	0	**4**
Planning and performance	0	1	0	**1**
Workforce	1	5	0	**6**
Total number of recommendations	**3**	**8**	**0**	**11**

Governance and Risk Management

Finding 1 – Risk management (Operating effectiveness)	Risk
We reviewed the 18 risks within the Datix system that were surgery directorate specific. We found: • 17 (94%) of the risks had passed their review date. Eight (44%) of these had a review date between 2014 – 2017, and three (17%) in 2018. • General Surgery reported ten high scoring risks (score above 15), two had not been reviewed since 2016, two should been reviewed in 2017, and three were not reviewed in 2018. The Health Board's risk management policy states that high scoring risks should be reviewed every three months. • Eight of the 18 risks associated with General Surgery had been allocated to a 'handler' that had retired from the Health Board in September 2017. We reviewed five of these risks in more detail to confirm that they were appropriately reviewed and monitored. We found: • Three had been allocated to a handler who, as stated above, had retired from the Health Board. All three of these were categorised as high (to be reviewed within three months), yet each had been allocated a six month review date, which at the time of our fieldwork had passed. • Two of the risks had not been updated or reviewed in Datix since they were logged in August 2017.	Risks materialise as they have not been identified and / or addressed.

• The remaining risk that was logged in 2016 had been reviewed in June 2018 but has not been updated in Datix. No actions have been recorded in the Datix for the risks in the sample.	
Recommendation	**Priority level**
1. The Directorate should review and update the risk register data within Datix to ensure that actions, review dates, and handlers are up to date. The inclusion of review dates will ensure reminders are sent to handlers. 2. Monitoring of risks recorded in Datix should be undertaken and appropriately reported to ensure action is taken in a timely manner.	**High**
Management Response	**Responsible Officer/ Deadline**
Recommendation 1 **Acknowledged.** There is an ongoing review of the Risk Register. Both the November and December 2018 Quality, Safety and Risk (QSR) meetings were used to undertake a review of the current risks on the Risk Register. The Heads of Nursing (HoNs) have also reviewed all nursing risks during the last 6-months. • By July 2019 the Risk Register will be updated and will identify the top ten risks. • The Risk Register will form a standard agenda item on the Directorate	Directorate Manager (DM) /Head of Nursing (HoN) /Directorate Governance Lead (DGL)/End of July 2019

Quality Safety and Risk Group (QS&RG). • Monthly updates on key risks are included in the HoN Patient Safety and Quality Report which is prepared for the Clinical Business Meeting and the quarterly Directorate QSR Report submitted to the Health Board QS&R Sub Committee. A quarterly update on the Risk Register will be presented in the Clinical Business Meetings.	Clinical Director/Head(s) of Nursing /Directorate Manager / Immediate
Recommendation 2 **Acknowledged.** Majority of incidents reported are for nursing. The Heads of Nursing have provided assurance that there are processes in place to manage and monitor risk, including monitoring outstanding relevant incidents and risks in all 1:1 meetings and in the bi-monthly Patient Safety and Governance meeting.	
• The QS&RG will monitor outstanding incident investigations to ensure timely they are processed in a timely manner and to ensure the responsible person has a plan to address these. To support this approach a Datix Incident Monitoring Report will be presented at the Directorate QS&RG.	Directorate Manager/June 2019
• Noting that there are a number of incidents that are allocated to staff who have left the Health Board, working in other Directorate or are members of the Corporate Teams. Datix incidents will be validated and if appropriate re-assigned.	Directorate Manager/Heads of Nursing/End of July 2019
• There are 9 risks under PCH nursing to be reviewed. These will reviewed by the PCH Head of Nursing	Head of Nursing PCH/End of July 2019
• Alerts messages will be activated on the Datix system to ensure they are	Patient Care and Safety Business Partner/July 2019

sent on a weekly basis • Training on the process for managing incidents and recording risk for all staff will continue to be reviewed in the PDR process by all line managers. For medical staff training will be addressed through joint audit and job planning • The highest volume of open incidents are in nursing, the most significant volume in PCH (108 open incidents). Work will therefore be undertaken to develop a plan to address these and to assess whether additional support is needed to clear the backlog of open incidents in PCH Nursing	Directorate Manager/Head of Nursing (s)/Clinical Director(s) Head of Nursing PCH/End of July 2019

Finding 2 – Risk monitoring (Operating effectiveness)	Risk
We understand that the directorate's risk register is reviewed at the Directorate Quality, Safety and Risk meetings and updates are made to Datix as risks are discussed during the meeting. We reviewed the agenda and attachments for the five meetings held in 2018 but did not see evidence of the risk register being discussed at the meetings held in November and December. In addition, from our testing of the information held within Datix we did not see evidence that it was being appropriately updated. We understand that quarterly Non-Patient Safety Incidents, Risk and Claims reports should be discussed at CBM meetings. However, our review of CBM agendas and action logs for the period July 2018 to March 2019 identified that at the end of quarter one, no report was produced by the central team and at the end of quarter two a report was produced but there was no evidence of it being discussed at the CBM. Therefore, we could only see evidence of the quarter three report going to the January 2019 meeting. As we only had the quarter three report, we were unable to make comparisons to early quarters to establish if risks awaiting approval are being approved in a timely manner. The quarter three report had ten risks awaiting approval, nine of which are allocated to the Senior Nurse at PCH. We also note that the report again shows that nine risks across the Directorate are allocated to a member of staff who retired in September 2017.	Risks materialise as they have not been identified and / or addressed.

Recommendation	Priority level
1. It should be ensured that the Non-Patient Safety Incidents, Risk and Claims report that contains the risk register is presented at each CBM meeting and if necessary at the Quality, Safety and Risk meetings in order for risks to be discussed in greater detail. The risk data contained in the report should be made more meaningful by including details of when the risk was first opened and when it was last reviewed. Where is it obvious that the data contained within the report is inaccurate, action should be taken to remedy this. Basic errors in information, such as risks being attributed to ex-employees, should not occur in consecutive reports. 2. Those potential risks awaiting approval should be assessed for inclusion on the register as a matter of urgency.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Recommendation 1 & 2 **Acknowledged.** The November and December 2018 QS&R meetings were used to review the Risk Register to allow members to gain an appreciation of the risks and the level of these risks. No separate notes were taken of the individual actions taken to update the Register in the meeting as there is an audit trail on Datix. • The Heads of Nursing(s), Directorate Manager and Clinical Governance lead will work with our Patient Care and Safety Co-ordinator to develop the Non-	Directorate Support Manager/Heads of Nursing/ Patient Care and Safety

Patient Safety Incidents, Risk and Claims Report and the General Surgery, Trauma and Orthopaedics and Urology Patient Experience and Feedback Report into a single meaningful and regular report that is discussed in the QS&R and integrated into the Hon update for CBM	Business Partner/ End of September 2019
• There are 9 risks under PCH nursing to be reviewed. These will reviewed by the PCH Head of Nursing	Head of Nursing PCH/End of July 2019
• There are a number of incidents that are allocated to staff who have left the Health Board, working in other Directorate or are members of the Corporate Teams. Datix incidents will be validated and where appropriate re-assigned	Heads of Nursing & Directorate Manager/End of July 2019
• The Risk Register will form a standard agenda item on the Directorate Quality Safety and Risk Group (QS&RG) to ensure it is regularly updated.	Directorate Manager/Immediate

Finding 3 – Governance Arrangements (Operating Effectiveness)	Risk
The main groups that oversee governance arrangements within the Directorate are the Quality, Safety and Risk group (QS&R), the Clinical Business Meeting (CBM) and the Senior Management Team (SMT). The QS&R and SMT report into the CBM. **Clinical Business Meeting** Clinical Business Meetings are held in all directorates. We note that the Health Board's standard ToR for this meeting has remained in a draft format since May 2018. Meetings should be held on a monthly basis, but between July 2018 and March 2019 two of the nine meetings were cancelled. As action logs are generated instead of minutes as a record of the meeting, we were unable to confirm that all appropriate matters were discussing. Our review of attendance over the five meetings that we reviewed identified that the Heads of Nursing and the Clinical Director only attended one meeting each. The ToR state that these officers form part of the core membership of the CBM and should attend. **Quality, Safety and Risk Group** The QS&R groups ToR should have been reviewed in January 2019, but at the time of our fieldwork the review had not taken place. In addition, it states that meetings are to be held quarterly, although the group now meets each month, highlighting the need for them to be updated.	The Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.

We were provided with five agendas for QS&R group meetings that were held in 2018. However, despite our request, we were not provided with the minutes or action logs for these meetings, so could not confirm if the meeting were attended by the correct people, if meetings were quorate, or the focus of the meetings. **Senior Management Team** The ToR for the SMT group was requested but was not provided during our period of fieldwork. We note that the meetings of this group are not minuted, therefore we could not confirm who was in attendance, what was discussed, or actions taken.	
Recommendation	**Priority level**
1. The terms of reference for the Quality, Safety and Risk Group should be reviewed and updated as necessary. 2. Minutes / action logs should be maintained for the Quality, Safety and Risk Group as this is a key governance group within the Directorate. 3. The terms of reference for the CBM should be finalised and implemented as soon as possible. 4. Officers who form the core membership of the CBM should be in attendance or send a representative where appropriate. 5. The documents that form the agenda items for CBM meetings should be available within the Directorate.	**High**

6. A terms of reference should be developed for the Senior Management Team meetings.	
Management Response	**Responsible Officer/ Deadline**
Recommendations 1- 6 Acknowledged. The Clinical Business Meetings are established corporately as part of the Health Board's Performance Management Framework to operate within a monthly cycle. They are planned and supported centrally by the Programme Management Office (PMO), including the format of recording actions. During the period of the review the PMO were not able to support all meetings due to staff shortages. The Directorates previously supported a programme of formal bi-monthly meetings or to switch to an informal / formal meeting cycle. The Directorate does not currently have a dedicated governance infrastructure/posts and providing the requisite support to the Quality, Safety and Risk Committee is challenging. There is also extremely limited administration support in the Directorate for the number of meetings established including the QSR. A dedicated Governance role to address this shortfall in the governance structure was included in the 2019/2020 Directorate IMTP. The Senior Management Team is an informal team meeting of the Business Partners and the Head of Nursing or relevant senior nurse to aid communication and to prepare and plan for the CBM. Members are expected to make a note of their own actions and when necessary key actions are followed up by the responsible person via mail. There is not sufficient administration resource in the Directorate to service this meeting.	

• The Terms of Reference (ToR) were due for review in January 2019. They will be reviewed in the July meeting	QSR Group/End of July 2019
• Key points and actions will be recorded for the Directorate Quality Safety and Risk Meeting	Operational Support Manager/Immediate
• The CBM ToR were developed corporately as part of the Health Board's Performance Management Framework and therefore this will need to be addressed corporately	Chief Operating Officer/TBC
• The Programme Management Office manage the CBM process. They have been asked to arrange CBMs to ensure core members are available and dates arranged when CDs are available or do not have clinical commitments. The HoN(s) have been asked to prioritise attendance at CBMs	Head of the PMO/TBC
• The PMO are resourced and are responsible for the co-ordination of the CBMs. The Directorate will request a full set of papers are sent to the Directorate Office (including PMO following up tabled papers)	Head of the PMO/Directorate Manager/Immediate
• A ToR will be developed for the Senior Team Meeting.	Directorate Manager/September 2019

Finding 4 – Declarations of Interest (Operating Effectiveness)	Risk
A revised Standards of Behaviour policy was approved by the Audit Committee in January 2019, however the Health Board's intranet links to the previous version of the policy. Our review of Declaration of Interest returns for September 2018 identified that 5/10 of the staff identified as needing to complete a return to corporate services had not done so, even though a reminder email had been sent to the staff member. We note from our discussion with the Directorate Manager, that she was not aware of the declarations made by staff within the Directorate. However, we understand that following completion of the current year returns that were requested in March 2019, directorate managers will be provided with reports of those declarations made, and nil returns.	The Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
Recommendation	**Priority level**
The Directorate should ensure that all staff required to complete a Declaration of Interest do so in a timely manner and that the relevant staff are aware of the declarations made in order for the information to be appropriately considered. The Health Board should ensure that the revised Standards of Behaviour policy is available to staff on the intranet.	**Medium**

Management Response	Responsible Officer/ Deadline
The Directorate will ensure that the policy and the Standards of Behaviour Framework is brought to the attention of the staff in the Directorate through relevant team meetings, PDRs and Job Plan Reviews.	Clinical Director/Directorate Manager/Ongoing
Currently the Corporate Teams prompt the Declarations of Interest for the specific groups of employees identified in the Standards of Behaviour Policy and also follow up the declarations and nil returns. Information on declarations made and nil returns have not been received for 2019 to enable any follow up in the Directorate.	Head of Corporate Governance/TBC

Performance and Planning

Finding 5 Reporting and monitoring performance (Operating effectiveness)	Risk
The monitoring of financial and non-financial performance information takes place during in the CBM. However, we identified that some of the workforce data presented to the CBM is often for the directorate as a whole and is not broken down by ward or department. For example, sickness data is for the directorate as a whole and whilst there is an accompanying narrative report, this does not appear to give ward or departmental level information. Whilst reporting at this level may be appropriate at this meeting, we would expect to see reporting at a more detailed level at other groups within the directorate so that areas of concern can be identified, and targeted action can be taken as necessary. We acknowledge that the Directorate Manager regularly meets with the workforce business partner, but senior nurses are not involved in those meetings. Furthermore, as reported in finding 3 above, as there are no minutes for the SMT we were unable to see evidence of monitoring so that issues at ward or department level are identified and disseminated down to relevant staff.	Non-compliance is not identified and therefore not addressed.
Recommendation	**Priority level**
It should be ensured that performance data is reported at a suitable level throughout the directorate, in order for potential issues to be disseminated down to relevant staff and problems and barriers to improvements escalated back to	**Medium**

directorate management. Evidence, via meeting minutes or actions logs should be retained to evidence this monitoring as happening.	
Management Response	**Responsible Officer/ Deadline**
• Nursing establishment meetings with Business Partners, E-Rostering and the Senior Nurses are held monthly with ward managers and these cover financial and operational performance. A new proforma has been implemented by the Heads of Nursing (June 2019) to capture key performance indicators. Where necessary improvement targets/actions are agreed at this meeting. This is escalated to the CBM as necessary.	Heads of Nursing/Immediate
• The Heads of Nursing have bi-monthly governance meetings where key performance data is discussed and this supports the ongoing development of the HoN Quality and Safety Report.	Heads of Nursing/Immediate
• Financial and Operational Performance is discussed in relevant Sub-Directorate meetings and directly with Clinical Directors in 1:1 meetings.	Directorate Manager/Clinical Director/ongoing

Workforce

Finding 6 – Agreeing consultant job plans (Operating effectiveness)	Risk
Consultant's job plans are an annual agreement between the Health Board and the consultant setting out, amongst other things, what work the consultant does for the Health Board, when and where the work is done, and how much time the consultant is expected to be available for work. Job plans cover a period of 42 weeks. At the time of our fieldwork there were 18 consultants working within the directorate. We tested a sample of six individuals to confirm that their job plans were in place, the standard form had been used, and had been signed appropriately. We note the following: • One job plan was not available as the individual was on maternity leave and a copy of the plan was not held by the directorate. • 3/5 provided had expired, with the oldest expiring in March 2018. • One of the two that was in date was still awaiting final sign-off despite the plan starting a month prior. • For 4/5 that were provided, the initial discussion date and final sign-off date was after the start of the job plan period. In one instance the final sign-off of the plan was seven months after the plan start date.	Consultants have not agreed and signed-off job plans, which could lead to changes to working commitments resulting in the Health Board being unable to meet short term demand.

We note that a report on the status of job plans taken to the March 2019 CBM. This reported that only 5/18 consultants working in the directorate had 'in date' job plans.	
Recommendation	**Priority level**
Management should work with consultants to understand what the barriers are to ensuring that job plans are agreed in good time. Actions from this exercise should be implemented to improve job plan sign-off. Management should work with consultants to ensure that job plans are discussed and agreed by all relevant parties ahead of the job planning period. Advice should be sought from other directorates where job plans are completed in a timely manner and a forward work plan should be developed to ensure planning takes place in a timely manner and the CBM should continue to monitor the ongoing status of job plans within the directorate.	**High**
Management Response	**Responsible Officer/ Deadline**
A plan to undertake consultant job plans that are out of compliance has been developed and this will be monitored through CBM. The major barrier to undertake consultant job plans is Directorate Manager and Clinical Director capacity. The COO has recently agreed an interim Deputy Directorate Manager to increase management capacity in the Directorate.	COO/Clinical Director/Directorate Manager/Ongoing

Finding 7- Annual leave (Operating effectiveness)	Risk
We reviewed the annual leave records for a sample of ten staff from ward 8 at PCH and ward 7 at RGH to ensure the leave had been appropriately planned, requested, recorded and authorised. Both wards use the Health Roster system to book annual leave although ward 8 also retains paper annual leave cards. At both wards, for all staff sampled the opening annual leave balances for 2018/19 had been incorrectly calculated, with the balance of leave input on Health Roster or paper records being greater than the value recorded in ESR. In 18/20 cases the error was because there was one less bank holiday in 2018/19 than the year before, and no adjustment had been made. The RGH Ward Manager has made adjustments to 2019/20 leave calculations to rectify this. At PCH, in two cases additional differences between ESR and paper records are greater (35.75 and 37.5 hours). As such, no reconciliation is being undertaken between Health Roster / paper records and ESR at the start of the year to ensure opening balances are correct or at any point during the year to ensure balances remain correct (changes may occur mid-year if staff change hours). **Ward 8 PCH** We make the following observations in relation to our testing on this ward: • 1/10 employees in our sample kept their own paper records as opposed to the Ward Manager retaining them. These were requested during the audit fieldwork but were not provided.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

• 2/10 people in our sample had differences between their annual leave card, roster records and ESR. One had an episode of leave where three days more had been booked on ESR than the other two records. In the other instance the leave was not recorded on ESR despite it being on the annual leave card and Health Roster. • Our wider review comparing remaining leave balances in Health Roster to ESR and paper records identified three other discrepancies where either leave was not on Health Roster, but was on the paper record or vice versa. For the above cases it is unclear which records are accurate and which are being used by individuals and the Ward Manager when requesting and approving annual leave. This will have an impact on the ensuring the individuals take the correct amounts of leave in the year. These discrepancies also highlight the fact that in-year reconciliations are not being undertaken. **Ward 7 RGH** We make the following observations in relation to our testing on this ward: One employee had differences between Health Roster and ESR, with ESR not showing the episode of leave. Upon further review of ESR it was reporting that this individual had not taken any annual leave since April 2018. Given that our audit fieldwork was undertake near the end of the financial year, we would have expected numerous episodes of leave to have been taken throughout the year. Had mid-year reconciliations been undertaken this matter would have been identified.	

Recommendation	Priority level
1. Supervisors should be reminded that annual leave entitlement balances may vary each years due to the number of public holidays in a year, when staff reach five and ten years' service, or when staff change their contracted hours. 2. A reconciliation between ESR and the Health Roster should be carried out at the start of the year to confirm the correct entitlement has been attributed. Periodic checks should be undertaken throughout the year to confirm that records remain accurate and staff do not take too much or not enough leave. 3. The need for paper records should be considered given the existence of annual leave data in ESR and Health Roster. Should paper records be needed then all records should be retained by one officer, such as the Ward Manager.	**Medium**
Management Response	**Responsible Officer/ Deadline**
• The anomalies identified in the audit have been addressed by the Heads of Nursing and the senior nurses. This includes the sign off of E-Roster with all annual leave allocations. Whilst annual leave is no longer recorded on ESR Ward managers are responsible for correlating ESR records with E-Rostering balances. • Monthly establishment meetings led by the Heads of Nursing review and monitor annual leave on E-Roster.	Head(s) of Nursing/Completed

Finding 8 – Absence management (Operating Effectiveness)	Risk
The Welsh Government target for absence is 4.5%. For the 9 month period to March 2019, the Directorate had an absence rate averaging 6.34%. Ward 8 at PCH had an average of 10.35% for the period, and ward 7 RGH had an average of 10.58%. We tested a sample of ten employees from Ward 8 at PCH and ten employees from Ward 7 at RGH who had periods of sickness during the year. At the time of our testing two employees from each of the wards remained absent. We note the following: **Ward 8 PCH** • Initial sickness notification had not been recorded on sickness notification forms at the point of contact for any of the selected sample. • 4/8 self-certification forms could not be located. • 2/8 return to work (RTW) forms had not been completed. Of the completed RTW forms, one had not been completed within 7 days of the staff member returning to work. • 7/10 required medical certificates to cover their period of absence. However, 5/7 did not have these medical certificates to fully cover their absence. We note that across the five employees a total of 160 days were not covered by a medical certificate. • For 5/10 employees the sickness was not correctly input in ESR, and one employee's absence had not been input onto ESR. Two employees who were	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

long term sick did not have their absence recorded in ESR, which may impact on sickness payments. Two employee's end date of absence on ESR did not correspond to other documentation such as the rosters or RTW documents. • In our sample 5/10 employees had hit triggers or prompts as a result of their absence. In two of these instances we could not see evidence of appropriate absence management interviews being conducted. We note that in one case the need for an interview was raised at the RTW meeting, but dismissed as it was felt the triggers in place then had not been hit, when in fact they had been. • 1/3 employees on LTS had no evidence of keeping in touch meetings taking place during their absence. **Ward 7 RGH** • 6/10 had no initial sickness notifications recorded at the point of contact. • 4/10 employees' sickness was not correctly recorded in ESR. In all cases the Ward Manager had input the absence on Health Roster, but it had not transferred to the ESR system. This may have an impact on the correct calculation of sickness payments. • 4/10 employees hit triggers / prompts and of these there was no evidence in three cases that the relevant absence management meetings had taken place, though in one case there was an invite letter on file, however the outcome letter was not present so it could not be confirmed the meeting was held.	

• 1 employee had discrepancies between their first day of sickness recorded on the off duty (worked) roster, occupational health letter, ESR and LTS invitation. • 2 /4 employees on LTS had no evidence of keeping in touch or other absence monitoring.	
Recommendation	**Priority level**
1. Comprehensive and timely records of sickness should be maintained to allow the proper management of sickness within the Directorate and accurate reporting. It should be ensured that self-certification and return to work forms are completed and in a timely manner. Medical certificates should be in place for the required period. All information contained on self-certification forms, RTW forms and ESR should correspond. 2. Absence records should be created on ESR or Health Roster at the start of a known absence in to ensure the correct calculation of sickness payments and prevent over payments. 3. LTS should managed in line with the All Wales Managing Attendance at Work Policy, with staff invited to attend absence meetings to help facilitate their return to work 4. Absence management prompts should be monitored and where periods of absence result in a prompt being breached, the appropriate action should be taken.	**Medium**

Management Response	Responsible Officer/ Deadline
RGH Ward 7 & PCH Ward 8 • All recommendations have been addressed and changes implemented by the HoN(s) supported by the senior nurses. • Monthly sickness meetings are in place with the senior nurse and the Workforce Business Partner and these will highlight concerns with processes and compliance. • The monthly establishment meetings also review and monitor sickness absence including the key performance indicators such as return to work interview compliance and sickness notification.	Heads of Nursing/Completed

Finding 9 – PDR completion (Operating effectiveness)	Risk
As part of our early fieldwork we obtained PDR compliance rate data as at September 2018. The Directorate as a whole (General Surgery, Trauma & Orthopaedics and Urology) had a compliance rate of 50%. Whilst this had improved to 58% by March 2019, it is still well below the Health Board target of 85%. The data shows that compliance rates across the directorate range between over 80% in a number of wards, to as low as 20% on another ward. Our workforce testing focussed on two wards (PCH ward 8 and RGH ward 7), which had compliance rates in September 2018 of 62% and 74% respectively. By January 2019, compliance for the whole directorate had risen to 58%, with ward 8s position falling slightly to 60%, and ward 7 improving to 83%. Whilst we identified some issues at PCH ward 8, as reported below, it is clear that there are other wards within the directorate where compliance rates are poor and therefore greatly impacting on the overall directorate compliance rate. It is unclear why there would be such contrasting differences between wards. <u>Testing</u> We tested a sample of 13 employees. Five from PCH ward 8, and eight from RGH ward 7 to establish if a PDR had been completed in the last year that was of a suitable quality, and had been recorded in ESR. <u>Ward 8 at PCH</u> • 1/5 did not have an in date PDR on file. • 2/5 the PDR on file prior to their current one, was over three years ago.	Staff performance is not effectively assessed and addressed.

• 1/5 PDR not signed as agreed by the completing manager. • 1/5 PDR not signed as agreed by the employee. • 1/5 was not fully completed with information such as the review date and mandatory training compliance data left blank. • 2/5 had not been recorded in ESR. <u>Ward 7 at RGH</u> We did not identify any issues at RGH Ward 7.	
Recommendation	**Priority level**
1. In line with Health Board targets, all staff should be subject to a PDR on an annual basis. 2. PDR documentation should be fully completed, with meaningful objectives agreed by the manager and employee. The document should be signed by both parties and ESR updated with the date the PDR took place. 3. Work should be undertaken between wards to gain an understanding of the processes in place in the wards where PDR compliance rates are high, in order for lessons to be learnt by the poorer performing wards.	**Medium**

Management Response	Responsible Officer/ Deadline
Ward 8 The new ward manager on Ward 8 has developed a plan for completion of PDR's by August 2019. Compliance is now monitored on a monthly basis through establishment meetings chaired by the HoN.	Head of Nursing PCH/End of August 2019

Finding 10 – Mandatory training compliance (Operating Effectiveness)	Risk
In September 2018 the average mandatory training compliance rate for the directorate as a whole (General Surgery, Trauma & Orthopaedics and Urology) was 50.34% and for Ward 8 PCH 38.24% and Ward 7 RGH 91.82%. As at January 2019 the compliance rate for the directorate had improved marginally to 51.14%. Data at a ward level for the core modules (level one) is no longer reported at CBMs as ESR has been updated to contain core training requirements specifically tailored to staffing groups. We tested a sample of 13 employees. Five from PCH Ward 8 and eight from RGH Ward 7 at to establish their level of mandatory training compliance against the core modules at level one. **Ward 8 at PCH** • None of the staff tested were 100% compliant. • 1 member of staff was 0% compliant, with all mandatory modules outstanding. • None of the staff had completed Ward/Departmental Fire Safety Training - this was also evidenced in the Directorate compliance report, which shows a 0% compliance. **Ward 7 at RGH** There were no significant findings from testing undertaken on mandatory training at RGH Ward 7. All staff were 100% compliant with all CSTF modules, including	Staff performance is not effectively assess and addressed.

department fire safety training. We understand that achievement of this rate is through proactive monitoring and allowing staff dedicated time to participate in the training.	
Recommendation	**Priority level**
The Directorate should ensure that all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary. Consideration should be given to understanding the approach taken by Ward 7.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The PDR compliance continues to be reported and monitored at Clinical Business Meetings. Nursing staff represent the largest staff group and therefore noting that the main forum for action are the monthly Establishment Meetings. • The new ward manager on Ward 8 has developed a plan for completion of all PDR's by August 2019, this will include compliance with the core mandatory training. Compliance is now monitored on a monthly basis through establishment meetings chaired by the HoN. • To share the good practice identified in RGH is noted and the Head of Nursing RGH will be asked to share the process of achieving this with PCH colleagues.	Head of Nursing PCH/End of August 2019 Head of Nursing RGH/TBC

Finding 11 – Roster management (Operating Effectiveness)	Risk
The rosters for PCH Ward 8 and RGH Ward 7 are generated via the E-rostering system. When ward managers first generate the weekly roster it is based on the current staffing establishment. At the time of our fieldwork, both wards had staffing vacancies. Our review of two weeks' rosters at each ward identified the following: **PCH Ward 8** • When the rosters were generated, due to the vacancies, each day and night period had up to three shifts that were offered to bank or agency staff. • During the period that we reviewed, the worked rosters show that in one week 6/18 qualified staff were sick, and in the second week 7/18 staff were sick. As such, there would have been an increased need to use bank and agency staff to cover absent staff. • Our review of the worked rosters identified 4/28 shifts in the two-week period where a nurse in charge was not clearly identifiable. • Annual leave should be evenly distributed over the year with a maximum number of staff granted leave on any one shift. In the case of Health Care Support Workers the template roster identifies that only two HCSW should be off at once, yet in the two-week period we identified two occasions where three HCSW were off at the same time. The impact being that shifts often have to be backfilled with more expensive bank or agency workers.	Reduced service provision / additional costs due to rosters not being generated in the most effective way.

RGH Ward 7 • Due to staff vacancies, for the two-week period that we received, each day and night shift had up to two shifts that had to be offered to bank or agency staff, as there were not enough staff in post to fill all shifts. However we noted that not all of these shifts were filled. • The review of the worked rosters identified 6/28 occasions in the two week period where a nurse in charge was not clearly identifiable. • Over the two week period that we reviewed, in both weeks more nursing staff were allowed to take annual leave at any one time than should have been based on the template roster. This would have resulted in shifts having to be back filled with bank or agency staff. However we were informed that this was due to staff changing wards and previously agreed annual leave requests being honoured, meaning more staff were off that would normally be the case. The Directorate has a CRES target to achieve and the two projects identified for 2019/20 directly relate to staffing costs. It is therefore essential that rosters are generated and managed in the most efficient way in order to prevent the use of costly bank and agency staff and to help achieve the CRES target.	
Recommendation	**Priority level**
1. The Directorate should explore its options going forward as to how it will sustainably manage wards where the current staffing levels fails to meet the required establishment. Annual leave should be carefully managed to ensure	**Medium**

too many staff are not off at once, meaning shifts cannot be covered from within the current establishment. 2. A nurse in charge should be clearly identifiable on the worked rosters for all shifts.	
Management Response	**Responsible Officer/ Deadline**
The Heads of Nursing are working closely with the senior nurses and ward managers to fully address the recommendation in the Audit. It is noted however that there is a high level of nursing vacancies on both DGH sites surgical wards that remains challenging. A recruitment drive is ongoing and work is being undertaken as part of the 'Every Voice Counts' initiative to identify and support measures to improve the retention of nursing staff. The Directorate also wishes to highlight that the unscheduled care pressures in PCH and model changes have from January 2019 resulted in a severe loss of surgical capacity. This overall reduction in surgical beds along with the number of medical outliers is having an adverse impact on surgical flow and therefore additional pressures on the ward teams to manage both elective and emergency patient admissions. • The ward managers are now supernumerary and are responsible for managing their ward rosters. Ward managers are asked to complete rosters in a timely manner to enable vacant shifts to be put out to agencies and with visibility to ensure the nurse in charge is clear on the roster. They are supported by the senior nurses as necessary • Rosters are signed off by senior nurses and reviewed in the monthly	Head of Nursing/Immediate Head of Nursing/Immediate

establishment meetings, this will include ensuring a nurse in charge is identified.	

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Appendix C – Detailed Scope and Objectives

Governance arrangements

- Appropriate governance structures, committees and groups are in place with clear reporting lines that support the key operational functions of finance, workforce, and planning and performance.
- Business partners provide appropriate support for the directorate's key operational functions.
- Directorate policies and procedures are owned and are up to date.
- There are appropriate mechanisms in place to ensure new legislative and regulatory information received is disseminated and actioned on a timely basis.

Risk management

- A risk management process is in place that ensures risks are appropriately identified, assessed, recorded, monitored and reported on. Risk owners are identified for each risk and mitigation plans are in place where appropriate.
- Risks associated with demand and capacity are appropriately captured.

Workforce management & service delivery

- Annual leave is appropriately planned, requested, recorded and authorised.
- Flexi time and Time off in Lieu (TOIL) is appropriately recorded, monitored and managed in accordance with local procedures and processes.
- Sickness absence is appropriately recorded, monitored and managed in accordance with the All Wales Sickness Management policy.
- Staff and management appropriately complete PDRs in good time.
- Staff complete mandatory training in line with specified timeframes.
- Staff rosters are planned and approved in line with the template.
- Systems are in place to ensure amendments to rosters that deviate from the template roster are appropriately reviewed and approved to ensure optimum workforce deployment and minimal use of overtime.
- Consultant job plans are reviewed and agreed annually, and monitored to ensure that clinical activity is delivered in line with the agreed job plans.
- Workforce planning arrangements exist to establish and plan for known future changes to the directorate. For example, key staff due to retire within three years.

- Timely references are obtained as part of the recruitment process.

Planning and performance

- The directorate has appropriate arrangements in place to ensure that its Integrated Medium Term Plan (IMTP) is developed in accordance with the Health Board's corporate planning framework.
- Budget holders and other relevant staff are appropriately engaged in the development of the directorate's IMTP.
- Budget holders within the directorate monitor budgets and agreed Cash Releasing Efficiency Scheme (CRES) targets and take action as appropriate.
- The directorate has appropriate non- financial performance measures and key performance indicators in place that cover relevant service delivery and cross-cutting themes such as workforce. These are formally reviewed and reported on a regular basis.
- The directorate has appropriate action and recovery plans and mechanisms in place, where required, in relation to both financial and non-financial activities. For example, should performance targets begin to show an adverse variance.
- Demand and capacity plans are owned and used as 'day to day' business planning tools for managing the directorate.
- Demand and capacity plans are monitored and reported to ensure they remain fit for purpose.

Standards of conduct

- Declarations of interest (or nil returns) are submitted for all relevant staff and the directorate is aware of the declarations made.

Directorate specific objective

- We also considered how good practice is captured and communicated between the directorate and other directorates so that shared improvements to services can be made where appropriate.

Directorate review – Surgery - Compliance

Internal Audit Report

Cwm Taf University Health Board 2018/19

July 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-28
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Executive sign off:	Steve Webster, Director of Finance
Distribution:	Paula Pearce, Directorate Manager
Committee:	Audit Committee

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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.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The review of the Surgery directorate's compliance with key documents such as Standing Financial Instructions, including the Scheme of Delegation, and Financial Control Procedures, was completed in line with the 2018/19 Internal Audit plan for Cwm Taf University Health Board (the 'Health Board' or the 'organisation').

The relevant Executive Director lead for the assignment is the Director of Finance and Procurement.

In addition to this review, we undertook a separate review of the directorate's management arrangements, which has been reported separately.

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to compliance with key documents, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The areas we sought to provide assurance on were:

- Awareness levels of key documents within the directorate. For example, staff can access key documents and changes to them are appropriately communicated.
- The directorate's compliance with the relevant elements of the Scheme of Delegation.
- The directorate's compliance with relevant Financial Control Procedures (FCPs).

We met with the Head of Corporate Finance and the Assistant Director of Finance to identify the FCPs most applicable to the directorate. These were:

- budgetary control;
- salaries and wages;
- income and debtors; and
- inventory of non-capital Assets.

As such, our testing of FCPs focused on these areas.

3. Associated Risks

The potential risks considered in this review were as follows:

- Inappropriate or unauthorised decisions are made if staff are unaware of the relevant key documents.
- Inappropriate or unauthorised decisions due to non-compliance with legislation or corporate and operational policies.
- Financial expenditure unnecessarily incurred.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the compliance risks associated with the Surgery directorate 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.

Staff within the directorate that we met had a sound understanding of the Financial Control Procedures and the relevant elements of the Scheme of Delegation, though not all had undertaken the Scheme of Delegation training available.

Our testing confirmed that the directorate is mostly compliant with requirements set out in the FCPs and the Scheme of Delegation, to support payments. In relation to the non-capital assets FCP, staff within the directorate did not appear to be aware of the requirement to maintain such an inventory, and therefore did not have any records in place.

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

5. Assurance Summary

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

Assurance Summary					
1	Key documents				✓
2	Scheme of Delegation				✓
3	Financial Control Procedures			✓	

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

Design of Systems/Controls

The findings from the review highlighted no issues that were classified as a weakness in the system control/design for compliance within the Surgery directorate.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as a weakness in the operation of the designed system/control for compliance within the Surgery directorate.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Awareness levels of key documents within the Directorate

We note the following area of good practice:

- Key staff within the directorate were aware of relevant FCPs and the Scheme of Delegation, and knew where to seek further advice if required.

We identified the following finding:

- The central finance team have identified all staff within the Health Board who they believe require training on the Scheme of Delegation. Not all of the identified staff within the directorate had undertaken Scheme of Delegation training.

Objective 2: Compliance to relevant elements of the Scheme of Delegation

We did not identify any issues to be reported from our testing of compliance against the scheme of delegation.

Objective 3: The Directorate's compliance with relevant Financial Control Procedures

We note the following area of good practice:

- Our testing against the budgetary control, and salaries and wages FCPs did not identify any issues.

We identified the following finding:

- The directorate does not maintain an inventory of non-capital assets in line with the requirement of the FCPs.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**0**	**1**	**2**

Finding 1 – Inventory of Non-Capital Assets (Operating effectiveness)	Risk
The Financial Control Procedure for the Inventory of Non-Capital Assets (FCP 11) identifies the requirement for directorates to have and control an inventory of non-capital assets. Items to include on the register should be valued over £1,000 and have a useful life of more than one year. Capital items, stock and consumable items should not be included. Following our discussions with the Directorate Manager, and subsequent requests for the inventory, we were not provided with any information and therefore could not undertake any testing in this area. We have concluded that the directorate does not currently hold an inventory of its non-capital assets.	Financial expenditure unnecessarily incurred.
Recommendation	**Priority level**
In accordance with Financial Control Procedure 11, an Inventory of Non-Capital Assets should be compiled and maintained for all areas within the directorate.	**High**
Management Response	**Responsible Officer/ Deadline**
The Directorate does not have an inventory of non-capital assets over 1k. The Directorate Support Manager will liaise with the Finance Business Partner and Senior Nurses to develop an inventory system. Due to limited administration resources, this will be established as a project for the current Graduate Manager.	Directorate Support Manager/September 2019

Finding 2 – Awareness of key documents (Operating effectiveness)	Risk
Training in relation to the Scheme of Delegation is available via ESR. In 2018 the finance team identified staff within each directorate that needed 'Scheme of Delegation' training as part of their role. This information has been recorded in ESR. Five staff within the Surgery Directorate were identified as requiring training due to the role they perform, but at the time of our audit fieldwork only one had completed the training module.	Inappropriate or unauthorised decisions are made if staff are unaware of the relevant key documents.
Recommendation	**Priority level**
Staff identified as requiring 'scheme of delegation' training as part of their role should complete the on-line training module in ESR as soon as practically possible.	**Low**
Management Response	**Responsible Officer/ Deadline**
All staff relevant staff will undertake on-line training within 3-months.	Directorate Manager/October 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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Cwm Taf University Health Board

Directorate review - Radiology Management Arrangements

Internal Audit Report

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NHS Wales Shared Services Partnership

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating
Appendix C Detailed scope and objectives

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Committee:	Audit Committee

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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.

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1. Introduction and Background

The review of the Radiology directorate's management arrangements was completed in line with the 2018/19 Internal Audit plan for Cwm Taf University Health Board (the 'Health Board' or the 'organisation').

As part of the 2018/19 programme of work, we reviewed the management arrangements for a number of directorates and it is anticipated that all directorates will be audited over a three year period.

In addition to this review of management arrangements within the Radiology directorate, a separate piece of audit work was undertaken within the directorate to establish the level of compliance within the Scheme of Delegation and a number of the most relevant or highest risk Financial Control Procedures applicable to the directorate.

As such, we produced two reports, one focussing on compliance with financial governance arrangements, and one focussing on management arrangements.

As part of our audit planning, we spoke with members of the finance team, the Director of Finance, the Directorate Manager and the Directorate's business partners.

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

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the management arrangements, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievements of system's objectives are managed appropriately.

The areas we sought to provide assurance on were:

- Governance arrangements
- Risk management
- Workforce management
- Planning and performance
- Standards of conduct
- Directorate specific objective

Our detailed scope and objectives are set out in Appendix C.

3. Associated Risks

The potential risks considered in the review were as follows:

- The Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
- Services are not effectively planned.
- Risks materialise as they have not been identified and / or addressed.
- Reduced service provision / additional costs due to inappropriate or unauthorised absence.
- Staff performance is not effectively assessed and addressed.
- Directorate objectives are not achieved as a result of demand and capacity data failing to be properly used and monitored.

OPINIONS AND KEY FINDINGS

4. Assurance Opinions

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. This review, focussing on management arrangements, covers risk management and governance (which includes the objectives for standards of conduct and any directorate specific areas), performance and planning, and workforce, giving three separate opinions relating to the relevant domain areas.

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

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

Risk management and governance

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with risk management and governance 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.

Governance Arrangements

The Directorate holds an up to date organisational chart that reflects the current governance structure and the committees and groups in place that are served by clear reporting and information lines. The two key groups within the Directorate are the Clinical Business Meeting (CBM) and Radiology Operational Group. In addition, a new Image Optimisation Group was set up in January 2019 to oversee the implementation and monitoring of image optimisation processes and review issues relevant to the Ionising Radiation (Medical Exposure) Regulations (IRMER).

With the exception of Workforce and OD, the Directorate appears to have good working relationships with its business partners, most of whom regularly attend the CBMs and the Operational Group meetings.

We note that CBMs and Operational group meetings were not being held each month, and the CBM did not have an approved Terms of Reference (ToR) in place. In addition, for some of the CBM meetings that we reviewed when certain key officers within the Directorate were unable to attend, no delegated deputy was sent to represent the key officer.

Risk Management

The Directorate uses the Datix Risk Management database to record, monitor and update its risks. Our review of the risk register on Datix showed that all risks were assigned to an appropriate risk handler and there was evidence that risks were being regularly reviewed and updated.

We saw evidence that risk management was discussed regularly at CBMs, the Operational Group meetings, and through the Radiology Integrated Governance meetings. The Directorate's top risks were periodically presented to the Health Board's Quality, Safety and Risk Committee via the Radiology Directorate Integrated Governance exception report.

Standards of Conduct

The Directorate Manager is not made aware of the Declarations of Interest (DoI) returned to the corporate team by senior members of the Directorate. As such, declarations and personal interests may not be taken into consideration when making decisions.

At the present time, not all staff within the Directorate had made a DoI or 'nil return' despite reminders to do so. As such, we have raised a finding to reflect this.

Performance and planning

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with performance and planning 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 Directorate has used the Health Board's Local Planning Framework to develop its 2019-22 IMTP and all draft submissions were made to the planning department in accordance with the Health Board's timetable. Additionally, we saw evidence of both stakeholder engagement and engagement with the relevant business partners.

The overall financial position and non-financial performance measures are monitored at the CBM, and through monthly meetings with the Finance Business Partner, who produces detailed budget reports.

The Directorate Manager's operational delivery report is taken to each CBM and provides an overview of the Directorate's position in respect of quality, performance and risk management. The monthly finance pack to the CBM allows budgets and Cash Releasing Efficiency Scheme (CRES) targets to be monitored monthly.

Detailed demand and capacity plans had been drawn up for 2019/20 based on the most up to date data available, and these were used to identify spare MRI capacity that could be 'sold' to neighbouring health boards. However, actual usage against the plans is not monitored throughout the year, so the directorate may not be aware of any additional capacity that could be sold.

Workforce

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with workforce 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.

We analysed absence rates, mandatory training, and PDR compliance rates for the Directorate and focused our detailed testing on a sample of directorate staff based at the Royal Glamorgan Hospital (RGH), and Prince Charles Hospital (PCH).

Our workforce testing was split into seven key areas; annual leave, flexi-time and Time of in Lieu (TOIL), sickness management, PDRs, mandatory training, staff rosters, and consultant job plans. We identified examples in both locations where the monitoring and management was not in accordance with the Health Board's policies.

As a result of our testing our key concerns relate to the errors at both locations in the calculation of annual leave entitlements, and reconciliations between ESR and the Health Roster system. We also identified errors in the completion of sickness records, and instances where sickness meetings were not being carried out.

Although overall mandatory training rates for the Directorate as at April 2019 were up to 59.25% from 53.51% in February 2019, they were still well below the Welsh Government target of 75%. Furthermore, at the time of our audit fieldwork consultant job plan sign off was low.

In the agenda's and action logs of the CBMs that we reviewed we saw evidence of sickness levels, PDR, and mandatory training rates being reported. In addition, the Directorate Manager's report to the CBM provided updates on the status of consultant job plans.

5. Assurance Summary

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

Assurance Summary					
1	Governance arrangements		✓		
2	Risk Management				✓
3	Workforce management & service delivery			✓	
4	Planning and performance			✓	
5	Standards of Conduct			✓	

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

Design of Systems/Controls

The findings from the review highlighted no issues that are classified as a weakness in the system control/design of management arrangements within the radiology directorate.

Operation of System/Controls

The findings from the review have highlighted eleven issues that are classified as weaknesses in the operation of the designed system/control of management arrangements within the radiology directorate.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Governance Arrangements

We note the following areas of good practice:

- The Directorate has a clear governance structure in place that outlines who the senior team are, the business partners, and the operational team that are in place. There is also a committee structure chart, which maps out the flow of information at a high level between the various groups.
- The governance structure shows a clear line of communication from the CBM to the monthly Operational Group and Image Optimisation Group meetings, quarterly Integrated Governance meetings and annual Radiation Protection Safety Committee meetings.
- The Directorate Manager appears to have a good working relationship with the finance, planning and information business partners and has regular monthly meetings with finance.
- The range of directorate policies and procedures relating to Ionising Radiation Medical Exposure Regulations (IRMER) had been assigned to the Superintendent Radiographer and had recently been reviewed and uploaded to SharePoint.
- There are systems in place to ensure new legislative and regulatory information received within the Directorate is disseminated and actioned on a timely basis.

We identified the following findings:

- The main groups that oversee governance arrangements within the Directorate are the CBM, the Radiology Operations Group and the Image Optimisation Group, supported by quarterly Integrated Governance Meetings, and the Radiation Safety Committee that meets annually. We note that the ToR for the CBM was still in draft.
- CBMs and Operational Group meetings were not held monthly in line with their ToRs.
- The ToR for the Operational Group lists the key staff that should be in attendance at meetings. For the five meetings that we sampled, some core members did not appear to be adequately represented as neither they, nor a nominated representative, were in attendance. For example, the Clinical Director, Head of Radiology, Patient Care Safety Business Partner and HR Business Partner had each only attended one of the five meetings held, and the Performance Business Partner had not attended any of the five meetings.

In addition, CBMs were not always quorate, as when core members were unable to attend, in most cases deputies were not attending in their place.

- There was no central record maintained of all the Directorate's policies and procedures together with their assigned 'owner' and review date.

Objective 2: Risk Management

We note the following areas of good practice:

- New risks are identified during directorate meetings or from incidents recorded on the Datix system by directorate staff.
- Directorate risks are assessed using standard risk assessment procedures and documentation and are recorded on the Datix system.
- Risks on the Datix Risk Register are assigned a risk handler and are regularly reviewed by the Directorate Manager and at Clinical Business Meetings, Operational Group meetings and quarterly Integrated Governance meetings.
- The directorate's top five risks are reported to each meeting of the Health Board's Quality, Safety & Risk Committee.

No findings were identified under this objective.

Objective 3: Workforce & Service Delivery

We note the following areas of good practice:

Annual leave

- A calendar system was in use in both areas that we tested to record and monitor the numbers of staff on leave at any one time.

Flexi Time / TOIL

- The accruing of TOIL hours was minimal with the management of it being recorded via the Health Roster system.

PDRs

- A PDR planner had been set up to monitor future reviews to ensure they are completed in line with the employee review dates.

Mandatory Training

- Records have been set up for each mandatory training module to ensure that staff are booked on to required training sessions.

Sickness

- Sickness notification forms were used in both of the areas that we reviewed.

Rosters

- The staff rosters that we tested were created in line with the template set up in HealthRoster and the Roster policy.

- Amendments to the roster are made appropriately with completed forms for authorisation and a procedure to be followed by staff and management.

Workforce Planning Arrangements

- Meetings were being held on a monthly basis between the Directorate Manager and Finance Business Partner to discuss vacancies within the Directorate.

We identified the following findings:

Annual leave

- Annual leave entitlements are not being appropriately monitored which has allowed some staff to book more leave than they were entitled to.

Sickness

- Sickness records were not being fully completed with all the relevant information.
- Long Term Sickness interviews and discussions when prompts were triggered had not always been completed in line with the Managing Absence at Work policy.

PDRs

- Our testing found that 8/20 staff had not had a PDR completed within the last 12 months and a number of cases where the time gap between PDRs was several years.
- There was one instance where the PDR documentation was not signed by the manager or the employee, and one instance where there was no evidence of objectives being set within the PDR documentation.

Mandatory Training

- Mandatory training had not been completed for all staff for the core skills modules. Of the 20 staff that we tested during our review, only one member of staff was fully compliant with their training of the core skills modules.

Consultant Job Plans

- While consultant job plans were available for the staff that we selected for testing, they were not signed off in a timely manner by the consultants or senior management.

Workforce Planning Arrangements

- An apparent lack of succession planning has meant that there is currently no cover for the Head of Radiology, which is a key post within the directorate.

References

- There was no evidence that references had been obtained for 1/10 new starters that we selected for testing. We also note that the recruitment process for this new starter had taken place outside of the TRAC recruitment system.

Objective 4: Planning and Performance

We note the following areas of good practice:

- The IMTP was developed in line with the timetable set out in the Local Planning framework and was produced with the full involvement of all business partners including finance, information, planning and workforce. The Directorate Manager also had meetings with representatives from other directorates to develop the IMTP.
- Budget and CRES monitoring takes place at the CBM where the finance pack is a standard agenda item and is presented and discussed. In addition, the Finance Business Partner meets monthly with the Directorate Manager to ensure that the monthly position, and the staff in post, are accurate.
- The directorate reviews non-financial performance measures and key performance indicators during the monthly CBM. The Directorate Manager's report is presented to each CBM and reports on the directorate's position in relation to Quality, Performance, Risk and Finance.
- In addition, workforce reports are presented at each. CBM. These look at sickness absence, PDR compliance, core mandatory training, and recruitment.

We identified the following finding:

- Whilst the current demand and capacity plans are based on the most up to date information, there is no formal, documented ongoing monitoring of actual usage against the plans during the year. Consequently, there will be insufficient data to prepare accurate Demand and Capacity plans for 2020/21.

Objective 5: Standards of Conduct

We identified the following areas of good practice:

- The Health Board has updated its Standards of Behaviour Policy to incorporate formally the need for all staff at Band 8a or equivalent and above to complete a declaration of interest or 'nil' return.
- The Health Board undertakes an annual process that requires relevant staff to complete a declaration of interest. Outcomes are reported to the Audit Committee.

We identified the following findings:

- The Directorate Manager was not aware of the declarations that had been made by staff within the Directorate and therefore was not considering that information when managing the Directorate.
- Approximately one third of relevant directorate staff failed to submit a DoI or 'nil' return despite reminders being sent by management within the Directorate.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Risk and governance	1	2	0	**3**
Planning and performance	1	0	0	**1**
Workforce	1	5	1	**7**
Total number of recommendations	**3**	**7**	**1**	**11**

Governance and Risk Management

Finding 1 - Governance arrangements (Operating Effectiveness)	Risk
The main groups that oversee governance arrangements within the Directorate are the Clinical Business Meeting (CBM), the Radiology Operations Group and the Image Optimisation Group. These are supported by quarterly Integrated Governance Meetings, and the Radiation Safety Committee that meets annually. **Clinical Business Meeting** Clinical Business Meetings are held in all directorates. As we have reported previously, the Health Board's standard ToR for this meeting has remained in a draft format since May 2018. Meetings should be held on a monthly basis, but in the seven-month period between July 2018 and January 2019 only three meetings were held, with the other meetings either not scheduled or cancelled. The three meetings that we reviewed were not quorate as when core members of staff were unable to attend, deputies often were not sent in their absence. In addition, the Directorate Manager's PA is a 'core member', but was not recorded as present at any of the meetings. **Radiology Operational Group Meetings** Our review of the Radiology Operational Group meetings for the nine month period between May 2018 and January 2019 showed that only five meetings were held. As such, the meetings were not being held monthly, and the minimum	The Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.

number of ten meetings per year was unlikely to be met in accordance with the group's terms of reference. Our review of the minutes of those meetings that did take place identified some core members of the group were not adequately represented at the meetings reviewed. For example, the Clinical Director, Head of Radiology, Patient Care Safety Business Partner and HR Business Partner had each only attended one of the five meetings held, and the Performance Business Partner had not attended any of the five meetings. Where core members were unable to attend, we note from the respective meeting minutes that deputies were not in attendance in their absence.	
Recommendation	**Priority level**
1. The terms of reference for the CBM should be finalised and implemented as soon as possible. 2. Clinical Business Meetings should be held monthly wherever possible. Officers who form the core membership of the CBM should be in attendance or send a representative where appropriate. 3. Directorate management should ensure that the minimum requirement to hold ten Radiology Operations Group meetings each year is met. Alternatively, consideration should be given to whether there is a need for a minimum of ten meetings per year and the terms of reference amended accordingly. 4. Officers who form the core membership of the Radiology Operations Group should be in attendance at each meeting or send a representative where	**High**

appropriate. This ensures that key messages can be cascaded to all relevant teams within the directorate. Where there is regular non-attendance, discussions should be held with relevant officers to establish the perceived barriers to attendance.	
Management Response	**Responsible Officer/ Deadline**
1. Agree with the findings. 2. For discussion and agreement with COO and to base future meetings around timescales indicated in the TOR. 3. To review frequency of meetings and ensure this is reflected accurately in the TOR. 4. Agree – confirm quorate membership of the group and as part of the meeting an ongoing attendance review sheet should be kept.	Alan Lewis, Radiology Directorate Manager 31 August 2019

Finding 2 - Directorate Policies & Procedures (Operating effectiveness)	Risk
The directorate has a large number of departmental policies and procedures, but currently no central record is maintained. A range of policies and procedures relating to IRMER have recently been reviewed and updated by the Superintendent Radiographer, and these have been made available to all directorate staff via SharePoint. We understand that a member of the Directorate Governance & Quality Improvement Group has been tasked with identifying and recording all of the Directorate's departmental policies and procedures, and for ensuring they are brought up to date and made available to all directorate staff. However, this work has not been completed and appears to have lapsed.	The Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
Recommendation	**Priority level**
All Radiology specific policies and procedures should be documented in a central record and assigned an 'owner' responsible for ensuring their assigned policies and procedures are maintained up to date. All directorate specific policies and procedures should be made available to all directorate staff via SharePoint.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Currently moving forward with a new SharePoint site for Radiology – linking with Karl Carpenter (Digital Services Manager) and maintenance of this will be part of	Alan Lewis, Radiology Directorate Manager

the remit of a Superintendent Radiographer post currently being advertised within the Health Board.	31 December 2019

Finding 3 - Declarations of Interest (Operating effectiveness)	Risk
The Audit Committee approved a revised Standards of Behaviour Policy in January 2019, however at the time of our review, the Health Board's intranet pages still link to the previous version of the policy. The revised policy refers to Band 8a and above making declarations, whereas the old policy lists posts. Whilst there could be ambiguity over interpretation of posts, we would deem all those graded as Band 8a and above to fall into one of the listed posts. Our testing in relation to the September 2018 returns established that 10/31 staff identified as needing to make a return had not completed a declaration of interest or a 'nil' return. We note from our discussion with the Directorate Manager, that he was not aware of the declarations made by staff within the Directorate. However, we understand that following completion of the current year returns that were requested in March 2019, directorate managers will be provided with reports of those declarations made, and nil returns.	The Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
Recommendation	**Priority level**
The Directorate should ensure that all staff required to complete a DoI do so in a timely manner and that the relevant staff are aware of the declarations made in order for the information to be appropriately considered. The Health Board should ensure that the revised Standards of Behaviour Policy is available to staff on the intranet.	**Medium**

Management Response	Responsible Officer/ Deadline
Do not agree with the statement that all staff banded 8a and above fall in to the categories indicated in the old policy. The email circulated specifically stated job titles and therefore certain staff did not complete returns, as it appeared that they were not requested to. It is acknowledged that other staff did fall in to the categories and they will be asked to complete their returns as soon as possible. The Directorate will ask for sight of the new policy to ensure all staff complete appropriately.	Alan Lewis, Radiology Directorate Manager 31 August 2019

Performance and Planning

Finding 4 - Demand and capacity monitoring (Operating effectiveness)	Risk
Whilst the three current demand and capacity plans in the draft IMTP (MRI, CT and Ultrasound) are based on the most up to date information, we saw no evidence of ongoing monitoring of actual usage against the plans during the year. We were informed that monitoring was previously being undertaken by the directorate with data and support provided by the Planning Information Team. However, this formal monitoring had now lapsed due to the reduction in support. We were informed that informal, high level monthly monitoring was being undertaken by the Superintendent Radiographer to establish the availability of available slots each month, but this was not documented. Consequently, there will be insufficient data to prepare accurate Demand and Capacity plans for 2020/21. We also note from the draft IMTP that there is the opportunity to increase the number of available 'slots' for use by other health boards by utilising the second scanner in the Royal Glamorgan Hospital (RGH) at weekends should there be sufficient demand from the neighbouring Health Boards.	Income is not maximised as services are not effectively planned.
Recommendation	**Priority level**
1. Formal documented monitoring of actual usage of the MRI scanner against the current Demand & Capacity Plan by the Planning Information Team should be re-instated as soon as possible.	**High**

2. The Directorate should contact neighbouring health boards to determine whether there would be sufficient demand to utilise the second scanner at RGH at weekends.	
Management Response	**Responsible Officer/ Deadline**
1. Agree with findings. Current method is reasonable for this financial year but future planning will be more difficult. Further discussions with P&I Director required. 2. This forms part of the remit of the Regional Diagnostic Hub Board and other Health Boards have been contacted and there is not currently sufficient demand / interest to extend the working week further.	Alan Lewis, Radiology Directorate Manager 31 Oct 2019

Workforce

Finding 5 - Succession planning (Operating Effectiveness)	Risk
In May, the Head of Radiology left the directorate to take up a secondment opportunity. The Head of Radiology position has responsibility for carrying out the day-to-day processes associated with risk management, and is a key role within the directorate with responsibility for governance, quality, complaints, and is the professional lead for radiology. A replacement for the Head of Radiology has not been identified. As such, there is a risk that until suitable arrangements are put in place the management of key aspects of role may not be appropriately covered. We note that, although the Directorate works closely with Workforce and Finance Business Partners on workforce planning for clinical posts, there is no clear succession planning for the senior management team.	Staff performance is not effectively assess and addressed.
Recommendation	**Priority level**
1. Suitable arrangements to cover the Head of Radiology role should be put in place as a matter of urgency. 2. Senior management posts should be included in future succession / workforce plans.	**High**

Management Response	Responsible Officer/ Deadline
1. Agree the previous Head of Radiography has gone on a 2 year secondment. A new Head of Radiography needs to be appointed, this will done via a HR process as part of restructuring required for the new Cwm Taf Morgannwg UHB.	Director of HR and OD Sept 2019
2. Agreed the Quality Lead Role for Radiology is included in our IMTP investment as our number one priority.	DoF – Finance IMTP Investment Schedule 1 August 2019

Finding 6 - Annual leave entitlements (Operating effectiveness)	Risk
We tested a sample of ten annual leave records at both PCH and RGH to ensure that leave had been appropriately planned, requested, recorded and authorised. **RGH** Annual leave is requested, recorded and authorised through HealthRoster, which then feeds into ESR. Of the ten samples selected: • For 3/10 the annual leave entitlements on ESR differed from the entitlement in HealthRoster. One of these was due to the employee taking too much annual leave in the previous year, so HealthRoster had been amended accordingly. One had reduced their working hours and while the ESR entitlement had been updated, the HealthRoster entitlement had not. In the final case, the difference was small and has been attributed to an error when being input on HealthRoster. • We also identified one instance where an employee took too much leave in 2018/19. The 2019/20 opening balances in ESR and HealthRoster had not been reduced to reflect this. **PCH** Annual leave in PCH is managed only through ESR, with the Superintendent Radiographer having to input the approved leave onto HealthRoster when they generate the rosters. Whilst we found no issues from our testing of a sample of 10 records, there is clearly an inconsistent approach within the directorate and	Reduced service provision / additional costs due to inappropriate or unauthorised leave.

currently a duplication of effort as annual leave is input separately onto the two systems.	
Recommendation	**Priority level**
1. A mechanism should be put in place to monitor annual leave balances throughout the year to enable management to make directorate staff aware of how much leave they have left and to ensure they do not exceed their annual entitlement. 2. The management of annual leave at PCH should be undertaken through HealthRoster, which automatically feeds into ESR. This would ensure consistency across both sites and prevent the duplication of effort caused by inputting annual leave into two different systems.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. Agree with findings – however, there may be occasional issues when the Easter Bank Holiday falls close to the end of the financial year as it is possible that staff may have taken leave and then appear on a shift pattern which means they then need to take leave for the Bank Holidays. The opposite also applies. 2. Agree and already complete with the exception of office staff – waiting for agreement from Health Roster team to be able to progress and support of Office Manager to be able to instigate.	Alan Lewis, Radiology Directorate Manager 31 December 2019

Finding 7 - Sickness absence records (Operating effectiveness)	Risk
Sickness within the Directorate has stayed below the Health Board's target of 4.5% throughout 2018/19. The overall sickness absence rate for the directorate at February 2019 for the 12-month rolling period was 3.06%, which has decreased from January's figure of 3.28%. The sickness absence rate for the directorate for February was 2.55%, which had slightly increased from 2.5% in January. We tested a sample of ten employees from PCH and RGH who had periods of sickness during the year. We identified: **PCH** • For 3/10, the dates of sickness recorded on the employees sickness file differed from the dates on other sickness records such as self-certification forms, sickness notification forms and ESR. • For 1/10, sickness dates were incomplete on the self-certification form. • For 1/10, a Return to Work form was not completed for an episode of sickness. • For 2/9 Return to Work (RTW) forms were not completed within seven days of the employee returning to work. One form took over two weeks to complete and the other took just under two months to complete. • For 1/10, a Long Term Sickness interview was not formally documented for the sickness episode, though notes of a discussion were sighted.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

• For 2/10, sickness trigger interviews were not completed (both were informal sickness triggers). **RGH Radiology** • For 1/10, the date on the sickness notification form differed to the dates on the self-certification form. • For 1/10, the dates of the sickness input on HealthRoster did not correspond to the dates on the documentation. • For 1/10, the return to work date had not been completed on the Return to Work form and the employee had not signed the form. In addition, we also noticed one instance of continual sickness since January 2018 where there were no supporting documents and no medical certificates to cover the staff member between February 2018 and June 2018. There was also no evidence of any long-term sickness interviews or discussions.	
Recommendation	**Priority level**
1. Comprehensive, accurate and timely records of sickness should be maintained to allow the proper management of sickness within the directorate and accurate reporting. It should be ensured that self-certification and return to work forms are fully completed and in a timely manner. All information contained on self-certification forms, RtW forms, Health Roster and ESR should correspond.	**Medium**

2. Long-term sickness should be managed in line with the All Wales Managing Attendance at Work Policy, with staff invited to attend absence meetings to help facilitate their return to work. 3. Absence management prompts should be monitored and where periods of absence result in a prompt being breached, the appropriate action should be taken.	
Management Response	**Responsible Officer/ Deadline**
1. Agree with the findings 2. Agree with the findings 3. Agree with the findings	Alan Lewis, Radiology Directorate Manager 31 July 2019

Finding 8 - PDR compliance (Operating Effectiveness)	Risk
The compliance rating in February 2019 for PDRs for the Directorate was 66.67%. The Health Board has a WG target of 85%. Although there was a dip in January 2019, the Directorate as a whole has been improving their compliance with the PDR completion target during 2018/19. We selected a sample of ten staff from each site to ensure that a PDR review had been carried out in the last year. **PCH** • 3/10 did not have a PDR that had had been carried out in the last year. In one case the last known PDR was dated 2015, one was dated January 2018 and in the final case no date could be found on either ESR or on a previous PDR carried out. • For one of the up to date PDRs there was no evidence of objectives being set within the PDR documentation. **RGH** • 5/10 did not have a PDR that had had been carried out in the last year. In three of these cases, the last PDRs we could evidence dated from 2014 and 2015. The Superintendent Radiographer was aware of the problem and stated more comprehensive planning is now taking place to ensure all PDRs are done annually.	Staff performance is not effectively assessed and addressed.

• For 1/5 up to date PDRs there was no evidence of the manager or employee signing the PDR form to agree the outcome of the review and future objectives.	
Recommendation	**Priority level**
1. In line with Health Board targets, all staff should be subject to a PDR on an annual basis. 2. PDR documentation should be fully completed, with meaningful objectives agreed by the manager and employee. The document should be signed by both parties and ESR updated with the date the PDR took place.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. Agree with the findings 2. Agree with the findings	Alan Lewis, Radiology Directorate Manager 31 July 2019

Finding 9 - Mandatory training (Operating effectiveness)	Risk
In February 2019, the average mandatory training compliance rate for the directorate as a whole was 53.51%. For Radiology staff at PCH the rate was 60.84% and for RGH 58.51%. As at April 2019 the compliance rate for the directorate had improved to 59.25%, with PCH showing a compliance rate of 66.63% and RGH showing compliance of 65.46%. While the Directorate is moving in the right direction, it has not met the Welsh Government target of 75% compliance. We tested a sample of 20 employees, ten from PCH and ten from RGH, to establish their level of mandatory training compliance against the core modules at level one. We note the following: **PCH** • Nine people were not fully compliant with all required modules, with one individual only compliant in one module. **RGH** • No staff were 100% compliant with all required modules, with two members of staff only compliant in one module.	Staff performance is not effectively assessed and addressed.

Recommendation	Priority level
The Directorate should ensure that all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agree with the findings however would point out that training allocated to staff on ESR has been done poorly and with no consultation with the Directorate. Directorate is in close consultation with Learning & Development but progress is very slow from L&D.	Alan Lewis, Radiology Directorate Manager 31 December 2019

Finding 10 - Timeliness of completing Consultant Job Plans (Operating Effectiveness)	Risk
Consultant's job plans are an annual agreement between the Health Board and the consultant setting out, amongst other things, what work the consultant does for the Health Board, when and where the work is done, and how much time the consultant is expected to be available for work. At the time of our audit fieldwork there were 21 consultants working within the directorate. We tested a sample of five consultant job plans to ensure that they had been completed correctly and subjected to appropriate sign off. As at the time of audit testing in April 2019 none of the job plans sampled had been signed off fully, although two had been signed by the consultant. We have since received confirmation from the Directorate Manager that all job plans have been fully signed off. However, as one of the job plans that we sampled commenced in October 2018, it meant it had been in existence for six months before being signed off.	Staff performance is not effectively assess and addressed.
Recommendation	**Priority level**
Management should work with consultants to ensure that job plans are discussed, agreed and signed off by all relevant parties ahead of the job plan period. A forward work plan should be developed to ensure planning takes place in a timely manner and CBM should continue to monitor the ongoing status of job plans within the Directorate.	**Medium**

Management Response	Responsible Officer/ Deadline
All of the Consultants have received a Job Plan meeting between Oct 18 and March 19 on the e-job planning tool. However 1 of the Consultants had not electronically signed off the job plan on the system albeit it was agreed at the meeting and sent for sign off. Reminders should be sent to Consultants automatically from the e-job planning system to remind the Consultants to sign off the job plan.	HR Deputy Director of Workforce and OD.

Finding 11 - Missing references (Operating Effectiveness)	Risk
We tested a sample of ten new staff appointed within the directorate since April 2018 to confirm that references had been obtained ahead of them commencing in post. In one instance, the recruitment (new starter) process including pre-employment checks had taken place outside of the TRAC recruitment system, which is where information for new starters is normally held. At the time of our fieldwork, no reference information relating to this individual could be traced.	Staff performance is not effectively assess and addressed.
Recommendation	**Priority level**
All information relating to applications and pre-employment checks should be stored centrally on the TRAC system.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agree with findings. Case above appears to be an anomaly where staff were interviewed as part of attendance at a jobs fair to help with recruitment. Other staff appointed at the same time did not have the same issue. We are tracking back to hopefully learn from this experience and to find out how this happened.	Alan Lewis, Radiology Directorate Manager 31 August 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Appendix C – Detailed Scope and Objectives

Governance arrangements

- Appropriate governance structures, committees and groups are in place with clear reporting lines that support the key operational functions of finance, workforce, and planning and performance.
- Business partners provide appropriate support for the directorate's key operational functions.
- Directorate policies and procedures are owned and are up to date.
- There are appropriate mechanisms in place to ensure new legislative and regulatory information received is disseminated and actioned on a timely basis.

Risk management

- A risk management process is in place that ensures risks are appropriately identified, assessed, recorded, monitored and reported on. Risk owners are identified for each risk and mitigation plans are in place where appropriate.
- Risks associated with demand and capacity are appropriately captured.

Workforce management & service delivery

- Annual leave is appropriately planned, requested, recorded and authorised.
- Flexi time and Time off in Lieu (TOIL) is appropriately recorded, monitored and managed in accordance with local procedures and processes.
- Sickness absence is appropriately recorded, monitored and managed in accordance with the All Wales Sickness Management policy.
- Staff and management appropriately complete PDRs in good time.
- Staff complete mandatory training in line with specified timeframes.
- Staff rosters are planned and approved in line with the template.
- Systems are in place to ensure amendments to rosters that deviate from the template roster are appropriately reviewed and approved to ensure optimum workforce deployment and minimal use of overtime.
- Consultant job plans are reviewed and agreed annually, and monitored to ensure that clinical activity is delivered in line with the agreed job plans.
- Workforce planning arrangements exist to establish and plan for known future changes to the directorate. For example, key staff due to retire within three years.

- Timely references are obtained as part of the recruitment process.

Planning and performance

- The directorate has appropriate arrangements in place to ensure that its Integrated Medium Term Plan (IMTP) is developed in accordance with the Health Board's corporate planning framework.
- Budget holders and other relevant staff are appropriately engaged in the development of the directorate's IMTP.
- Budget holders within the directorate monitor budgets and agreed Cash Releasing Efficiency Scheme (CRES) targets and take action as appropriate.
- The directorate has appropriate non- financial performance measures and key performance indicators in place that cover relevant service delivery and cross-cutting themes such as workforce. These are formally reviewed and reported on a regular basis.
- The directorate has appropriate action and recovery plans and mechanisms in place, where required, in relation to both financial and non-financial activities. For example, should performance targets begin to show an adverse variance.
- Demand and capacity plans are owned and used as 'day to day' business planning tools for managing the directorate.
- Demand and capacity plans are monitored and reported to ensure they remain fit for purpose.

Standards of conduct

- Declarations of interest (or nil returns) are submitted for all relevant staff and the directorate is aware of the declarations made.

Directorate specific objective

- We also considered how good practice is captured and communicated between the directorate and other directorates so that shared improvements to services can be made where appropriate.

Directorate reviews – Compliance - Radiology

Internal Audit Report

Cwm Taf University Health Board

2018/19

July 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-29
Report status:	Internal Audit Report
Fieldwork commencement:	26 February 2019
Fieldwork completion:	3 June 2019
Draft report issued:	14 June 2019
Management response received:	8 July 2019
Final report issued:	9 July 2019
Auditors:	Emma Samways, Ken Hughes, Sian George
Executive sign off:	John Palmer, Chief Operating Officer
Distribution:	Alan Lewis, Directorate Manager
Committee:	Audit Committee

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

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party

1. Introduction and Background

The review of the Radiology directorate's compliance with key documents such as Standing Financial Instructions, including the Scheme of Delegation, and Financial Control Procedures, was completed in line with the 2018/19 Internal Audit plan for Cwm Taf University Health Board (the 'Health Board' or the 'organisation').

The relevant Executive Director lead for the assignment is the Director of Finance and Procurement.

In addition to this review, we undertook a separate review of the directorate's management arrangements, which has been reported separately.

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to compliance with key documents, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The areas we sought to provide assurance on were:

- Awareness levels of key documents within the directorate. For example, staff can access key documents and changes to them are appropriately communicated.
- The directorate's compliance with the relevant elements of the Scheme of Delegation.
- The directorate's compliance with relevant Financial Control Procedures (FCPs).

We met with the Head of Corporate Finance and the Assistant Director of Finance to identify the FCPs most applicable to the directorate. These were:

- budgetary control;
- salaries and wages;
- capital asset register;
- capital monitoring; and
- inventory of non-capital Assets.

As such, our testing of FCPs focused on these areas.

3. Associated Risks

The potential risks considered in this review were as follows:

- Inappropriate or unauthorised decisions are made if staff are unaware of the relevant key documents.
- Inappropriate or unauthorised decisions due to non-compliance with legislation or corporate and operational policies.

- Financial expenditure unnecessarily incurred.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the compliance risks associated with the Radiology directorate 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.

Staff within the directorate that we met had a sound understanding of the Financial Control Procedures and the relevant elements of the Scheme of Delegation, though only one had undertaken the Scheme of Delegation training available on ESR.

Our testing confirmed that the directorate is mostly compliant with requirements set out in the FCPs and the Scheme of Delegation. An issue was identified in relation to the Capital Asset Register, where assets had been disposed of, but the required paperwork had not been completed to prompt the removal of the items from the asset register

It is pleasing to note that the Directorate did hold an Inventory of Non-Capital Assets that was in line with the FCP.

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

5. Assurance Summary

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

Assurance Summary					
1	Key Documents			✓	
2	Scheme of Delegation				✓
3	Financial Control Procedures			✓	

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

Design of Systems/Controls

The findings from the review highlighted no issues that were classified as a weakness in the system control/design for compliance within the Radiology Directorate.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as a weakness in the operation of the designed system/control for compliance within the Radiology Directorate.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Awareness levels of key documents within the Directorate

We note the following area of good practice:

- Key staff within the directorate were aware of relevant FCPs and the Scheme of Delegation, and knew where to seek further advice if required.

We identified the following finding:

- The central finance team have identified all staff within the Health Board who they believe require training on the Scheme of

Delegation. Not all of the identified staff within the directorate had undertaken Scheme of Delegation training.

Objective 2: Compliance to relevant elements of the Scheme of Delegation

We did not identify any issues to be reported from our testing of compliance against the scheme of delegation.

Objective 3: The Directorate's compliance with relevant Financial Control Procedures

We note the following areas of good practice:

- Budget holders have been appropriately identified for the directorate and there is a good working relationship with the Finance Business Partner to monitor budgets.
- An inventory of non-capital assets is held by the directorate.

We identified the following finding:

- During the testing of a sample of assets it was found that one item had been disposed of in approximately November 2017, however the appropriate disposal paperwork had not been completed and therefore the Capital Accountant had never been informed. The item continued to appear on the quarterly reports send by Finance to the Directorate for verification, without the Directorate identifying that they had disposed of it.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding -1 - Scheme of Delegation training (Operating effectiveness)	Risk
Training in relation to the Scheme of Delegation is available via ESR. In 2018 the finance team identified staff within each directorate that needed 'Scheme of Delegation' training as part of their role. This information has been recorded in ESR. Seventeen staff within the Radiology Directorate were identified as requiring training but at the time of our audit fieldwork only one had completed the training module.	Inappropriate or unauthorised decisions are made if staff are unaware of the relevant key documents.
Recommendation	**Priority level**
Staff identified as requiring scheme of delegation training as part of their role should complete the on-line training module in ESR as soon as practically possible. Where it is felt that there is no requirement, the directorate should liaise with the Finance team and the Learning and Development team to amend records accordingly. Conversely, if it is felt that other staff should participate in the training, their ESR records should be updated accordingly.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agree with the findings and will discuss with Finance those people on the list as several of the staff members are thought to have this training requirement identified inappropriately.	Alan Lewis, Radiology Directorate Manager. 1 September 2019

Finding -2 – Disposals of capital assets (Operating effectiveness)	Risk
We tested a sample of 15 assets from the Directorate's asset register (10 at Royal Glamorgan Hospital and 5 at Ysbyty Cwm Rhondda) to verify their existence and correct location within the directorate. One of the assets at RGH had been disposed of in approximately November 2017, however no disposal form had been completed, therefore the Capital Accountant had not been made aware that this item was no longer held by the directorate and required removal from the capital asset register. Furthermore, the Capital Asset Register FCP requires directorates to verify their capital asset register on a quarterly basis. It appears that this asset has not been identified as missing on any of the quarterly returns issued since November 2017. Through discussion with the Superintendent Radiographer, we understand that it is sometimes difficult to determine items on the capital asset register if a number of identical items are bought at the same time. The register description can be vague and makes no differentiation between the items.	Inappropriate or unauthorised decisions due to non-compliance with legislation or corporate and operational policies
Recommendation	**Priority level**
1. It should be ensured that all assets which are disposed of have the appropriate paperwork completed, authorised and submitted to finance to ensure that the items are removed from the asset register. This will ensure all records held by the Health Board in relation to assets are correct and appropriately maintained.	**Medium**

2. The directorate should liaise with the finance team to ensure that as assets are added to the capital asset register, that a meaningful description is included to allow the tracing of that asset in the future.	
Management Response	**Responsible Officer/ Deadline**
1. Agree with the finding. This was an initial oversight during changes in equipment for the Diagnostic Hub but was not subsequently identified on later registers. 2. Have contacted Finance Department to discuss a better pathway for identifying new equipment being added to the asset register (24.06.19).	Alan Lewis, Radiology Directorate Manager, 31 July 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

Freedom of Information (FoI)

Final Internal Audit Report

2019/20

Cwm Taf Morgannwg University Health Board

July 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1920-21
Report status:	Final
Fieldwork commencement:	22 May 2019
Fieldwork completion:	17 June 2019
Draft report issued:	24 June 2019
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Final report issued:	9 July 2019
Auditor:	Martyn Lewis
Executive sign off:	Director of Corporate Services & Governance / Board Secretary
Distribution:	
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT

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1. Introduction and Background

A review of the arrangements in place for the management of Freedom of Information (FoI) within Cwm Taf Morgannwg University Health Board (the 'Health Board' or the 'organisation') has been completed in line with the 2019/20 Internal Audit Plan.

The Freedom of Information Act (the 'Act') came into effect on 1 January 2005. It affects all public sector organisations including the Health Board.

The Act is intended to ensure openness, transparency and accountability of all public organisations. Under the Act all public bodies have a legal duty to ensure that the public, staff and other organisations are able to access information about how they operate and make decisions about their performance.

The Health Board has a statutory responsibility to respond to these requests initially to inform the applicant whether the information falling within the scope of their request is held and later to provide that information within a 20 working day timescale. The Information Commissioners Office (ICO) currently expects public bodies to have a 90% compliance rate with this timescale.

The relevant lead for the assignment is the Director of Corporate Services and Governance / Board Secretary.

2. Scope and Objectives

The overall objective of the audit was to provide assurance to the Health Board that the mechanisms in place for ensuring requests for information under the appropriate legislation are dealt with appropriately.

The areas the review sought to provide assurance on were:

- there is a governance framework to support compliance with FoI responsibilities;
- there are policies and procedures in place which explain the organisation's approach to, and responsibilities for FoI;
- there are procedures in place to deal with requests for information which ensure that information is provided in compliance with FoI; and
- there are procedures in place for the provision and monitoring of staff training in relation to FoI and the awareness of associated requirements relating to their roles and responsibilities.

3. Associated Risks

The potential risk considered in the review is as follows:

- controls not operating resulting in non-compliance with FoI.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Freedom of Information is Substantial assurance.

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

There are good processes in place for ensuring compliance with FoI requests. There is a FoI policy, which clearly defines responsibilities. The policy contains a procedure list and a flowchart for dealing with requests and there is a dedicated resource in place to handle requests.

Requests are recorded and monitored by the FoI Officer using a spreadsheet and there is a good process in place for distributing requests across the Health Board and then collating and quality assuring responses prior to release.

Responses that we reviewed were accurate, complete, dealt with within the defined timescales and where exemptions were used, generally valid. Our testing identified some minor areas where the use of exemptions may have been excessive, and the process for appeals did not always comply with the appropriate timescale.

We note that the current compliance for FoI responses is 92%, although it is worth noting that there has been a steady increase in the level of requests received, at an average of approximately 15% per year and a total increase of 53% since 2015. The Information Governance (IG) Team is currently coping with the level of requests, and has recently recruited extra

staff, however the level of requests received should continue to be monitored along with the resource requirements.

There is a good monitoring framework in place with accurate and comprehensive reports on FoI presented to the Information Governance Group (IGG) and included in Quality, Safety and Risk Committee briefings.

The Health Board website has a page for FoI and this includes the disclosure log, which is the record, and detail of all requests received and responded to. This is generally kept up to date, although we note that some responses were missing, the total of these make up 6.8% of the requests for the period that we reviewed in 2018 and 1.5% for 2019. The website also includes the publication scheme, which complies with the ICO model, although our testing identified areas of weakness in maintaining the publication scheme, with some information being out of date.

We did not identify any findings that we would consider to be high priority during our audit fieldwork.

5. Assurance Summary

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

Assurance Summary					
1	Governance			✓	
2	Policies and Procedures				✓
3	Provision of Information				✓
4	Training and Awareness				✓

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

Design of Systems/Controls

Our findings from the review did not identify any issues that would be classified as a weakness in the system control/design for FoI.

Operation of System/Controls

Our findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system/control for FoI.

6. Summary of Audit Findings

In this section we highlight areas of good practice that we identified during our review. We also summarise the high and medium priority findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: There is a governance framework to support compliance with FoI responsibilities.

We note the following areas of good practice:

- the Information Governance Group (IGG) regularly reviews the performance of FoI;
- the Quality, Safety and Risk Committee regularly reviews the performance of FoI;
- the risk associated with FoI is noted in the IG register;
- the Health Board website has a defined page for FoI and this includes a link to information on the publication scheme;
- the publication scheme follows the model set by the ICO;
- the FoI Policy is explicit in defining the responsibilities associated with FoI;
- The Health Board has recently recruited an additional two people into the IG team;
- there is dedicated resource in place for dealing with FoI requests;
- the IGG monitors performance and a report with KPIs is provided to each meeting. We note that the current compliance is 92%;
- the process for dealing with FoI requests has a quality assurance stage built in, with all responses reviewed and approved by the Head of Corporate Services and additionally by the Communications Team;
- request for reviews are undertaken by the Board Secretary as someone not involved in the original process; and
- the responses to FoI requests makes clear that there is a right to request a review, and also that a complaint can be made to the ICO.

We note the following medium priority finding in relation to this objective.

- The Publication Scheme is the mechanism by which the Health Board provides key information on its business to the public, however some of the information contained within the publication scheme has not been updated, or is not easily available due to broken links.

  Without the Publication Scheme being up to date, the Health Board will not be fully compliant with FoI.

Objective 2: There are policies and procedures in place which explain the organisation's approach to, and responsibilities for FoI.

We note the following areas of good practice:

- there is a comprehensive FoI Policy;
- there is a procedure list contained within the Policy and a flowchart for dealing with requests;
- as part of the testing we note that personal information was not provided as part of the FoI responses; and
- the FoI policy contains guidelines for release of staff information and provides guidance on what is and is not releasable.

We did not note any issues under this objective.

Objective 3: There are procedures in place to deal with requests for information, which ensure that information is provided in compliance with FoI.

We note the following areas of good practice:

- the Health Board website includes guidance on how to make a request under FoI;
- FoI requests are acknowledged within two days;
- requests are responded to within 20 working days;
- responses are full, accurate and match the department information provided;
- responses are authorised prior to release;
- there is evidence of good management of the process, with departments being reminded to provide information if required;
- the FoI process includes information from Princess of Wales Hospital where appropriate;
- the disclosure log is generally up to date; and
- in general, the use of exemptions is supported and appropriate.

We did not note any issues under this objective.

Objective 4: There are procedures in place for the provision and monitoring of staff training in relation to FoI and the awareness of associated requirements relating to their roles and responsibilities.

We note the following area of good practice:

- FoI is included in the Information Governance mandatory training module and also within the induction process.

We did not note any issues under this objective.

7. Summary of Recommendations

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

A summary of these recommendations by priority are outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**1**	**2**	**3**

Finding 1 Publication Scheme – (Operating effectiveness)	Risk
The Publication Scheme is the mechanism by which the Health Board provides key information on its business to the public, however some of the information contained within the publication scheme has not been updated, or is not easily available due to broken links: • information on the executive team is out of date, as are the Annual Governance Statement (which links to the 2013/14 statement), the Caldicot assessment (2014) and the Strategic Equality Plan (2012-15); • the link for the 3 year plan contains no information; • much of the information is within the 3 year plan, which as noted above is not provided, such as business plan, targets, aims, objectives, and strategic direction; • a number of the items just say "for future publication" without this information being provided. For example: the capital programme; scheme of delegation; procurement policy; SFIs; quality and safety reports; and lists and values of contracts awarded; • the link for performance leads to a page for mortality scores, with no other performance information provided; and • links to policies and procedures only have 3 policies. Without the Publication Scheme being up to date, the Health Board will not be fully compliant with FoI.	Controls not operating resulting in non-compliance with FOI.

Recommendation	Priority level
The Health Board should review and confirm either its commitment to following the ICO Model Publication Scheme or consider defining its own scheme. The Information on the scheme should be subject to a six monthly review to ensure that documentation is kept up to date and links are active.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Health Board confirms its commitment to following the ICO Model Publication Scheme, with a defined content. The IG team will review the content on a six monthly basis as recommended.	Claire Northwell Todd December 2019

Finding 2 Exemptions – (Operating effectiveness)	Risk
The FoI Act contains a number of exemptions detailed in sections of the Act, which allow organisations to withhold information from a requester. We reviewed the use of these as part of our testing and although in general, the use of exemptions is appropriate, there were two occasions where the use of exemptions may not have been appropriate, these relate to the use of section 29 (economic interests of the UK). There was also once occasion where information was given when it may have been more appropriate to use a section 43 exemption (commercial interests). In addition, there appears to be some minor inconsistencies in applying (or not) exemptions to information requests under section 40 (personal information). We saw evidence that in some cases requests for information with quantities less than five have been exempted in decisions supported by previous ICO adjudications, as the low numbers may make individuals identifiable. However, we saw instances where other requests for similar information classes with low quantities had been approved and provided. We acknowledge that the use of exemptions is a subjective endeavour, however excessive use of these may result in an increase in requests for review / referrals to the ICO.	Controls not operating resulting in non-compliance with FOI.

Recommendation	Priority level
The organisation should continue to ensure that exemptions are carefully considered and there is consistency in application.	**Low**
Management Response	**Responsible Officer/ Deadline**
We agree that there needs to be consistency with the application of exemptions. It is however important to note that exemptions are applied on a case by case basis and is dependent on the nature of the request. Therefore, whilst we may withhold some information, on another request we may disclose. There is consistency in the decision making of whether an exemption is applied. Less than five may or may not be identifiable depending on the request. It is not a blanket exemption. e.g. issues of prescriptions may not necessarily relate to one individual. The IG team will discuss the process with the local procurement team to ensure there is consistency on the application of exemptions where required.	Claire Northwell Todd September 2019

Finding 3 Internal Review – (Operating effectiveness)	Risk
At the time of our fieldwork the level of requests for review or challenge to the FoI responses made by the Health Board is low, with only three received in the previous 12 months, however our testing of the process for the most recent noted some minor weaknesses: • the timescales did not quite match those set out within the code of practice, with the acknowledgement taking 4 days and the response 22 days against targets of 2 and 20 working days respectively; and • the review process is undertaken by the Board Secretary, however the process itself is not documented, only the outcome. Without the review itself being recorded, there is a risk that the Health Board would not be able to fully demonstrate its position in the event that the appeal goes further.	Controls not operating resulting in non-compliance with FOI.
Recommendation	**Priority level**
The internal review process should be documented and recorded.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. Internal processes are documented and recorded however, we will ensure that this is strengthened so the reasoning is clearly documented. We will develop an appeals section into the FOI policy.	Claire Northwell Todd / August 2019

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit Committee Update – **Cwm Taf Morgannwg University Health Board**

Date issued: July 2019

Document reference: 123A2017

Purpose of this document

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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Summary report

About this document

1 This document provides the Audit Committee of the Cwm Taf Morgannwg University Health Board (the Health Board) with an update on current and planned Wales Audit Office work. Financial and performance audit work is considered and information is also provided on the Auditor General's programme of national value-for-money examinations.

Financial audit update

Exhibit 1: financial audit update

Work area	Progress	Conclusions
Annual UHB Accounts 2018-19	Our audit work over the 2018-19 Health Board accounts is now complete, and our Audit of Financial Statements (ISA 260) Report was presented to the Committee on 30 May, summarising our findings. The one outstanding matter outlined in our ISA 260 report was resolved the following day, so the accounts were certified by the Auditor General for Wales and laid with the National Assembly as planned on 11 June.	Work complete.
Charitable Funds Accounts 2018-19	These financial statements are subject to an independent examination, rather than a full audit. This work is scheduled to take place over the autumn, allowing the accounts to be filed with the Charity Commission in advance of the 31 January 2020 deadline.	Work ongoing.

Performance audit update

Work currently underway or planned

Exhibit 2: work currently underway or planned

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Work in progress				
Review of temporary staffing	Work in relation to temporary staffing usage within the Health Board	**Draft report being completed**	Director of Workforce and OD	Next audit committee
Cross-cutting review	This crosscutting review will involve all public-sector bodies. The review will focus on whether the ICF is being effectively managed to deliver integrated and sustainable services to achieve better outcomes for services users. The work will focus at arrangements at both a national and regional level. Fieldwork is anticipated to take place between February and June 2018 to take account of the bid process for the 2018-19 ICF monies.	**Fieldwork complete and locally reported.** **National report 18th July 2019 & Local Output as well will be produced**		Regional Partnership Board (November 2018)
Well Being of Future Generations	This work will consider the Health Board's overall corporate approach to applying the "Sustainable Development Principle" and "Five Ways of Working". It will seek to examine one of the Health Board's well-being objectives in more detail, reviewing the steps that have been taken to achieve that objective.	**Workshops in August 2019**	Director of Public Health	October 2019
Orthopaedic	This work will examine the progress made in orthopaedic services since our 2015 all Wales review. The will assess whether	**Terms of Reference issued**	John Palmer	October 2019

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
	recommendations and areas we identified for improvement have been effectively responded to and to determine whether health boards are developing arrangements to help manage the demand on, and supply of, orthopaedic services.			
Clinical coding follow-up	We will review the progress made in responding to the recommendations set out in the 2014 review of clinical coding arrangements. This review will assess the extent to which there have been improvements in raising the profile of clinical coding, the timeliness and quality of clinical coding data, and the quality of the medical records, which are the predominant source of the coding process.	**Waiting for approval to changes following clearance comments and management response to be completed**	Ruth Treharne	March 2019
Operating theatres – follow-up (Local work)	We will undertake a follow-up review of our previous reports on operating theatres, with an increased focus on economy and efficiency of services. We will consider the developments made by the Health Board since our previous reviews, opportunities for further improvement and identify barriers that may affect progress.	**Drafting report**	John Palmer	September 2019
Joint Review	Following recent issues with maternity, and HIW and WAO intentions to undertake work on governance arrangements at the Health Board. It has been decided that it is appropriate, necessary and timely to undertake a joint review to examine quality governance arrangements within the Health Board in more detail.	**Fieldwork**	Chief Executive	September 2019

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Structured Assessment	We will assess progress that is being made in embedding sound arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management.	**Not Yet Started**	Chief Executive	January 2020

NHS Related National Studies and Publications

2 The Audit Committee may also be interested in the following studies/planned outputs. Where the work is completed and reported, these are highlighted in red, and include a link to the report.

Exhibit 3: other Auditor General Studies

Recent publications / planned publications	
Topic	**Update**
Counter- Fraud Arrangements in the Welsh Public Sector June 2019	An overview for the Public Accounts Committee. Fraud is prevalent across all sectors including the public sector. Every pound stolen from the public sector means that there is less to spend on key services such as health, education and social services. At a time of austerity, it is more important than ever for all public bodies in Wales to seek to minimise the risk of losses through fraud.
What's the hold up? Discharging patients in Wales April 2018	NHS bodies need assurance that hospital discharge arrangements are safe and timely. We have produced this checklist to help NHS board members get this assurance.
Expenditure on agency staff by NHS Wales	Expenditure on agency staff by NHS Wales has increased markedly in recent years About 80% of agency expenditure is providing cover for vacant positions, but information on the number of agency staff used is limited. NHS Wales is seeking to reduce the demand for agency staff as well as controlling the price it pays for them.

Good Practice Exchange

3 The Good Practice Exchange (GPX) helps public services improve by sharing knowledge and practices that work. We run events where people can exchange knowledge face to face and share resources online.

4 Details of confirmed events, shared learning seminars and webinars can be found on the forthcoming pages on the Wales Audit Office's website.

Exhibit 4: event/product details

Event/Product	Details
Key Issues for Regional Partnership Boards	These webinars will highlight solutions to issues relating to fund implementation and ways of working in multi-agency partnerships. 17 July 6.00pm - 7.30pm (webinar)
Making an Equal Wales a Reality	This seminar will look at what public services are doing to contribute to a More Equal Wales. 12 Sep 2019 – 9:00am - 1:00pm 19 Sep 2019 – 9:00am - 1:00pm Venue to be confirmed
Further events	The following events are planned but we are awaiting further details. We are taking registration of interests for places; • How technology is enabling collaborative working across public services • Violence against women, domestic abuse and sexual violence • Accountability and governance in partnership services • Adverse Childhood Experiences – alternative delivery models

5 Diary markers and details of new events are circulated in advance to the Health Board, together with information on booking delegate places. Further information on any of our past or planned GPX events can be obtained by contacting the local audit team or emailing good.practice@audit.wales.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

Date issued: [07 June 2019]

Joint Review of Quality Governance Arrangements at Cwm Taf Morgannwg University Health Board

Terms of Reference

Why are we doing this work

1 Healthcare Inspectorate Wales (HIW) and the Wales Audit Office (WAO) have already signalled their intention to undertake work on the governance arrangements to ensure the quality and safety of services at Cwm Taf Morgannwg University Health Board. Following the recent publication of a highly critical report on maternity services by the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives, and associated changes to the Health Board's escalation status, HIW and WAO have decided that it is appropriate, necessary and timely to undertake an urgent joint review to examine quality governance arrangements within the Health Board in more detail.

Background

2 Concerns in respect of serious incident reporting within maternity services at the former Cwm Taf University Health Board led to the Minister for Health and Social Services commissioning an independent review by the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives. The findings from that review were published on 30 April 2019 and highlighted a number of serious concerns and service failures within maternity services at the Health Board. In a written statement following publication of the review, the Minister announced that the Heath Board's maternity services would be placed in special measures and the organisation's overall status within the escalation framework would be raised to "Targeted Intervention". In that announcement, the Minister also highlighted that the Royal Colleges' report raised serious concerns about wider board governance and leadership.

3 Prior to the publication of the Royal Colleges' review, both the WAO and HIW had raised concerns around aspects of quality governance. The Wales Audit Office structured assessment review in 2018 pointed to the need to strengthen a number of facets of quality governance and risk management within the Health Board. In

addition, a number of issues relating to governance have been identified during HIW's inspection activity, including inspections of:

- Mental health services - Royal Glamorgan Hospital – 2015-2018
- Acute medical wards 12 and 19 – Royal Glamorgan Hospital – March 2018
- Surgical services - Royal Glamorgan Hospital – September 2018
- Maternity services – Royal Glamorgan Hospital – October 2018
- Radiology department, focusing of the use of ionising radiation - Prince Charles Hospital – December 2018.

4 It is important to recognise that the Royal Colleges' findings on maternity services relate to the former Cwm Taf University Health Board and not to services in Bridgend, which transferred to the Health Board as part of a boundary change on the 1st April 2019. However, the Health Board is aware of the importance of ensuring that any wider improvements that it makes to its quality governance arrangements are applied to the Bridgend services for which it now has responsibility.

Scope of work

5 The joint review will seek to address the following overall question: Do Cwm Taf Morgannwg University Health Board's governance arrangements support delivery of high quality, safe and effective services? In looking to answer this question we will consider the following key lines of enquiry:

- Is the quality and safety of services understood at an operational level, with concerns adequately acted upon?
- Is the quality and safety of services understood at the corporate level, with concerns adequately acted upon?
- Does the organisation promote an open, listening and learning culture to support the delivery of high quality, safe and effective services?

6 To test these arrangements, our fieldwork will include a review of the quality governance arrangements within the surgical services directorate, from ward to board, focusing on the Prince Charles Hospital and Royal Glamorgan Hospital sites. The work will also include consideration of governance processes for managing and learning from concerns and incidents.

7 Recognising the recent Bridgend boundary change on 1 April 2019, the review will also consider the transition arrangements for quality, risk and assurance at the Princess of Wales Hospital.

8 During the course of our review, should we identify any issues around quality governance that have wider relevance to NHS Wales, we will consider how best to report and escalate these.

9 The joint review team will ensure that its work is appropriately co-ordinated with other interventions and external review underway at the Health Board, most notably the work being carried out by the Independent Maternity Services

Oversight Panel, the Delivery Unit, David Jenkins, and the independent review into the commissioning and publishing of the consultant midwife report.

10 The joint review will also draw upon the findings of other relevant audit and inspection work undertaken by the WAO and HIW at the Health Board.

Review Approach

11 The following table sets out the evidence sources the review will seek to draw on:

Methodology	Activity
Interviews with Health Board staff	We will arrange interviews with health board staff, covering a range of corporate and operational responsibilities.
Observations	We will aim to observe relevant operational meetings within the Health Board, including at directorate / speciality level. We will also draw on observations at relevant Board and committee meetings within the review period as appropriate. We will also visit wards/areas within the surgical services directorate to observe those environments and provide an opportunity for staff to speak to the review team (see drop in session below).
Drop in sessions	Linked to the visits to wards / clinical areas we will look to hold informal drop in sessions with operational staff within the surgical services directorate. We will aim to set up two drop in sessions at each of the two hospitals (Prince Charles and Royal Glamorgan Hospitals).
Document review	Supporting documentation will be requested to provide evidence against our lines of enquiry.
Staff survey	We will be asking staff within the surgical services directorate to complete an online survey to help gauge their views of current quality governance arrangements and work place culture.

12 We will discuss the details and practical arrangements associated with the above approach with the Health Board.

Timing of the work

The indicative timescales for the key stages of the work:

Key stage	Timing
Set up	June 2019
Fieldwork	July 2019
Draft report issued to the Health Board	August – September 2019
Final report published	September 2019

13 The above timetable is predicated on the ability of the Health Board to provide the joint review team with the required information to support our evidence gathering. This includes the availability of Health Board staff to speak to review team members, noting that review is taking place over the summer months. Any changes to the timetable will be communicated to the Health Board.

Reporting our findings

14 Where appropriate, the WAO/HIW review team will give interim feedback if any issues of immediate concern arise during the fieldwork phase.

15 We will produce a joint written report that summarises the findings from our work and recommendations will be made to support improvements. The Health Board will be provided with a copy of the draft report to comment on factual accuracy and will receive a copy of the final report prior to publication.

16 In line with the HIW's and WAO's arrangements for public reporting, we will publish the report on our websites once final.

Joint Review team contacts

17 The following HIW/ WAO staff will be the main contact points for the joint review:

Review team member	Contact details
Alun Jones (HIW)	Email: Alun.Jones39@gov.wales; Tel: 0300 062 8120
Erica Emes (HIW)	Email: Erica.Emes@gov.wales; Tel: 0300 062 8400
Jane Dale (HIW)	Email: Jane.Dale@gov.wales ; Tel: 0300 062 2349
Dave Thomas (WAO)	Email: Dave.thomas@audit.wales; Tel: 02920 320604
Sara Utley (WAO)	Email: sara.utley@audit.wales.; Tel: 0786 931886

18 Further information on the HIW and WAO staff involved in the joint review is provided in Appendix 1.

Personal data

19 This work is being undertaken under various statutory requirements and powers associated with the functions of the Auditor General for Wales and Healthcare Inspectorate Wales.

20 Section 61 of the Public Audit (Wales) Act 2014, requires the Auditor General for Wales to satisfy himself that NHS bodies have proper arrangements in place to secure the efficient, effective and economical use of resources. In addition, section 145 of the Government of Wales Act 1998 gives the Auditor General the power to undertake studies to enable him to make recommendations for improving efficiency, effectiveness and economy in the discharge of the functions of an NHS body.

21 For HIW, this review forms part of its work to provide independent assurance on the quality and safety of healthcare services in Wales. The Health and Social Care (Community Health and Standards) Act 2003 (Part II, Chapter 4) gives HIW (on behalf of Welsh Ministers) the power to carry out inspections, reviews and investigations of the NHS or services provided for the NHS.

22 This terms of reference sets out our intended approach to the review.

23 Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation. Further information is set out in WAO's fair processing notice and HIW's privacy notice in Appendices 2 and 3.

24 We ask that you share this terms of reference with any member of staff that we will be interviewing or will be taking part in a focus group. This will help interviewees or focus group participants understand the purpose of our review and how we will use information collected.

Appendix 1 – Joint review team members

Healthcare Inspectorate Wales:

Alun Jones, Rhys Jones, Erica Emes and Jane Dale

Wales Audit Office:

Dave Thomas, Sara Utley, Carol Moseley and Gabrielle Smith

Appendix 2 – WAO fair processing notice

This privacy notice tells you about the potential collection of your personal information by the Auditor General for Wales (and by the Wales Audit Office on his behalf). Our full privacy notice can be found on our website: http://www.audit.wales/privacy.

Who we are and what we do

The Auditor General's work includes examining how public bodies manage and spend public money. We are collecting information to help us to assess whether NHS bodies have proper arrangements in place to secure economy, efficiency and effectiveness in the use of their resources and whether these could be improved. The information collected will be used for this review and may also be used in our wider statutory audit work (such as the Structured Assessment and Annual Audit Report).

The relevant laws

We process your personal data (including special category personal data) in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation.

Our work in relation to the NHS is done under section 61 Public Audit (Wales) Act 2004, section 145 Government of Wales Act 1998 and/or s15 of the Well-being of Future Generations (Wales) Act 2015.

What we will do with your information

We are asking for opinions and information about NHS services and how they are provided. Some of this information may be information about identifiable individuals, which would make it personal information, even though the purpose of our work is not in itself to collect information about identifiable individuals.

The Auditor General and the audit team from the Wales Audit Office will have access to the information you provide. We may share some information with the Health Board/NHS Trust in our discussions with its senior managers, and our report may include some information as outlined below.

The information that we share and publish will be anonymous and will be about the themes and trends that we identify.

We will not use information to investigate specific complaints arising from use of the service. If you have a complaint about a service, we will direct you to the health body's complaint procedure.

We will keep the information collected, including your personal data, for a period of 7 years following publication of our report.

We will keep your personal data for a period of 7 years following publication of our report, or 25 years if published within a report, and we will hold your data securely in accordance with our Information Security Policy.

Your rights

Under data protection law you have the right to request a copy of the current personal information held about you and a right to raise an objection to data processing that causes unwarranted and substantial damage and distress.

If you wish to discuss any objections or concerns, or obtain a copy of the current personal information held about you, please write to: The Information Officer, Wales Audit Office, 24 Cathedral Road, Cardiff, CF11 9LJ or email infoofficer@audit.wales

The Information Commissioners Office

If you require further information in relation to your rights under data protection law or are dissatisfied with how we are handling your personal data you may contact the Information Commissioner at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, or email casework@ico.gsi.gov.uk, or telephone 01625 545745.

Appendix 3 – HIW privacy notice – summary

Your privacy is important to the Healthcare Inspectorate Wales as part of the Welsh Government and in line with General Data Protection Regulations (GDPR) we have developed a Privacy Notice that covers why we collect and use your information.

Our full privacy notice can be found on our website

http://hiw.org.uk/privacy_policy/?lang=en

Who we are

Healthcare Inspectorate (HIW) is part of the Welsh Government. Our role is to regulate and inspect NHS services and independent healthcare providers in Wales against a range of standards, policies, guidance and regulations and to highlight areas requiring improvement.

Why we collect and process your personal data

The information HIW collects, uses and processes is necessary to enable us to carry out tasks in the public interest and in the exercise of our official authority. The purpose of data collection and the types of personal information we hold is given below:

Investigation of Concerns and safeguarding issues

In order to investigate a concern or safeguarding issue, we are required to collect the following personal data:

- Name;
- date of birth;
- address;
- telephone number;
- email address;
- language and communication preferences; and
- allegations of misconduct at work and protection and abuse allegations.

We also collect special category data such as:

- medical records and care and treatment plans.

Your information will be processed internally and only be passed to officers within the relevant departments who need to provide input into the handling of your complaint and our response. All information relating to complaints are administered and held on secure records management systems. We will share your information when there are potential risks to public, patient or staff safety, with regulatory bodies and relevant authorities/organisations.

Your information will be kept for 10 years after the date of the last document.

Special reviews and investigations, including homicide reviews

In order to investigate a homicide, death in prison and undertake special investigations, we are required to collect the following personal data:

- name;
- date of birth;
- address;
- telephone number;
- email address;
- police records;
- convictions; and
- allegations of misconduct at work.

We will share your information when there are potential risks to public, patient or staff safety, with regulatory bodies and relevant authorities/organisations.

Your information will be kept for 15 years after the date of the last document.

Inspection of services

In order to carry out inspections of healthcare services, we may collect the following personal data:

- patient name;
- patient date of birth;
- patient gender;
- patient identification number;
- NHS commissioner of services being provided;
- staff names;
- staff roles;
- staff appraisal records;
- staff supervision records;
- staff DBS checks;
- staff photographs;
- staff recruitment/pre-employment checks, references; and
- qualifications/professional body registration and employment history.

We may also collect special category data such as:

- patient information from medical records, care and treatment;
- plans including diagnosis, risk, forensic type, treatment type and medication;
- details of detention if applicable;
- ethnicity, including religious/cultural needs.

HIW uses patient information in order to:

- track the effectiveness of care that a patient has received over time, reference any issues of ineffective or unsafe care when reporting back to healthcare providers.

HIW uses staff information in order to:

- ensure that necessary pre-employment checks have been carried out; and
- evaluate whether staff have received relevant training and/or development, reference staff, if necessary, when reporting back to healthcare providers.

We will share personal information with regulatory bodies and relevant authorities/organisations when there are potential risks to public, patient or staff safety.

Who do we share your information with

HIW has a number of information sharing agreements with other organisations that we work closely with. These agreements set out the rationale for information sharing to assist the organisations in meeting their common statutory objectives and to focus respective activities. They support the creation of work programmes which are complementary ensuring that there are clear processes in place for sharing information, risks and concerns. Where there are potential risks to public, patient or staff safety. HIW will share information with relevant authorities/organisations such as the police and local authority safeguarding boards. HIW will only share your personal data as set out above.
You can access the information sharing agreements by selecting the above link or accessing the documents on our website: http://hiw.org.uk/about/workingwithother/mou

Your rights under the General Data Protection Regulations (GDPR)

You have the right to:

- Have access to the personal data that HIW are processing about you.
- Require HIW to rectify inaccuracies in that data.
- The right (in some circumstances) to object to processing.
- The right for your information to be erased.
- Lodge a complaint with the Information Commissioner who is the independent regulator for data protection.

For further information about the data which HIW holds and its use, or if you wish to exercise your rights under GDPR, please contact the following:

Departmental Knowledge Information Manager
Healthcare Inspectorate Wales
Rhydycar Business Park
Merthyr Tyfil,
CF48 1UZ
Email: HIW@gov.wales

Data Protection Officer
Welsh Government
Cathays Park
Cardiff, CF10 3NQ
Email: data.protectionofficer@gov.wales

For independent advice regarding the GDPR, please contact the following:

Information Commissioner's Office
Wycliffe House
Water Lane
WILMSLOW
Cheshire SK9 5AF

Telephone: 01625 545 745 or 0303 123 1113
Website: www.ico.gov.uk

AUDIT COMMITTEE FORWARD WORK PLAN 2019/20

Meeting	Standing items/Governance	Internal control and risk management	Part II meeting – hosted bodies	Internal control and risk management
15 July 2019 9am Ynysmeurig House	Minutes Action Log Declarations of Interest Forward Work Programme Charitable Fund Balances last quarter Audit Recommendation Tracker Report Losses and special payments Local Counter Fraud update (Closed) Head of Internal Audit Report Internal Audit Reports (any limited or no assurance reports require lead director presence) WAO Progress Report and any related external audit reviews WAO Audit Reports (as per Annual Audit Plan 2018/19) Items for information (not normally for discussion) Referrals to other committees Any other urgent business	Procurements and Scheme of Delegation Report (to include an update on actions and progress relating to PSPP) Clinical Audit and Effectiveness 2019/20 (and summary against 2018/9 plan) ~~Board Assurance Framework~~ (for Board Development discussion)	Minutes Action Log Declarations of Interest	Audit Recommendation tracker report WHSSC CRAF update EASC Risk Register Update Receipt of any hosted body internal / external audit report and management responses

Meeting	Standing items/Governance	Internal control and risk management	Part II meeting – hosted bodies	Internal control and risk management
28 October 2019 9am Ynysmeurig House	Minutes Action Log Declarations of Interest Forward Work Programme Charitable Fund Balances last quarter Audit Recommendation Tracker Report Losses and special payments – review of plans and priorities Local Counter Fraud update (Closed) Head of Internal Audit Report Internal Audit Reports (any limited or no assurance reports require lead director presence) WAO Progress Report and any related external audit reviews WAO Audit Reports (as per Annual Audit Plan 2018/19) Items for information (not normally for discussion) Referrals to other committees Any other urgent business	Procurements and Scheme of Delegation Report (to include an update on actions and progress relating to PSPP) Board Assurance Framework Review of internal communications for LCFS (from April 2019) Len Couzens	Minutes Action Log Declarations of Interest	Audit Recommendation tracker report WHSSC CRAF update EASC Risk Register Update Receipt of any hosted body internal / external audit report and management responses

Additional items – January 2020 Review of the resource allocation to the Counter Fraud Service (Director of Finance)