NWSSP Audit Committee (Part A Public)

Wed 13 July 2022, 14:00 - 16:00

By Teams appointment

Agenda

14:00 - 14:10
10 min

1. Standard Business

Martin Veale

1.1. Welcome and opening remarks (verbal)

Martin Veale

1.2. Apologies

Martin Veale

1.3. Declarations of Interest

Martin Veale

1.4. Minutes of Meeting Held on 5 April 2022

Martin Veale

1.4 Audit Committee Minutes 05042022 V2[89].pdf (8 pages)

1.5. Matters Arising

Martin Veale

1.5 Matters Arising.pdf (1 pages)

14:10 - 14:20
10 min

2. NWSSP Update

Neil Frow

2. MD Update Jul 22.pdf (5 pages)

14:20 - 14:40
20 min

3. External Audit

Steve Wyndham

3.1. Audit Wales update

Steve Wyndham

3.1 Audit Wales update paper - NWSSP July 2022 AC meeting.pdf (3 pages)

3.2. Management Letter

Steve Wyndham

3.2 NWSSP_Management_Letter_2021-22 NWSSP - final.pdf (10 pages)

3.3. Nationally Hosted NHS Systems Report

Andrew Strong

3.3 _nationally_hosted_nhs_it_systems_nwssp_report FINAL 10 7 22.pdf (36 pages)

14:40 - 14:55
15 min

4. Internal Audit

James John

4.1. Progress Report

James John

4.1 A&A NWSSP Audit Cttee Progress Report July 2022 FINAL.pdf (8 pages)

4.2. Audit Reports

James john

4.2.1. Medical Examiner Service

James Johns/Sophie Corbett

4.2.1 NWSSP-2122-09 Medical Examiner Service IA Report (Final).pdf (15 pages)

4.2.2. Payroll Services

James Johns/Sophie Corbett

4.2.2 NWSSP-2122-14 Payroll Final Report.pdf (15 pages)

4.3. NWSSP Head of Internal Audit Opinion and Annual Report 2022-23

James Johns

4.3 A&A NWSSP HIA Opinion and Annual Report 21-22 Final.pdf (24 pages)

4.4. Quality Assurance and Improvement Programme

Simon Cookson

4.4 QAIP Report 2021-22 Final.pdf (24 pages)

14:55 - 15:15
20 min

5. Counter Fraud

5.1. Progress report

Gareth Lavington

5.1 CF Progress report .pdf (9 pages)

5.2. Annual Counter Fraud report 2021-22

Gareth Lavington

5.2 SSP Annual Report 21-22 .pdf (12 pages)

5.3. Counter Fraud Annual Plan 2022-23

Mark Weston

5.3 SSP Annual Plan FINAL.pdf (21 pages)

15:15 - 15:55
40 min

6. Governance, Assurance & Risk

6.1. Final Annual Governance Statement 2021-22

Peter Stephenson

- 6.1 Cover FINAL Annual Governance Statement 2021-22.pdf (2 pages)
- 6.1 FINAL Annual Governance Statement 2021-22.pdf (36 pages)

6.2. Governance Matters

Andrew Butler

- 6.2 Governance Matters _.pdf (13 pages)

6.3. LFT Write-Off

Andrew Butler

- 6.3 LFT write off.pdf (2 pages)
- 6.3 Rapid Test Kit write off - WG updated.pdf (6 pages)

6.4. Annual Report of Conflict of Interest Declarations 2021-22

Andrew Butler

- 6.4 AC Report Conflict of Interests Declarations 2022-23.pdf (5 pages)

6.5. Corporate Risk Register

Peter Stephenson

- 6.5 Corporate Risk Register.pdf (2 pages)
- 6.5 Corporate Risk Register 20220707.pdf (3 pages)

6.6. Tracking of Audit Recommendations

Peter Stephenson

- 6.6 Tracking of Audit recommendations report July 2022.pdf (2 pages)
- 6.6 07072022 Appendix A Audit recommendations Tracker_ (2).pdf (9 pages)

6.7. Audit Committee Terms of Reference

Peter Stephenson

- 6.7 NWSSP Audit Committee Terms of Reference July 2022.pdf (12 pages)

15:55 - 16:00
5 min

7. Any other Business (By Prior Approval Only)

16:00 - 16:00
0 min

8. Time and Date of Next Meeting, 11 October 2022

VELINDRE UNIVERSITY NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP

DRAFT MINUTES OF THE MEETING HELD ON
TUESDAY 5 APRIL 2022 / 14:00 – 16:00
BY TEAMS APPOINTMENT

EXPECTED ATTENDEES:		
ATTENDANCE	**DESIGNATION**	
INDEPENDENT MEMBERS:		
Martin Veale (Chair)	Chair & Independent Member	
Gareth Jones (GJ)	Independent Member	
Vicky Morris (VM)	Independent Member	
ATTENDANCE	**DESIGNATION**	**ORGANISATION**
Tracy Myhill (TM)	NWSSP Chair	NWSSP
Neil Frow (NF)	Managing Director	NWSSP
Andy Butler (AB)	Director of Finance & Corporate Services	NWSSP
Linsay Payne (LP)	Head of Financial Management	NWSSP
Simon Cookson (SC)	Director of Audit & Assurance	NWSSP
James John (JJ)	Head of Internal Audit	NWSSP
Sophie Corbett (SC)	Deputy Head of Internal Audit	NWSSP
Nigel Price (NP)	Local Counter Fraud Specialist	Cardiff and Vale UHB
Gareth Lavington (GL)	Lead Local Counter Fraud Specialist	Cardiff and Vale UHB
Steve Ham (SH)	Chief Executive	Velindre
Matthew Bunce (MB)	Director of Finance	Velindre
Lauren Fear (LF)	Director of Corporate Governance	Velindre
Steve Wyndham (SW)	External Audit Lead	Audit Wales
Peter Stephenson (PS)	Head of Finance & Business Improvement	NWSSP
Carly Wilce (CW)	Corporate Services Manager	NWSSP
Gareth Price (GP)	Personal Assistant	NWSSP

Item		**Action**
1. STANDARD BUSINESS		
1.1	**Welcome and Opening Remarks** Welcome was given to Tracy Myhill, Shared Services Partnership Committee Chair, who was attending her first NWSSP Audit Committee.	
1.2	**Apologies** No apologies had been received.	
1.3	**Declarations of Interest** None received.	
1.4	**Minutes of Meeting held on 25 January 2022** The minutes of the meeting held in January 2022 were **AGREED** as a true and accurate record of the meeting.	
1.5	**Matters Arising from Meeting on 25 January 2022** All matters arising are complete or on the agenda.	

Item		Action
2.0	**NWSSP Update** NF updated the Audit Committee on recent developments within NWSSP: • As part of a UK-wide response coordinated by the Department for Health and Social Care to the war in Ukraine, NWSSP has donated a number of surplus items and consumables to the value of £131k; • As a consequence of the situation in Ukraine, risks of a potential cyber-attack have significantly increased, and business continuity measures are being revisited. All staff are reminded of the need to be extra vigilant; • Procurement supplier data has been reviewed to ensure compliance with the sanctions on purchasing goods and services from either Russia or Belarus. This has confirmed that NHS Wales do not purchase any goods or services directly from any company and/or businesses associated with either country; • The purchase of Matrix House in Swansea was successfully completed on 30 March 2022. Acquisition of this building reduces future revenue costs to NHS Wales and provides an opportunity to create a wider public sector hub. • The International Recruitment drive is complete and NWSSP continues to support Health Boards to recruit staff from overseas. • The CIVAS facility at IP5 was subject to its third inspection by the Medicines and Healthcare Regulatory Agency. A number of minor housekeeping issues were identified which are being rectified, and there is no need for a further inspection for another two years. • The Minister for Health and Social Care undertook a very positive visit to IP5 on 17 March to review the facilities and operations on site. • The Laundry and TrAMS programmes continue to progress, however due to significant increase in material prices, teams are in consultation with stakeholders and partners to identify ways to reduce costs. • Approval has been given by Welsh Government for recurring funding to support the Decarbonisation Strategy. GJ highlighted that at the last Velindre Board meeting, an error was noted in the title on the contract documents for Matrix House in that the word “University” was missing from the title (i.e. of Velindre University NHS Trust). AB confirmed that all documents would be checked to ensure accuracy and any corrective actions taken if needed. (It was subsequently confirmed that this error had been rectified). NF thanked Velindre Board Members, management and their staff for their help in getting the documentation turned round quickly for the purchase of Matrix House. The Committee **NOTED** the update.	
3. EXTERNAL AUDIT		
3.1	**Audit Wales Update** SW presented the latest position statement and detail as to current and planned work. The 2021-22 financial audit work and associated audit assurance arrangements remain ongoing and are on track to complete within the agreed timescales for the next Audit Committee in July. There are no significant matters to raise at present and any findings would be brought back to the next meeting. It was agreed that any discussion over stock would be deferred until later in the agenda when there were papers covering this specific item. The Committee **NOTED** the update.	
4. INTERNAL AUDIT		

Item		Action
4.1	**Internal Audit Position Statement** JJ presented the latest Internal Audit Position Statement together with an overview of other activity undertaken since the previous meeting. Good progress continues to be made in completing the 2021-22 plan. There are three finalised reports on the agenda for the consideration of the Committee. The planned audit work on Agile has been deferred. The draft 2022-23 internal audit plan has been prepared and is included later on the agenda seeking Committee approval. The Committee **NOTED** the Position Statement.	
4.2	**Internal Audit Reports** The following internal audits were presented to the Audit Committee for consideration. • The overall objective of the Primary Care Contractor Payments review was to assess the controls in place for the administration of timely and accurate payments to Primary Care Contractors. The review achieved Substantial Assurance with only one medium and one low priority recommendation for action. • The purpose of the Legal and Risk Services review was to establish whether appropriate arrangements are in place for the governance, performance, and risk monitoring within the Directorate. There was only one medium priority recommendation for action, with an overall rating of substantial assurance. A discussion took place concerning the management response regarding PADRs and whether the timescale was achievable. NF emphasised that he was confident that it would be achieved. • The scope of the Procure to Pay (P2P) review had been extended to include Procurement Services. The review received, one high priority, two medium and three low recommendations, and an overall rating of reasonable assurance. The high-rated recommendation related to an approximately 30% increase in the number of invoices on hold since the start of the 2021/22 financial year. AB highlighted that this was an issue that would be raised at the Finance Academy P2P group. There was also discussion on the medium finding relating to supplier bank account mandate changes where a number of attempted and actual frauds were noted in March 2021. Controls were enhanced to mitigate frauds and only one further fraudulent attempt had been made in the early summer of 2021 which was picked up by the enhanced checks and no loss was incurred. However, AB reported that a further attempted fraud had been made on the morning of the Committee, but which again had been picked up by NWSSP with no loss to suppliers or the NHS. AB also highlighted that he had shared the findings in respect of delegated authority with the Directors of Finance of the three NHS bodies concerned. VM congratulated NWSSP on the very positive report outcomes of those listed above. The Committee **NOTED** the Internal Audit Reports.	
4.3	**Internal Audit Operational Plan 2022-23** JJ presented the draft 2022-23 Internal Audit Operational Plan and Charter. The plan has been developed following discussion with the Director of Finance & Corporate Services and the Head of Finance & Business Development and had also been presented to the NWSSP Senior Leadership Group in March. It was reiterated that the plan would be subject to continual review throughout the year, and it was highly likely that additional and/or replacement audits would be included to respond to changing circumstances and risks. Any such changes are always reported to the Audit Committee for formal approval. The plan has been completed in compliance with required standards, which are documented in the Internal Audit Charter along with the key indicators to measure performance.	

Item		Action
	The Committee **APPROVED** the Internal Audit Operational Plan and the Internal Audit Charter for 2022-23**.**	
5. COUNTER FRAUD		
5.1	**Counter Fraud Position Statement** MV welcomed the newly appointed Lead Local Counter Fraud Specialist, Gareth Lavington to the Audit Committee meeting. Gareth has been appointed to fill the vacancy in the C&VUHB team caused by Craig Greenstock's retirement. NP presented the Counter Fraud Position Statement to the Committee, with an overview of other activity. There has been one opened and one closed case during the reporting period and one further case remains open. All 75 days assigned to NWSSP have been completed. The team recently undertook a Risk Assessment exercise across several organisations to test the integrity and effectiveness of pre-employment checks carried out by recruiting agencies. The review was positive with only one anomaly noted. A number of recommendations have been made to mitigate any future risks. NP confirmed that the 2022-23 Counter Fraud Work Plan would be brought to the July 2022 meeting for review and ratification. The Committee **NOTED** the Position Statement.	**NP**
6. GOVERNANCE, ASSURANCE AND RISK		
6.1	**Stock Taking Update** AB presented the Inventory Stock Assurance Arrangements Report updating the Committee on current stock taking arrangements. As a result of Audit Wales being unable to undertake a physical stocktake for 2020-21 period due to the pandemic, a 'limitation of scope' for the financial period was received. Significant effort has been undertaken to ensure that this problem does not reoccur, and thus far Audit Wales have been able to attend six physical stock takes across stores operated or outsourced by NWSSP with no significant issues raised. Stock volumes continue to remain high but are starting to fall as stock continues to be utilised. SW explained that there is still more audit work to do but that plans remain on target and results thus far are positive. SW thanked all those who made the necessary access arrangements for respective sites to support Audit Wales in carrying out their reviews. Questions were asked of SW regarding the opening balance position for stock, given that Audit Wales were unable to attend and/or test closing stock balances in the previous year. NWSSP, following discussions with Audit Wales, had undertaken a lot of work in reconciling back from closing balances at the end of 2021/22, recording all receipts and issues, to validate the opening balance. This has required support from the NWSSP Central Team to develop a sophisticated programme to interrogate the Oracle databases and the significant number of PPE transactions. SW was asked whether he could give any assurance as to whether he would be able to rely on this work to support the opening balances. SW acknowledged the support provided by NWSSP and was hopeful that the programme would provide them with the requisite audit assurance. Notwithstanding that SW stated that Audit Wales had not had the reconciliation figures for long, and would need to undertake and complete their audit testing before he could provide this assurance. GJ stated that it seemed very unfair for NWSSP and the Trust to be potentially hit with a double whammy (i.e. qualification accounts in 2020/21 of the closing stock balance, and then again in 2021/22	

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	over the opening balances). SW was unable to provide any assurances, but he was asked to ensure that there were no last-minute surprises (i.e. to communicate any potential issues as soon as he was able to). AB confirmed that a full-scale review of current warehouse provisions is underway, to determine a potential solution of storage requirements. The Committee **NOTED** the update.	

6.2	**Valuation of PPE – DHSC/NHS Wales**
	
	AB presented the Valuation of PPE report to the Audit Committee. Following recent media coverage regarding the write off of PPE for 2020/21 accounts in NHS England, this report was prepared at the request of the Audit Committee Chair and sets out the Welsh position against the category of headings reported in England.
	
	AB reminded the Committee that Welsh Government policy was for NWSSP to hold 16 weeks' worth of stock, which has posed some challenges concerning the devaluation of stock and equipment approaching lifetime expiry. To reduce the impact of loss across the UK, Surgical Materials Testing Laboratory (SMTL) are working with the UK Department of Health & Social Care (DHSC) to potentially identify new ways to extend the shelf life of specific PPE products.
	
	In England, the DHSC estimates that there has been a loss in value of £8.7 billion of the £12.1 billion of PPE purchased in 2020-21. By comparison, in NHS Wales, the total PPE spend to the end of February 2022 was £385m. The loss in NHSE was spread over the following categories:
	
	• Defective PPE (£0.67bn in England) – the figure for Wales is £0 although there is one order for gowns which have been potentially identified as faulty. The value of this order is £9.4m but we anticipate that this stock will either be determined as being useable or will be replaced by the supplier;
	• PPE unsuitable for use in the NHS or Social Care but which may be able to be used elsewhere (£2.6bn in England) – the figure for Wales is £0 in this category;
	• Surplus stocks (i.e. that may go out of date before they can be used – (£0.75bn in England)). In Wales there are a number of items that my need to be included in this category as follows:
	  ○ Fit Test Solutions – Due to the implementation of a new fit testing methodology these solutions are no longer required in Wales and as such will become out of date. There are currently 26,000 items in stock at a total value of £0.277m.
	  ○ Face Visors – At the height of the pandemic 131,000 visors were issued each week. This has now fallen to approximately 14,000 items per week. Consequently, there are approximately 620,000 visors with a book value of £1.055m in stock. SMTL have been commissioned by NHS England to investigate the possibility of extending the date life of their visors. The results of the testing will be reviewed once completed and it may be possible to extend the shelf life of the visors that NWSSP have in stock.
	  ○ Type II Masks - 237,000 Type II masks with a value of £0.159m will reach the end of their date life within a month. This product was widely used prior to the pandemic but has been replaced with the fluid resistant Type IIR mask and there is no longer a market for this product.
	• A provision of £1.491m will be made for the above items in the 2021/22 accounts. Regular discussions have been held with Welsh Government who have agreed to provide funding to cover the provision.
	• Adjustment to Year-End Valuation due to falling prices (£4.7bn in England) – the NHS Wales Manual of Accounts allows NHS stocks to be valued at cost, rather than net realisable value, on the basis that stocks are not held for resale and that they turnover relatively quickly. NWSSP have valued stocks on this basis which avoids	

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	significant write-downs in value, but there are two items which are considered slow-moving, and which therefore need to be written down to the current market price as follows: ○ ***Gowns*** – As highlighted above NWSSP is holding a stock of 2,242,676 gowns from a single supplier where problems have been experienced with the quality of the items. This issue is being pursued with the supplier and it is anticipated that this will be resolved through product replacement. Following discussions with Welsh Government it has been considered prudent to revalue the stock at 28p per item. resulting in a devaluation of £8.793m ○ ***Goggles*** – Currently a stock of 585,000 goggles is held. Early in the pandemic, national guidance required the use of goggles, and these were purchased at £5.03 each in early 2020. The guidance was amended to require the use of face visors in mid-2020 and, therefore, these goggles were not issued and remain in store. This product is used as eye protection in some areas of NHS Wales where purchases are made directly with the suppliers. To facilitate the promoting of this product to this new market it is proposed to revalue this product to the current market price of £2.50, resulting in a reduction in value of £1.457m • An adjustment of £10.250m will be made against the value of the above stocks in the 2021/22 accounts. This has been discussed with WG who have agreed to provide funding to cover this. The paper included a comparison with the position in NHS England, where 72% of the total spend on PPE is being written off compared to just over 3% in NHS Wales. The Audit Committee **APPROVED** the application for NWSSP to seek approval from Welsh Government to write off loss for PPE.	
6.3	**Stock Write-Offs/Donations** A further report was presented by AB to provide background information to three sub-papers relating to the donations of PPE and other medical supplies and equipment to Ukraine and Namibia, and the general write-off of stock at year-end. Checklists were presented to seek approval from the Audit Committee to formally request Welsh Government approval to write off losses for the following- ○ Ukraine, additional surplus PPE, and Medical Equipment to the value of £10,138.36 ○ Namibia, Surplus PPE to the value of £156,092 to reflect a price adjustment to a previously approved write-off by the Audit Committee in 2021 increasing the total value of the donation to Namibia to £11.147m; and ○ Year End Stock adjustment to the value of PPE and general stock to the value of £11.6m – these largely relate to the items documented in 6.2 above. The Audit Committee **APPROVED** the write-offs of the stock donated separately to Ukraine and Namibia, and the stock impairment in the 2021/22 accounts.	
6.4	**Energy Update** The Committee received a paper relating to the current situation with energy prices. Due to the nature of the markets and high expenditure, the Energy Price Risk Management Group (EPRMG) was formed in 2005 to manage exposure to risk across the NHS Wales energy contracts. The overarching aim of the group is to minimise the impact of energy price rises through proactive management and forward buying. There have been very significant increases in gas and electricity prices during the year, particularly during recent weeks following the outbreak of the Ukraine war. The EPRMG strategy of purchasing ahead has meant that NHS Wales has benefitted substantially and avoided most of the price increases for gas and electric supply. Whilst this strategy has	

Item		Action
	protected NHS Wales from the huge increase in market prices for 2021/22 it is likely that there will be very significant hikes in energy costs in 2022/23 because of current contracts coming to an end. The recent increase in energy costs is very unwelcome, but is unavoidable given the current war in Ukraine, the sanctions applied to Russia and the removal of Russian Gas and Oil from supplying the global market. However, the EPMRG will attempt to manage the energy costs for NHS Wales as best as we can over the year ahead. The Committee **NOTED** the paper.	
6.5	**Governance Matters** AB presented the Governance Matters paper, providing the Committee with the contracting activity since the last meeting. The report summarises that: • There were no departures from the Standing Orders; • NWSSP let 43 contracts during the reporting period; • 64 All-Wales contracts were let of which 20 were at briefing stage, 35 at ratification stage and nine were extensions against contracts; • There have been two declarations as to gifts, hospitality, or sponsorship made since the last reporting period. GJ raised a question regarding the contract details included in Appendix B, asking for clarity on what the Committee were being asked to with regards to these. As an example, he quoted Ref 34 relating to a DHCW framework contract for £105m where prior to the establishment of DHCW as a legal entity, the responsibility for this contract would fall to the Velindre Board. Subsequent discussion outside of the meeting highlighted that the current title of Appendix B (All-Wales Contracting Activity in Progress) contains both contract details for activity taken on an all-Wales basis, but also for contracts relating to specific NHS Wales bodies (e.g. DHCW in the case of item 34). It was therefore agreed that in future the report would be split as follows: • Appendix A – internal contracts within NWSSP; • Appendix B – contracts let by NWSSP on an all-Wales basis; and • Appendix C – all other contracting activity for NHS Wales organisations. The Committee **NOTED** the report.	
6.6	**Corporate Risk Register** PS presented the Corporate Risk Register, which contains two red risks, relating to the pressure on Recruitment and Payroll functions due to the increased demand across NHS Wales, and the impact of increasing energy costs as a result of the war in Ukraine. These risks would continue to be monitored and assessed. The Committee **NOTED** the Corporate Risk Register.	
6.7	**Tracking of Audit Recommendations** PS presented the tracking of audit recommendation paper to the committee and noted the following summary: • The tracker contains information on 64 reports, of which 17 achieved substantial assurance, 27 reasonable assurance, one limited assurance and 19 reports were generated with no assurance applicable (e.g. Advisory reports);	

Item		Action
	• The tracker contains 241 recommendations, of which 226 were implemented, 11 were not yet due, three are outstanding and one is not within NWSSP's gift to implement. Of the three outstanding audit recommendations, one relates to an issue that has been overdue for some time and where the Overpayments Policy needs to be approved on an all-Wales basis and this is currently proving difficult. The other two outstanding recommendations were due for completion either at the end of February or March 2022, and the Committee were asked for a short extension in the due dates for each for the following reasons: • Review of National Hosted NHS IT Systems. Oracle Financial Management System: Extension requested from 28/02/2022 to 31/05/2022. The planned disaster recovery testing of the Oracle system in mid-February had to be postponed due to Storm Eunice; and • Review of Laundry Services: Extension requested from 31/03/2022 to 31/05/2022. Good progress has been made in completing PADRs, but a few remain outstanding. The lack of any information from previous employers has hindered the process. The Audit Committee **APPROVED** the revised deadlines for the two recommendations detailed above.	
6.8	**Draft Annual Governance Statement 2021/22** PS provided the Audit Committee with an update and reported that good progress has been made in completing the Statement which requires formal sign-off at the July Committee. To ensure that Committee members had sufficient time to review the Statement, it was proposed that the draft Statement be e-mailed to each Audit Committee member once available for comment and the final version be brought back to the July meeting for approval. The Audit Committee **NOTED** the arrangements for the review of the Draft Annual Governance Statement.	**PS**
7. ITEMS FOR INFORMATION		
7.1	**NWSSP Counter Fraud Newsletter** Provided for information only – no further comment.	
7.2	**Audit Committee Forward Plan 2022-23** Provided for information only – no further comment.	
8. ANY OTHER BUSINESS		
8.1	**Any Other Business** No further issues were raised.	
DATE OF NEXT MEETING: Wednesday, 13 July 2022 from 14:00-16:00 via Teams		

Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Matters Arising

Actions arising from the meeting held on 5 April 2022			
Item	**Responsibility**	**Description**	**Status**
5.1	NP	**Counter Fraud** To ensure the 2022-23 Counter Fraud Work Plan is included in July's 2022 meeting for review and ratification.	**On the agenda.**
6.8	PS	**Annual Governance Statement** To circulate NWSSP's draft Annual Governance Statement to each Audit Committee member by email for comment and the final version to be brought back to the July meeting for approval.	**Complete.**

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	13 July 2022
AGENDA ITEM	2.0
PREPARED BY	Peter Stephenson, Head of Finance and Business Development
PRESENTED BY	Neil Frow, Managing Director
RESPONSIBLE HEAD OF SERVICE	Neil Frow, Managing Director
TITLE OF REPORT	NWSSP Update

PURPOSE
To update the Committee on recent developments within NWSSP.

Introduction

This paper provides an update into the key issues that have impacted upon, and the activities undertaken by, NWSSP, since the date of the last meeting in April.

IMTP

Senior NWSSP management participated in the meeting with Welsh Government in early May to review the IMTP. The meeting was very positive, and the IMTP has been well-received with the Outcome Letter expected shortly. The first round of quarterly reporting for the current IMTP is being reviewed by the Partnership Committee later this month.

Financial Position

The 2021/22 year-end position was an underspend of £11k, which when viewed in the context of an overall budget of £870m is a very impressive result. COVID costs totalled almost £58m which were funded in full by Welsh Government. Variable pay has increased in March, but this is due to the

Annual leave accrual and pension adjustments. The underlying variable pay spend for March was £635k.

In terms of the Welsh Risk Pool, the DEL expenditure for the year was £129.615m including £1.679m for Redress. The Risk Share agreement was invoked at the IMTP value of £16.495m. Additional WG funding of £4.861m was agreed. £17.018m capital funding was received in 2021/22 and fully utilised. As per the forecast, £12.348m was spent in March 2022, including the purchase of Matrix House which completed on 30th March 2022.

Looking to the current financial year, NWSSP reported the Month 2 financial position at break-even with an underlying underspend of £1.061m after anticipating £0.577m of WG funding for the 1.25% NI increase, Covid recovery support costs and Energy pressures. This funding can only be anticipated at risk at present –our financial position would have been £0.484m underspent without the assumption of this funding or any utilisation of centrally held reserves.

Community Care

Recent discussions amongst Chief Executives in NHS Wales have led to the commencement of establishing work programmes to take forward the Community Care Programme and this will involve NWSSP supporting various Task & Finish Teams. There will need to be significant activity in terms of both local and international recruitment, and substantial support will also be needed from Procurement colleagues.

Patient Safety

Under the direction of the NWSSP Medical Director, Ruth Alcolado, there have been a number of initiatives driven within NWSSP to help improve patient safety. These include:

1) ***Radiology report reviewing in rapid turnover environments*** – an issue identified by Welsh Risk Pool pre-pandemic, but services are waiting for an 'All Wales'/DCHW technological solution. The issue of sign off and action from Radiology reports that return long after a patient has been discharged from high volume/high turnover specialties has been a complex issue and has been highlighted as a cause of patient harm and patient claims for the past three to five years. NWSSP convened a group representing Radiology and Emergency Department services across Wales along with DCHW. Despite repeated highlighting of the issue, we had been awaiting a technological solution to this for some time, which has not yet emerged. We agreed a methodology for highlighting incidental important findings and differentiating new abnormal findings. A meeting with the Wales Imaging Board in the coming weeks will be asked to agree the 'All Wales' approach. A request for change will be

submitted to go DCHW, sponsored by Welsh Risk Pool and the Radiology community, highlighting the change as a clear patient safety improvement. Further action will include a letter to Medical Directors regarding automation of copying unexpected new cancer findings to cancer services.

2) ***The Primary Care division of NWSSP provide the Primary Medical Care Advisory Team (PMCAT) Service*** under a Service Level Agreement to Health Boards. It was initially set up to support work with underperforming GPs and practices. Since the service inception the Primary Care landscape has changed, thus the work now undertaken by the PMCAT team has also evolved. The advent of General Medical Practice Indemnity and Locum Hub Wales have brought more opportunities to intervene at an earlier stage to prevent issues from becoming entrenched and to support practices learning and improving from patient concerns. The review of the PMCAT service will help us to identify where the specialist expertise of the team can be best used to continue to improve services to patients. All stakeholders will be involved with submitting information against an agreed set of criteria and follow up interviews will take place.

3) ***Medical Examiner Service***. The service is currently examining around 1000 deaths a month, with a target of 2500 monthly by the time the service is launched on a statutory footing. The nature of the set-up of the service in Wales allows identification of local, regional, and national issues, including recently:
    a. excess deaths in a service which was subsequently confirmed by an external review.
    b. issues raised with expected deaths which lead to a Health Board putting in a Quality Improvement Plan around 'End of Life' care.
    c. Coroners feedback that more appropriate cases are being referred to them.
    d. A cluster of diabetic ketoacidosis (DKA) deaths across Wales, which would not have been picked up if individual Health Boards ran their own services. All Health Boards were alerted and reviewed their admissions with DKA and community diabetes monitoring.
    e. Nursing Home deaths where families raised concerns but where homes on the borders of Health Boards may mean patients being admitted to different places so would not be alerts to similar presentations, but the 'All Wales' nature of the service enabled this to be identified.

As deaths being examined extend to include all hospitals (District General Hospitals and Community Hospitals) as well as primary care deaths, the pattern of learning will no doubt change but the potential for assurance and learning is only going to increase.

Single Lead Employer

The November 2019 and February 2020 Partnership Committee meetings signed off the proposal that NWSSP should become the Single Lead Employer (SLE) for Pre-Registration Pharmacists, Foundation Doctors, Foundation Dental, Specialty and Core Medical and Dental Trainees not subject to an existing SLE arrangement in NHS Wales. The initial completion date for the roll-out of the new model was scheduled for August 2021 but subsequently amended to May 2022 because of COVID. I am now pleased to confirm that the SLE model has been rolled out to eligible trainees in accordance with this agreed timescale.

Implementation of the new model has not been without its challenges and resulted in the need to simplify, rationalise, and change numerous transactional processes whilst rolling out the model. NWSSP now employees over 3,000 trainee medical and dental staff. The intended benefits of the new arrangements are now coming into fruition with medical workforce resources being released back to the UHBs, those trainees opting to stay and train in Wales only requiring one round of employment checks prior to the start of their initial training, trainees experiencing less problems with tax codes when rotating to a new Health Board, trainees being able to access various salary sacrifice schemes and additional duties being paid through one payslip (only applicable to participating Health Boards).

IP5

We have been working with colleagues from Welsh Government and Public Health Wales regarding the future plans for the vacated Lighthouse Laboratory at our IP5 facility. The Surgical Materials Testing Laboratory (SMTL) have had a new laboratory completed on site which will enable them to perform additional tests and to develop new testing regimes for medical devices, which they were unable to do at the existing Bridgend site. It is anticipated that the additional testing functionality should be in place by August. We are also in the process of working towards full accreditation for the SMTL facility in IP5.

TRaMS

Progress continues to be made in terms of the overarching Outline Business Cases, with a number of workshops held to consider site selection. There is on-going discussion with workforce colleagues and Chief Pharmacists regarding the Organisational Change Programme, and we continue to work with Chief Pharmacists to develop the product ranges. We are also working with Welsh Government to ensure the resilience of Pharmacy Stores, particularly through bringing together these services under the IP5 and Picketston banners.

The service was initially funded on a two-year temporary basis which expires in March 2023. The temporary nature of the funding has made some staff posts difficult to fill and retain. There are currently 13 staff in post and three vacancies. The temporary nature of the unit and uncertainty regarding its future has resulted in a 63% turnover of staff since April 2021, with seven staff initially employed having left the service for permanent employment elsewhere within the NHS. This has had a noticeable impact on service delivery and development has been hampered due to the training burden.

Despite the issues highlighted above, the service has been well received and has been recognised nationally in receiving the Patient Safety Development in Secondary Care Award at the Welsh Pharmacy Awards 2021 and the Deloitte Innovation Award at the Shared Services Conference Awards 2021.

Cyber Security

Our recent cyber security assessment, conducted as part of the NHS Wales Cyber Resilience Unit's work to implement the Network Information Security (NIS) Regulation in all health organisations in Wales, demonstrated that generally NWSSP is well protected from cyber-attacks. We continue to work closely with colleagues in DHCW to refine and improve our defences against such attacks. A formal project has been launched to address the key areas for improvement identified in the report's recommendations. One of the key tasks in the initial phase, a desktop exercise based around a cyber incident, was carried out at the May Informal Senior Leadership Group.

Decarbonisation

Additional monies have been received from Welsh Government to fund the setting up of the internal programme arrangements to support the required work. We have now received a number of further electric vans for the Health Courier Service taking the total of electric vehicles in the fleet up to 30. The trial of electric HGVs has unfortunately been delayed due to technical problems at a national level, but the local infrastructure to support the trial is being implemented.

Citizens' Voice Body

Progress continues in supporting the establishment of this organisation, with Hazel Robinson appointed as the Programme Director. A number of additional appointments will be made in the coming weeks.

Neil Frow,
Managing Director, NWSSP,
July 2022

Date issued: July 2022

Audit Wales update for the NWSSP Audit Committee – July 2022

Introduction

1 This document provides the NWSSP Audit Committee with an update on current and planned Audit Wales work, together with information on the Auditor General's planned programme of studies and publications together with the work of our Good Practice Exchange (GPX).

Audit Progress update

2 Our 2021-22 financial audit work and associated audit assurance arrangements is complete and we have communicated our findings to the various NHS external audit teams to inform their 2021-22 opinion work.

3 Our high level findings concerning this work have also been reported in the separate Management Letter within the papers issued to the July NWSSP Audit Committee.

General Audit Wales Update

4 Other areas of Audit Wales activity of potential interest are outlined below for your information.

5 For latest news and updates you can also **subscribe to our newsletter.**

Good practice events and products

6 We continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research. Up to date details of future events are available on our GPX webpages.

Recent Audit Wales Publications

7 A summary is provided below of the NHS-related or relevant national studies published in the last twelve months:

Title	Publication Date
Tackling the Planned Care Backlog in Wales	**May 2022**
Unscheduled Care in Wales	**April 2022**
Joint working between Emergency Services	January 2022
Care Home Commissioning for Older People	December 2021
Taking Care of the Carers?	October 2021
A Picture of Healthcare	October 2021
Infographic on the NHS (Wales) summarised accounts for 2020-21	September 2021
Picture of Public Services 2021	September 2021
NHS Wales Finances Data Tool - up to March 2021	June 2021
Rollout of the COVID-19 vaccination programme in Wales	June 2021
Welsh Health Specialised Services Committee Governance Arrangements	May 2021
Procuring and Supplying PPE for the COVID-19 Pandemic	April 2021

8 The table below provides a summary of NHS-related or relevant national studies work currently in progress with indicative publication dates:

Title	Indicative publication date
Orthopaedic services	2022
Unscheduled care	2022
NHS waiting times tool	2022
Recovery planning	2022
Welsh Community Care Information System follow up	2022
NHS quality governance	2022
Collaborative arrangements for managing local public health resources	2022
Covid-19 response and recovery – third sector support;	2022

Archwilio Cymru
Audit Wales

Management Letter - NHS Wales Shared Services Partnership

Audit year: 2021-22

Date issued: July 2022

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

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.

Contents

Our work did not identify any significant issues concerning the services provided by NHS Wales Shared Services Partnership (NWSSP) although improvements could be made in some areas.

Summary report

Appendices

Summary report

Introduction

1 The Auditor General is responsible for providing an opinion on whether each NHS body's financial statements represent a true and fair view of the state of its financial affairs as at 31 March 2022.

2 The audit teams of each individual health body are responsible for undertaking audit work to enable the Audit General to provide his opinion and in doing so they determine the audit and assurance work required on the services provided by the NHS Wales Shared Services Partnership (NWSSP).

3 On 25 January 2022, we presented a paper to the NWSSP Audit Committee – 2021-22 Audit Assurance Arrangements – setting out the external audit assurance work to be undertaken on those services provided by the NWSSP to the various NHS bodies across Wales.

4 In this report we outline the findings identified from this work in respect of:

- Audit and Assurance Services (NWSSP – AAS);
- Primary Care Services (NWSSP – PCS);
- Employment Services (NWSSP – ES);
- Procurement Services (NWSSP – PS); and
- Legal and Risk Services (NWSSP – LARS) which includes Welsh Risk Pool Services (WRPS).

5 We will issue a separate report detailing the findings from our review of the nationally hosted NHS IT Systems.

Issues arising from the audit

6 Our work did not identify any significant issues that prevented auditors relying on services provided by NHS Wales Shared Services Partnership (NWSSP) other than those set out below in this report. We have also identified that improvements could be made in some other areas.

7 Our high-level findings in respect of each of the services subject to our review are outlined below.

Audit and Assurance Services (AAS)

8 Local health body audit teams need to consider ISA 610 – Using the work of internal auditors – to assess the adequacy of Internal Audit work for the purposes of the audit. To inform this evaluation, we considered the arrangements in place against the requirements of the Public Sector Internal Audit Standards (PSIAS).

9 We did not identify any issues regarding NWSSP – AAS's compliance with the PSIAS standards that would prevent us taking assurance from their work.

Primary Care Services (PCS)

10 Local Health Board audit teams planned to place reliance on specific key controls within the general medical services (GMS), general pharmaceutical services (GPS) and community pharmacy prescription services (CPPS) systems. We therefore documented, evaluated and tested controls in respect of:

- global sum payments to general medical practitioners (capitation lists and patient rates); and
- payments to pharmacists (checks undertaken by the Professional Services Team and drug tariff rates).

11 Our testing covered the primary care teams in Swansea and Mamhilad and the CPPS team in Companies House. We found that one of the controls for ensuring the reasonableness of patient numbers used for the calculation of global sum payments was not operating effectively during the year. GP practices are required to submit quarterly patient numbers which are then compared to the patient numbers held by PCS. From a sample of 14 monthly global sum payments only 3 patient number reports were received. GPS provided further details of missing quarterly patient number reports which demonstrated that over 40% had not been received.

12 We were informed that during the year there had been a reorganisation of resources in PCS which resulted in GP practices not being reminded to provide these quarterly figures.

13 Other controls tested in PCS were operating effectively overall and could therefore be relied upon although some issues were identified regarding the GPS and CPPS functions which are set out below.

14 Recommendations for improvement have been made which are documented in **Appendix 1**.

Employment Services

15 Local health body audit teams planned to place reliance during 2021-22 on the key controls in respect of exception reporting within the payroll system. We therefore documented, evaluated, and tested these controls regarding the payroll services operating at Companies House, covering both payroll teams.

16 All-Wales exception reporting parameters were agreed and implemented in July 2018 and our testing found that exception reports were produced and there was generally evidence of an investigation of the variances and the action taken to amend where necessary. However, internal control procedures in respect of the review of exception reports were not being consistently applied within both payroll teams, as set out below:

Cardiff and Vale payroll team

- Testing of monthly exception reports found that for two reports there was no evidence that they had been reviewed by the payroll officer and seven which had not been checked by a senior officer;
- We also found two cases where the initial check of the reports and their review were undertaken by the same officer, meaning that the segregation of duties internal control was not applied; and
- Three of the payroll exception reports had outstanding queries meaning that insufficient information existed to record the fact that these variances had been appropriately explored and explained.

17 It is recognised that Covid-19 restrictions and in particular the adoption of remote working has continued to pose additional complications for the period subject to our review, however similar recommendations were also made pre Covid-19. Although there is some improvement in the number of cases found, and no cases were found in the Aneurin Bevan team, the agreed actions have not yet resulted in full compliance. A recommendation for improvement has been made which is documented in **Appendix 1**.

Procurement and Accounts Payable Services

18 Our assurance work focussed on the approval arrangements in respect of contracts exceeding £1 million, awarded by the Procurement Unit in NWSSP. We found no cases of contracts exceeding £1m being awarded without Welsh Government approval.

Legal and Risk Services (LARS)

19 The local audit teams at each NHS body need to consider ISA 500 – Audit evidence – to assess the adequacy of Legal and Risk Services as a management expert for the purposes of their audits. To aid this evaluation, we considered the arrangements in place at NWSSP against the requirements of ISA 500. Based on the work undertaken, we did not identify any issues that would prevent auditors relying on NWSSP – LARS's work as a management expert.

20 We did however find that LARS were unable to demonstrate full compliance with the requirement for all its staff to complete declaration of interest in 2021-22 due to an IT issue. We understand that this was a one-off issue this year following the transfer of staff on the ESR system from the Velindre payroll to a separate NWSSP payroll. Therefore we have not made a recommendation in respect of this matter.

Recommendations

21 The recommendations arising from our 2021-22 work are set out in **Appendix 1**. Management has responded to them and we will follow up progress on them during next year's audit.

22 The recommendations raised following our 2020-21 audit work have been satisfactorily addressed with the exception of the issue concerning the control weaknesses on payroll exception reports and GP practice patient number returns, which has been repeated again this year.

Appendix 1

Action plan

Exhibit 1: recommendations

We set out all the recommendations arising from our audit with management's response to them.

Para	Issue	Recommendation	Priority	NWSSP responsibility and action	Completion date
14	**NWSSP – Primary Care Services** Capitation reports were not always received from GP practices and have not been chased for by PCS	R1 NWSSP – PCS should chase for outstanding capitation reports from GP practices.	Medium	Agreed. Change process to allow the Quality Assurance Team to obtain capitation data directly from Digital Health and Care Wales rather than practices	May 2022
17	**NWSSP – Employment Services** Internal control procedures for the review of exception reports are not being complied with by the Cardiff and Vale Payroll team.	R2 NWSSP – ES should ensure that internal control procedures for reviewing exception reports are complied with.	Medium	We have implemented a new checking process that has been adopted across Wales, it is embedded in the Payroll Process schedule and will be checked that all Exceptions reports are checked and signed by a member of the Payroll Team. We are piloting with the teams an automated checking	Implemented on 01.06.2022

Para	Issue	Recommendation	Priority	NWSSP responsibility and action	Completion date
				report, whereby the information is extracted from all documents, NAF, PIF, EEF and match electronically with the data in ESR, this will produce a Power BI report of the checks undertaken for audit purposes that are correct, any discrepancy will be checked by the Team and probity to the process.	

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Archwilio Cymru
Audit Wales

Nationally Hosted NHS IT Systems – NHS Wales Shared Services Partnership

Audit year: 2021-22

Date issued: June 2022

Document reference: 3044A2022

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Contents

The IT controls we examined assured us that financial values produced by the systems for 2021-22 were likely to be free from material misstatement, although some controls could be strengthened.

Summary report

Summary

1 NHS bodies in Wales are responsible for preparing financial statements that give a true and fair view of the state of their financial affairs as at 31 March 2022. They must ensure that they are properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made thereunder by Welsh Ministers. NHS bodies are also responsible for preparing Annual Governance Statements in accordance with guidance issued by HM Treasury and the Welsh Government.

2 The Auditor General is responsible for providing an opinion on whether each NHS body's financial statements represent a true and fair view of the state of its financial affairs as at 31 March 2022.

3 NHS Wales has a variety of arrangements in place to provide and support IT systems used for financial reporting purposes. Since June 2012, Velindre University NHS Trust (the Trust) has hosted the NHS Wales Shared Services Partnership (NWSSP) and is responsible for its governance and accountability.

4 This report covers the national NHS IT applications and infrastructure which NWSSP manages for use by other NHS organisations in Wales. These systems include the:

- Prescription Pricing System (formerly known as the Community Pharmacy System) which is used to process prescriptions and calculate reimbursement for pharmacy contractor payments. This system is used by the Prescription Services Team of Primary Care Services (PCS).
- National Health Application and Infrastructure Services (NHAIS) or Exeter, used for NHS demographics and calculating primary care General Medical Services (GMS) contractor payments. NHS Digital in NHS England manages and supports the NHAIS system software for use in NHS Wales. Digital Health and Care Wales (DHCW) manage and support the NHAIS IT infrastructure used in NHS Wales.
- Oracle Financial Management System (FMS) is supplied by a third party called Version One and managed for NHS Wales by the Central Team e-Business Services (CTeS) within the NWSSP. The Oracle FMS is used by NHS Wales as the main accounting system for managing and producing the NHS accounts.
- Electronic Staff Record (ESR) systems administration is the responsibility of each individual Local Health Board and Trust through delegated responsibility passed to NWSSP via a Service Level Agreement (SLA). Payroll access by NWSSP Employment Services to process the payroll in Wales is managed in accordance with the Trust's ESR system access process. The ESR Payroll system is managed and hosted nationally by IBM on behalf of NHS England and NHS Wales under a managed service contract.

5 International Auditing Standard (ISA) 315 requires us to obtain an understanding of the general IT and application controls of the financial systems used by NHS Wales. As part of the National Hosted NHS IT Systems audit plan, Audit Wales reviewed the above-mentioned systems during 2021-22 and followed up our prior audit recommendations in these areas. This work reviews the ICT environment and application controls that are applied to the National Hosted NHS IT Systems solely for the purposes of providing assurance for NHS audit opinions. We have taken the opportunity to identify actions that, in our view, would help NHS Wales improve its governance and use of these systems.

6 This work is undertaken to identify potential risks which may include:

- out-of-date and unsupported infrastructure;
- access security arrangements that leave the system vulnerable to unauthorised access and attack;
- loss or unauthorised access of data; and
- change control procedures which are inadequate meaning that the system could be compromised or unavailable following the application of a new patch, upgrade or release of the database or the application software or infrastructure change.

7 We have therefore undertaken a review that sought to answer the question:
'Can auditors be assured that the IT system controls are such that financial values are likely to be free from material misstatement?'

8 **We concluded that the IT controls applied to the Prescription Pricing, National Health Application Infrastructure, Oracle Financials systems and ESR Payroll systems administration managed by NHS Wales Shared Services, were sufficiently effective to allow financial auditors to take assurance that financial values produced by the systems for 2021-22 were likely to be free from material misstatement. However, NWSSP could strengthen some controls.**

9 In summary, the reasons for this conclusion are set out below:

- the Prescription Pricing System's controls support the production of information that is free from material misstatement;
- the National Health Application and Infrastructure Service system's controls support the production of information that is free from material misstatement, however, system replacement plans are underway and almost complete;
- the Oracle FMS's IT controls support the production of information that is free from material misstatement, although system should be disaster recovery tested; and
- the ESR Payroll's Shared Services system administration controls support the production of information that is free from material misstatement.

10 This report summarises the more detailed matters arising from our audit, our recommendations made from this year's audit and our follow-up of last year's recommendations.

Detailed report

The Prescription Pricing System's controls support the production of information that is free from material misstatement

11 We have identified no significant IT application or infrastructure issues likely to result in a material misstatement within the Prescription Pricing System. However, we identified some issues that should be addressed by Primary Care Services in order to minimise the potential for future application and infrastructure system risks. From our IT work in 2021-22, we have identified four recommendations to NWSSP for improvement. These are outlined below:

- reduce the number of users with access to create, amend or delete user access to the prescription pricing system. Access to higher level or privileged accounts should be restricted to an appropriate number;
- review user access rights to the prescription pricing system on a regular basis, for example, at least annually, to ensure that users have appropriate access rights, and that any potential leavers, or inactive users are identified and their access amended appropriately;
- update the prescription pricing change control policy to record and confirm that it has been updated and include this in the document revision history. The change control policy was last updated in 2017; and
- update the Service Level Agreement (SLA) with Digital Health Care Wales to specifically name the prescription pricing system within its scope, update the document revision history and expected review dates, include details around the responsibilities and frequency in taking of data backups and monitoring the successful completion of backups.

12 NWSSP have made progress to address prior year IT recommendations made for improvement and some of these remain in progress. Further details of our findings and progress against actions for the Prescription Pricing System agreed with Primary Care Services officers can be found in **Appendix 1**.

The National Health Application and Infrastructure Service system's controls support the production of information that is free from material misstatement, however, system replacement plans are underway and almost complete

13 We have identified no significant issues within the NHAIS system likely to result in a material misstatement. However, we have identified some issues that should be addressed by NWSSP in order to minimise the potential for future application and infrastructure system risks. From our work in 2021-22 we have identified no significant areas for improvement for NWSSP and as the system was planned to be replaced in quarter one 2022-23 for GMS processing we have made no recommendations for improvement.

14 Plans to replace the NHAIS functionality in Wales for GMS processing for the 'global sum' or 'per capitation' payments are underway. NWSSP has delayed the planned implementation until early in 2022-23 due to a number of issues identified in system testing. NWSSP has since implemented the Family Payment Practitioner System (FPPS) in April 2022 after a period of parallel system running in 2021-2022. Plans to decommission the NHAIS system and ensure continuity of continuing NHAIS services required have been agreed with both DHCW and NHS Digital.

15 NHS England and NHS Digital are decommissioning NHAIS. NWSSP will be required, in 2022-23 to work jointly with DHCW to support these preparations, where necessary, on the system replacement options and Welsh requirements. NHS Digital plans to decommission the NHAIS in England as early as during 2022-2023. NHAIS will be replaced by a number of other systems and the Capita system will be the payments engine in NHS England for calculating general medical services payments. NHS Digital have developed the demographic registration and reporting systems required to replace NHAIS demographics functionality for NHS England. We plan to complete audit work on the IT controls over the Family Payment Practitioner System in our 2022-23 audit.

16 NWSSP have made progress to address prior year IT recommendations made for improvement and some of these remain in progress Further details of our findings and progress against actions for the NHAIS system agreed with Primary Care Services officers can be found in **Appendix 1**.

The Oracle FMS's IT controls support the production of information that is free from material misstatement, although the system should be disaster recovery tested

17 We have identified no significant IT application or infrastructure issues likely to result in a material misstatement within the Oracle FMS. However, we identified some issues that should be addressed by Shared Services in order to minimise the potential for future application and infrastructure system risks. The planned significant system upgrade to version 12.2.9 of the Oracle ledgers has been completed in October 2021. From our work in 2021-22, we have identified one recommendation to NWSSP for improvement. This is outlined below:

- the Oracle central team e-business services do not currently receive a regular confirmation of backup success or failures from Version 1, the software supplier. The Oracle central team should receive assurances from the supplier, Version 1, that full data and system backups are taken as planned should they be required in the event of a system continuity incident.

18 NWSSP should arrange an IT Disaster Recovery (DR) test as soon as practical later in 2022 on the new Oracle version to provide assurance plans work as intended and the incident recovery procedures work as intended and to confirm the Oracle system could be fully recovered in an emergency in a reasonable timeframe. We recommended in our work from 2020-21 that this should be completed but the scheduled tests in early 2022 was delayed. The annual Oracle IT Disaster Recovery test has not been run on the Oracle finance system since November 2019. The DR test was originally postponed due to Covid 19 and the need to focus all staff from the supplier (Version 1) and the CTeS on keeping the system working and ensuring staff had the necessary access. The DR test was then rescheduled for February 2022 but was again postponed due to storm Eunice.

19 NWSSP have made progress to address prior year IT recommendations made for improvement and some of these remain in progress. Further details of our findings and progress against actions for the Oracle FMS agreed with Shared Services can be found in **Appendix 1**.

The ESR Payroll's Shared Services system administration controls support the production of information that is free from material misstatement

20 The Electronic Staff Record (ESR) Payroll system is managed and hosted nationally by IBM on behalf of NHS England and NHS Wales under a managed service contract. We have reviewed the ESR Payroll systems administration controls (payroll elements only) managed by NWSSP. This responsibility includes managing user access to the payroll system in Wales by the NWSSP Employment Services staff who process the Welsh NHS organisations' payrolls. In addition to seeking to place reliance on the International Standard on Assurance Engagements (ISAE) 3000 report of the IBM Service Auditor noted below, Audit Wales IM&T auditors have reviewed the controls in place over the ESR Payroll systems administration managed under a delegated authority by NWSSP, Employment Services.

21 We have not identified any significant IT issues likely to result in a material misstatement within these ESR Payroll systems' administration controls. From our work in 2021-22, we have identified two recommendations to NWSSP for improvement. These are outlined below:

- during our audit fieldwork in March 2022, it was identified that there is only one ESR system administrator in place for a number of months since early 2022. This presents is a potential single point of failure as only one systems administration is in place. We were informed that recruitment for replacement would be commenced later in 2022. It is good practice to have at least two systems administrators to set up user access and to allow for cover should it be required also to be able to complete monitoring of payroll user accounts.
- There are a number of access security reports available in ESR, however these are not all used or currently reviewed infrequently or in response to a particular issue. The ESR system administration function should initiate weekly monitoring checks of the ESR access security reports in ESR and consider ways of automating the production and monitoring of these reports including exception reporting.

22 In 2020-21, we identified one recommendation for improvement for the ESR Payroll systems access controls. The NWSSP has made progress to address this action by:

- completing the six monthly control review of all payroll access to ESR User Resource Profiles (URPs) in December 2021 as planned due to COVID

disruptions. We were also made aware during our audit that Employment Services were completing the next review by June 2022.

23 We sought to place reliance on the ISAE 3000 report of the IBM Service Auditor, PwC, on the general IT controls applied at IBM. PwC conducted the review in accordance with the ISAE 3000 'Assurance Engagements Other Than Audits or Reviews of Historical Financial Information'. For the period 1 April 2021 to 31 March 2022, PwC concluded that the ESR payroll general IT controls and environment were suitably designed and operated effectively with the exception of the one area noted below. PwC qualified their opinion on one control objective covering the ESR system logical access security. Recommendations have been made in prior years for the NHS ESR Central Team and IBM to strengthen the IT controls around access security between the development and live payroll application environments. This control has been put in place by the ESR central Team in mid June 2021. PwC has not identified any other areas in their 2021-22 work for improvement or recommendations to the IT controls used by the NHS ESR Central Team and IBM.

24 Further details of our findings and progress against actions for the ESR Payroll systems administration control agreed with Shared Services can be found in **Appendix 1**.

Recommendations

25 **Exhibit 1** sets out the recommendations that we have identified in 2021-22. NWSSP should take action to address these recommendations. The appendix to this report also sets out progress made against all the previously reported recommendations that remain in progress and ones that have been completed in 2021-22.

Exhibit 1: 2021-22 recommendations

Recommendations
Prescription Pricing System
R 2021-22.01
Reduce the number of users with access to create, amend or delete user access to the prescription pricing system. Access to higher level or privileged accounts should be restricted to an appropriate number.
R 2021-22.02
Review user access rights to the prescription pricing system on a regular basis, for example, at least annually, to ensure that users have appropriate access rights, and that any potential leavers, or inactive users are identified and their access amended appropriately.
R 2021-22.03
Update the prescription pricing change control policy to record and confirm that it has been updated and include this in the document revision history.
R 2021-22.04
Update the Service Level Agreement (SLA) with DHCW to specifically name the prescription pricing system within its scope, update the document revision history and expected review dates, include details around the responsibilities and frequency in taking of data backups and monitoring the successful completion of backups.

Recommendations

NHAIS

No recommendations have been made on NHAIS in 2021-22

Oracle FMS

R 2021-22.05

Obtain a regular confirmations of backup success or failures from Version 1, the software supplier, that full data backups are taken as planned should they be required in the event of a system continuity incident. These assurances should be received regularly, for example, on a daily or weekly summary basis.

ESR Payroll system IT controls

R 2021-22.06

Increase the number of ESR system administrators in place to at least two separate user accounts. This reduces a potential single point of failure if only one systems administration is in place.

R 2021-22.07

Introduce regular monitoring checks by the ESR system administrators of the ESR access security reports available in ESR and consider ways of automating the production and monitoring of these reports including exception reporting.

Appendix 1

Issues and recommendations arising from the review of National Hosted NHS IT Systems in prior audit years and in 2021-22 – NHS Wales Shared Services Partnership

Exhibit 2: issues and recommendations from 2021-22

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**NWSSP responsibility**	**NWSSP actions & current status – June 2022**
Prescription Pricing System – IT controls work						
2021-22.01	During our fieldwork in March 2022 we identified that 29 users had access to create, amend or delete user access to the prescription pricing system. We consider this to be a very high number of users with this higher level access	Reduce the number of users with access to create, amend or delete user access to the prescription	Medium	Yes	Simon Johnson-Reynolds - Service Improvement Manager	**Management comment** **Completed** In the past the ability switch between live and test environments

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
	account to authorise and manage user accounts. It is good practice to restrict access to higher level or privileged accounts to an appropriate number of staff.	pricing system. Access to higher level or privileged accounts should be restricted to an appropriate number;				was completed with a separate Application (Admin DT) which required users requiring this function being in a System Access group. Since a new version of the processing app has been released that includes a function to change environments managed within the application negating the need for those users being in the SA group. As result the SA group has been reduced to just those

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
						in data capture support.
2021-22.02	We identified that a review of user access rights to the prescription pricing system does not take place on a regular basis, for example, at least annually. This is good practice to ensure that users have appropriate access rights, and that any potential leavers, or inactive users are identified and their access amended appropriately.	Review user access rights to the prescription pricing system on a regular basis, for example, at least annually, to ensure that users have appropriate access rights, and that any potential leavers, or inactive	Medium	Yes	Simon Johnson-Reynolds - Service Improvement Manager	**Management comment** PCS Business support have a leaver process where these individuals will be removed from systems via Access Control within the systems and Active Directory. Where users are

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
		users are identified and their access amended appropriately;				inactive due to sickness or maternity leave or secondment there isn't presently a policy removing access to systems. Consideration will need to be given to whether this practice would impact the services concerned when the users returned. However, an annual audit could be implemented where an active list of users is reviewed by Service leads to identify users that require action.

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
						Also PCS will need to follow an NWSSP corporate policy as connectivity via o365 maybe managed differently
2021-22.03	The prescription pricing system has a documented change control policy in place. We could not identify and confirm whether it has been updated recently. We understand the change control policy was last updated in 2017. It is good practice to have a review by date and confirm a review has taken place to evidence, even if no changes	Update the prescription pricing change control policy to record and confirm that it has been updated and include this in the document revision history.	Medium	Yes	Simon Johnson-Reynolds - Service Improvement Manager	**Management comment** **Completed** The Change Control Policy referred was a generic policy for PCS. The Data Capture team have specific well documented

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
	are required, that the control check has been undertaken.					procedures for version builds, testing and version release including a release log and since the visit a library of Standing Operating Procedures competed.
2021-22.04	A corporate wide Service Level Agreement (SLA) with Digital Health Care Wales is in place but it is high level and does not specifically name the prescription pricing system (whilst other IT systems are named) within its scope. In addition, it can be strengthened by adding a document revision history and	Update the Service Level Agreement (SLA) with Digital Health Care Wales to specifically name the prescription pricing system	Medium	Yes	Neil Jenkins – Chief Digital Officer	**Management comment** **Work in progress** The SLA is a corporate document, but we will request that it is updated as

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**NWSSP responsibility**	**NWSSP actions & current status – June 2022**
	expected review dates, including details around the responsibilities and frequency in taking of data backups and monitoring the successful completion of backups.	within its scope, update the document revision history and expected review dates, include details around the responsibilities and frequency in taking of data backups and monitoring the successful completion of backups.				suggested in the recommendation.
Oracle Financial Management System – IT controls work						

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
2021-22.05	We identified that the Oracle central team e-business services do not currently receive a regular confirmation of backup success or failures from Version 1, the software supplier. The Oracle central team should receive assurances from the supplier, Version 1, that full data and system backups are taken as planned should they be required in the event of a system continuity incident.	Obtain a regular confirmations of backup success or failures from Version 1, the software supplier, that full data backups are taken as planned should they be required in the event of a system continuity incident. These assurances should be received regularly, for example, on a	Medium	Yes	Stuart Fraser – Head, CTeS	**Management comment** **Work in progress** This matter is in hand and Version 1 working on either automatic alterations update or a reporting dashboard to confirm completion this is expected to be addressed by the end of August 2022.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**NWSSP responsibility**	**NWSSP actions & current status – June 2022**
		daily or weekly summary basis.				
ESR Payroll systems administration – IT controls work						
2021-22.06	During our audit fieldwork in March 2022, it was identified that there is only one ESR system administrator in place for a number of months since early 2022. This presents is a potential single point of failure as only one systems administration is in place. We were informed that recruitment for replacement would be commenced later in 2022. It is good practice to have at least two systems administrators to set	Increase the number of ESR system administrators in place to at least two separate user accounts. This reduces a potential single point of failure if only one systems	Medium	Yes	Samantha Graf – Head of People and Business Partnering	**Management Comment** **Completed** An additional 1 WTE Workforce Information Analyst appointed April 2022, bringing

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
	up user access and to allow for cover should it be required also to be able to complete monitoring of payroll user accounts.	administration is in place.				establishment to 2 WTE.
2021-22.07	There are a number of access security reports available in ESR, however these are not all used or currently reviewed infrequently or in response to a particular issue. The ESR system administration function should initiate weekly monitoring checks of the ESR access security reports in ESR and consider ways of automating the production and monitoring of these reports including exception reporting.	Introduce regular monitoring checks by the ESR system administrators of the ESR access security reports available in ESR and consider ways of automating the production and monitoring of	Medium	Yes	Samantha Graf – Head of People and Business Partnering	**Management Comment** **Work in progress** This will require development work through MO365 and potentially changes to cost centres. A scoping meeting will need to be arranged to

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
		these reports including exception reporting.				determine whether automation is possible. Capacity in RPA team may also be an issue.

Exhibit 3: issues and recommendations from prior audit years

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**NWSSP responsibility**	**NWSSP actions & current status – June 2022**
Prescription Pricing System – IT controls work						
2020-21.01	The last IT Disaster Recovery (DR) system test was in March 2020 and the IT DR plan dated March 2021 requires a testing schedule every two years. It is good practice to test the recovery of IT systems at least annually. The DR plan should be amended to document and require an annual testing requirement.	Test the Prescription Pricing systems IT Disaster Recovery (DR) plans at least annually. The DR plan should be amended to document and require an annual testing requirement.	Medium	Yes	Simon Johnson-Reynolds - Service Improvement Manager	**Completed** Test of the Prescription Pricing system IT Disaster Recovery was carried out on the 26/02/22. The DR plan has been updated to reflect the test, and that the DR plan is reviewed,

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**NWSSP responsibility**	**NWSSP actions & current status – June 2022**
						updated, and signed off annually.
National Health Application and Infrastructure Services – IT controls work						

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
2020-21.02	We identified during our fieldwork in April 2021 a number of issues with the NHAIS system administration access and review of user access activity: a) a system administrator who has left NWSSP has not had their user account deleted. b) the NHAIS user access log that records NHAIS user access and used to review user access to job functions has not been updated. This control has not been completed by the NHAIS systems administrator in 2020-21	Strengthen the NHAIS system administration access and review of user access and activity by: a) removing the system administration access account for the NHAIS systems administrator who has left NWSSP; b) updating the NHAIS user access log that records	High	Yes	Neil Jenkins - Head of Modernisation & Technical Services	**Complete** a)Administrator access account has been removed. b) User Access Log set up to a Unix file location not available to the system administrator. Resolution now in place and notification set up to ensure checks are undertaken monthly.

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
	and the access log could not be located. c) DHCW send a user access activity report to NWSSP NHAIS systems administrators to monitor access, the access report could not be located and the control has not been undertaken in 2020-21.	NHAIS user access and used to review user access to job functions; and c) reviewing the NHAIS user access activity report sent to NWSSP NHAIS systems administrators by DHCW to monitor user access.				C) System Administrator liaising with DHCW to access this report.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**NWSSP responsibility**	**NWSSP actions & current status – June 2022**
Oracle Financial Management System – IT controls work						
2020-21.03	CTES has completed and a gap analysis assessment of the Oracle FMS to the Information Security Management Standard (ISO 27001) to identify potential improvement areas. The outcome will be a set of recommendations for implementation during 2021-22. It is good security management practice to assess and baseline a comparison to the ISO 27001 standard.	Complete the accreditation to the Information Security Management Standard (ISO 27001) to identify potential improvement areas.	Medium	Yes	Stuart Fraser – Head of CTeS	**Work in progress** It was agreed by the All Wales Oracle (STRAD) Board in 2021 that this should be deferred due to high priority projects and in particular the requirement to complete the major Oracle system upgrade and that we will seek to obtain accreditation by 31

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
						December 2022. A dedicated project manager has been appointed to progress this action and good progress is now being made, with gap analysis underway and outcomes recorded.
2020-21.04	CTES provides FMS services to the consortium of Welsh NHS organisations. It is good practice IT service management to conform or be accredited to the Information Technology Service Management (ISO 20000) standard.	Complete CTES accreditation to the Information Technology Service Management (ISO 20000) standard for service management.	Medium	Yes	Stuart Fraser – Head of CTeS	**Work in progress** As above noted in recommendation 2020-21 – 03.

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
	CTES have completed the gap analysis and we were informed during our fieldwork that they aim to complete accreditation during 2021-22 cycle. CTES consider there are benefits to complete accreditation to the Information Technology Service Management (ISO 20000) standard for service management.					
2020-21.05	The last IT DR test was completed in November 2019 and the scheduled test in November 2020 was deferred due to disruptions	Complete the Oracle FMS IT Disaster Recovery (DR) test in 2021-22 as soon as is practically	High	Yes	Stuart Fraser – Head of CTeS	**Work in progress** It was agreed that a full Business

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
	caused the pandemic. We were informed during our fieldwork that the next scheduled IT DR test would not be until after both the Oracle version upgrade to 12.2.9 has been completed in October 2021 and the February 2022 Oracle patch release.	possible ensuring all NHS organisations attend the next scheduled test.				Continuity (BC) & DR test involving all Health Board & Trust Finance departments would be undertaken during a weekend in February 2022 across all FMS Services. This unfortunately had to be cancelled due to Storm Eunice and the operational issues that taking down the FMS ledger would have caused. This was rearranged initially for May after the

Issues identified during IT audit work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
						financial year end however this also needed to be cancelled by to Cardiff and Vale who formally requested we cancel the DR exercise as this clashed with a weekend power circuit infrastructure upgrade. It was agreed at the June 2022 all-Wales STRAD meeting that the DR review would be undertaken in November 2022.

ESR Payroll systems administration – IT controls work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
2019-20.01	Local HR staff manage access to the local HR side of the ESR payroll and those with HR administrator access for recruitment and applications can allocate payroll related User Resource Profiles (URP's). However, they are not permitted to use these roles and this access is restricted to approximately 2-3 staff per NHS organisation.	Establish a monitoring report of local HR administration staff that have allocated ESR users to payroll URP's when they are not permitted to. Monitor the report produced on a quarterly basis.	Medium	Yes	Angela Jones - Assistant ESR Programme Director, Workforce & OD	**Completed** URP reports are run from ESR on a quarterly basis for validation/amendments as appropriate. On completion, the URP access in ESR is updated. URPs are monitored across the organisation and not just for the payroll department.

ESR Payroll systems administration – IT controls work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
	It was identified during the audit fieldwork that there is no scheduled reporting or monitoring of this potential HR administration user activity.					This is incorporated into the Workforce Information Manager's business as usual work programme for continuity.
2020-21.06	The six monthly control review of all payroll access to ESR User Resource Profiles (URPs) was not completed in early 2021 as planned due to COVID disruptions. During our fieldwork in	Complete the six monthly control review of all payroll access to ESR User Resource Profiles (URPs). This was not completed in early 2021 as planned due to COVID disruptions and was last completed in October 2020.	Medium	Yes	Stephen Withers – Head of Payroll	**Completed** The six-monthly URP review has taken place in December 2021. The next audit is scheduled for July 2022.

ESR Payroll systems administration – IT controls work

Ref	Issue	Recommendation	Priority	Agreed	NWSSP responsibility	NWSSP actions & current status – June 2022
	April 2021 it was identified that the last review was in October 2020 and the next review was being planned for later in 2021. We were also made aware during our audit that Employment Services were considering strengthening this control to quarterly reviews thereafter.					

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NHS WALES SHARED SERVICES PARTNERSHIP

Audit Committee

July 2022

Audit & Assurance Services
Internal Audit Progress Report

CONTENTS Page

1. Introduction

The purpose of this report is to highlight the progress of the Internal Audit Plan to the Audit Committee and provide an overview of other activity undertaken since the previous meeting.

2. Outcomes from Finalised Audits

Three Internal Audit reports from the 2021/22 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings. The full versions of these reports are included on the agenda as separate items.

ASSIGNMENT	ASSURANCE RATING
Payroll	 Reasonable
Medical Examiner Service	 Reasonable

3. Planning and Delivery Update

2021/22

Work to deliver of the Internal Audit Plan for 2021/22 has been completed, with just the Capital Project Governance advisory review requiring finalisation. The assignment status schedule at Appendix A sets out the planned audit work for the year along with current progress.

The Head of Internal Audit Opinion and Annual Report has been issued giving an overall opinion of Reasonable Assurance and is included as a separate item on the agenda for this meeting.

2022/23

The Internal Audit plan for 2022/23 was approved at the April meeting of the Audit Committee. Work to deliver the plan has commenced, with five audits in the planning stage and two work in progress. The schedule of audit work for 2022/23 is set out at Appendix B.

4. Other Internal Audit Activity & Engagement

Ongoing liaison and planning meetings have continued to take place in this period including with Head of Finance & Business Development and the new Local Counter Fraud Manager. In addition, meetings with Directors and senior managers have taken place as part of the planning and delivery of individual audits.

Internal Audit representatives also attend meetings of the following:

- Health Roster Project Board
- Finance Academy All Wales P2P Group

5. Recommendation

The Audit Committee is invited to note the progress with the delivery of the Internal Audit Plan.

Appendix A: Assignment Status - 2021/22 Internal Audit Plan

Review	Status	Assurance Rating	Matters Arising			Audit Committee *planned
			High	Medium	Low	
Primary Care Contractor Payments	FINAL	Substantial		1	1	April 22
Payroll	FINAL	Reasonable	1	2		July 22
Procure to Pay (P2P)	FINAL	Reasonable	1	3	1	April 22
Medical Examiner Service	FINAL	Reasonable		3	1	July 22
Laundry Service	FINAL	Reasonable		6	3	October 21
Student Awards Follow up	FINAL	Reasonable		3		October 21
Legal & Risk Directorate	FINAL	Substantial		1		April 22
Stores	FINAL	Reasonable		3		January 22
Salary Sacrifice	FINAL	Substantial			2	January 22
Wales Infected Blood Support Scheme (WIBSS)	FINAL	Substantial		1		January 22
IM&T Infrastructure	FINAL	Limited	2	7		January 22
Single Lead Employer	FINAL	n/a	Advisory Review			June 21
Capital Project Governance	DRAFT	n/a	Advisory Review			*October 22**

Appendix B: Assignment Status - 2022/23 Internal Audit Plan

Review	Status	Assurance Rating	Matters Arising			Anticipated Audit Committee[1]
			High	Medium	Low	
Primary Care Contractor Payments						April 23
Payroll						April 23
Procure to Pay (P2P)						April 23
Procurement: Local Procurement	Planning					Jan 23
Health Courier Service	Work in Progress					Oct 22
Surgical Materials Testing Laboratory (SMTL)	Planning					Oct 22
Laundry Service	Planning					Oct 22
Recruitment Services	Planning					Oct 22
Cyber Security						Jan 23
Decarbonisation	Work in Progress					Jan 23
Operational ICT Infrastructure Follow up						April 23
Student Awards	Planning					Jan 23
Risk Management and Assurance Mapping						Jan 23

[1] May be subject to change

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Medical Examiner Service
Final Internal Audit Report

June 2022

NHS Wales Shared Services Partnership

Audit and Assurance

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

Contents

Review reference:	NWSSP-2122-09
Report status:	Final
Fieldwork commencement:	7th January 2022
Fieldwork completion:	9th May 2022
Draft report issued:	30th May 2022
Debrief meeting:	1st June 2022
Management response received:	31st May 2022
Final report issued:	1st June 2022
Auditors:	Henry Wellesley, Audit Manager
Executive sign-off:	Ruth Alcolado, Medical Director Andrew Evans, Director of Primary Care Services
Distribution:	Jason Shannon, Lead Medical Examiner Daisy Shale, Lead Medical Examiner Officer
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.

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

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Executive Summary

Purpose

The overall objective of this audit was to assess the governance and management arrangements within the new Medical Examiner Service.

Overview

Overall, we can confirm that the Medical Examiner Service has in place a formal structure with appropriate governance arrangements, whilst mandatory training and continued professional development processes have been embedded.

Three medium priority matters were identified in relation to the continued need to meet staffing statutory requirements, the updating of procedure documents and the inclusion of identified KPI's within quarterly returns.

The overall assurance rating of Reasonable is given.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Assurance objectives		Assurance
1	Progress of the service implementation programme	Reasonable
2	Policies and procedures	Reasonable
3	Mandatory training and continuing professional development	Substantial
4	Governance arrangements	Reasonable

Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Service Staff Recruitment	1, 4	Operation	Medium
2	Standard Operating Procedures	2	Operation	Medium
3	Key Performance Indicators	4	Operation	Medium
4	Complaints Process	4	Operation	Low

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 A review of the Medical Examiner Service has been completed in line with the agreed 2021/22 Internal Audit Plan. The Executive lead for this review was the Director of Primary Care Services and Medical Director.

1.2 The Medical Examiner Service ('the Service') was established in January 2021 following the recognition that an independent scrutiny of a death allows the cause of death to be more accurately identified, and the circumstances surrounding the death to be more objectively assessed in order to identify any concerns about the treatment or care provided that may require further investigation.

1.3 The Service provides independent scrutiny of all deaths that occur in Wales that are not immediately taken for investigation by Her Majesty's Coroner. Scrutiny is undertaken by a Medical Examiner - an experienced doctor with additional training in death certification and the review of documented circumstances of death. Medical Examiners, and their officers, will ensure that an accurate cause of death is recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration.

1.4 Medical Examiner Officers are hosted by NHS Wales Shared Services Partnership (NWSSP) and work peripatetically within the service. The seven health boards in Wales link into one of four hub sites in Wales, which are managed by a Senior Medical Examiner Officer (SMEO). The UK Government initially set a deadline for the full statutory implementation of the service by 1st April 2022. Whilst the Service has been operational and covering all areas of Wales in a phased implementation rollout since 1st January 2021, it does not currently have the capacity to scrutinise all deaths in Wales due to the impact of COVID-19 on engagement and implantation parts of the process. It is anticipated that the UK Government will postpone the deadline for full implementation of the Service from Summer 2022 (the latest official deadline) until April 2023, to reflect the impact of Covid has had on implementing the Service across England and Wales.

1.5 The Medical Examiner Service in Wales is split across four hub sites, which are based at the centre of each area:

North Wales	**7,000 Average Deaths per year**
Betsi Cadwaladr Health Board	
Mid & West Wales	**6,000 Average Deaths per year**
Hywel Dda Health Board	
Swansea Bay Health Board	
South Wales Central	**5,000 Average Deaths per year**
Powys Health Board	
Cwm Taf Morgannwg Health Board	
South Wales East	**9,000 Average Deaths per year**
Cardiff & Vale Health Board	
Aneurin Bevan Health Board	

1.6 Health Boards either scan and send notes to the Medical Examiner offices, or allow remote access to clinical systems, which are then reviewed and scrutinised by the Medical Examiner Service.

1.7 The risk considered in the review was as follows:

- the Service is not operating effectively or in line with the UK Government requirements due to poor governance arrangements and/or lack of Medical Examiner training, potentially resulting in reputational damage to NWSSP or the NHS Wales health bodies it serves.

2. Detailed Audit Findings

Objective 1: Arrangements are in place to progress the Service implementation programme in line with UK Government deadlines

2.1 The Service was due to be fully implemented during 2021. However, following the issuing of the National Medical Examiner bulletin in February 2022, it was noted that the requirement of a statutory medical examiner systems to be in place within organisations was expected to be introduced before Summer 2022. The delayed implementation was due to the impact of Covid-19 on acute and primary care services.

2.2 The Department of Health and Social Care (DHSC) has estimated that for approximately 3,000 deaths a medical examiner system will require the equivalent of one whole time equivalent (WTE) Medical Examiner (ME), supported by 31 WTE Medical Examiner Officers (MEOs). We can confirm that a full management structure compliant with that recommended by the DHSC was in place for the Medical Examiner Service (see Table A) and was reported in the Shared Services Partnership Committee in November 2021.

Region	MEs In Structure	MEs In-post (WTE)	SMEOs In Structure	SMEOs In-post (WTE)	MEOs In Structure	MEOs In-post (WTE)
North Wales	2.3	7.0	1.0	0	6.5	6.0
Mid & West Wales	2.7		1.0	1.0	7.5	4.0
South Wales Central	2.0		1.0	1.0	5.5	5.22
East Wales	3.0		1.0	1.0	8.5	4.7
Management Office			1.0	0		
TOTAL	**10.0**		**5.0**		**28.0**	
VARIANCE		**-3.0**		**-3.0**		**-8.08**

ME – Medical Examiner
SMEO – Senior Medical Examiner Officer
MEO – Medical Examiner Officer
In Post as at 08/03/22

Table A

2.3 Current figures, as at March 2022, show that the Service has not yet been fully recruited with the statutory requirement to have a full complement of employees in place by the Summer of 2022. In addition, the Service has not been fully rolled out into the Primary Care sector. The NWSSP integrated medium term plan (IMTP) for 2022-25 summarises the recruitment challenges and action to be taken across the whole organisation. However, we were also unable to identify a detailed plan or paper to identify the recruitment strategy or process to ensure remaining posts were filled prior to the Summer 2022. **[Matter Arising 1]**

2.4 A Datix module is used for administering and monitoring the Service through the allocation of cases and performance monitor of the Service, as well as individual MEOs and MEs. This allows the Lead ME and Lead MEO to obtain data from the system to the monitor the Service and report the required information to the National Medical Examiner for England and Wales.

Conclusion:

2.5 We have concluded Reasonable assurance for this objective due to the Service not having a full complement of employees in order to meet the statutory requirement.

Objective 2: Policies and procedures have been developed, approved, and communicated to employees, Health Boards and stakeholders, where appropriate

2.6 The Service has in place 43 Standard Operating Procedures (SOPs) that had been developed and made available to staff via the SharePoint site.

2.7 A review of a sample of SOPs identified the use of a document version management system in place to record the version, review date, issued and approving officers. However, this system was not evident on all documents, with a number of SOPs out of date for review, whilst others required updating to ensure the documents were fully complete. In addition, no timetable or register was in place to aid in the regular reviewing of SOPs. **[Matter Arising 2]**

Conclusion:

2.8 We have concluded Reasonable assurance for this objective, as the Service has procedures in place that require reviewing and updating.

Objective 3: The Medical Examiners and Medical Examiner Officers complete mandatory training and continuing professional development activities relevant to their roles

2.9 MEs must complete 26 core e-learning modules before they can be appointed, with the remainder of the e-learning programme to be completed within one year of appointment for MEs. The ME and MEO e-learning programme was commissioned by the DHSC and is delivered by Learning for Health. MEs are required to complete face-to-face training available from the Royal College of Pathologists within six months of appointment. Once appointed, MEs should undertake continual professional development activities relevant to their role

2.10 MEOs are required to complete a training and competence portfolio that has been produced by the Royal College of Pathologists and is made up of four key modules, with the training logs being retained on file. At the time of the audit 25 MEOs were in post with five having been in post for more than 24 months. Evidence was obtained and confirmed that the five MEOs had completed the training programme within the designated period. MEOs are also expected to complete face-to-face training available from the Royal College of Pathologists within six months of appointment. Once appointed, MEOs should undertake continual professional development activities relevant to their role

2.11 Whilst the training of MEOs is monitored and signed off by the Lead MEO, a different approach is taken with MEs, who are expected to monitor their own continued professional development and highlight any learning points they may have in their one-to-ones with the Lead ME.

Conclusion:

2.12 We have concluded Substantial assurance for this objective.

Objective 4: Appropriate governance arrangements have been established for the operation of the Service

2.13 The Service is hosted by NWSSP and has an organisational structure in place identifying the managerial and professional reporting arrangements in place (see Table A).

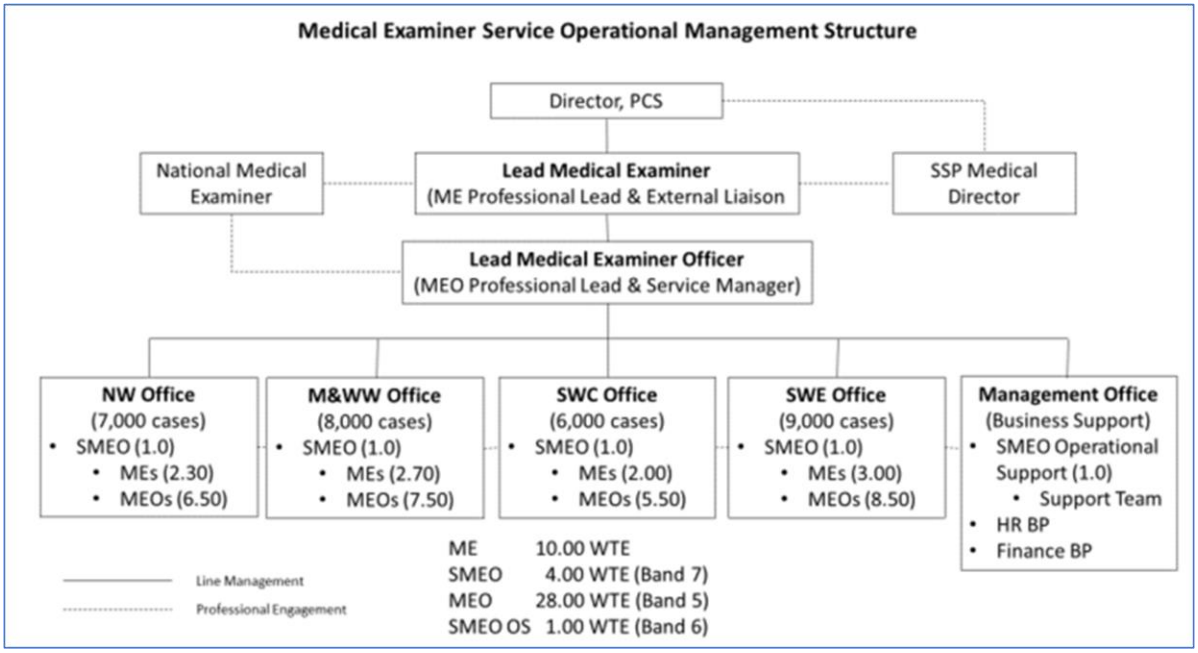

Table A

2.14 The operational performance of the Service is monitored daily by the Lead MEO who is responsible for addressing MEO/process or case related matters, whilst the Lead ME would address clinical issues. The Lead ME submits a quarterly performance report to the National Medical Examiner in a prescribed report format. A review of the Quarter 3 performance report 2021-22 supported that this action had been completed.

2.15 The Service also reports internally via quarterly performance reviews and we were able to confirm that monthly KPIs had been reported. We also understand that Performance Reporting will be a standing item on the Formal Senior Management Team agenda from April 2022 onwards.

2.16 There was a risk register in place for the Service and was last updated in January 2022. However, the risk register did not include the risk of the Service not being fully recruited and compliant with statutory requirements by the Summer 2022. **[Matter Arising 1]**

2.17 The *Implementing the Medical Examiner System Good Practice Guide* advises that key performance indicators are established to monitor the performance of the system, such as turnaround times, complaints, coroner concerns. A review of the Quarter 3 Service Performance Report 2021-22 did not include these performance indicators in the report. **[Matter Arising 3]**

2.18 The *Implementing the Medical Examiner System Good Practice Guide* states that a complaints process should be in place that allows 'timely escalation' and a mechanism for receiving and responding to complaints about a medical examiner office.

2.19 We can confirm that a corporate complaints system is in place within NWSSP to capture this information. To date there have been no formal complaints about a medical examiner office in Wales. Whilst we can confirm contact details for key members of the Service were on the

NHS Wales Medical Examiner website, we could not locate a direct link for a member of the public to submit a complaint. **[Matter Arising 4]**

Conclusion:

2.20 We have concluded Reasonable assurance for this objective due to a key risk not recorded on the risk register and identified KPIs not being listed in the quarterly returns.

Appendix A: Management Action Plan

Matter Arising 1: Service Staff Recruitment (Operation)	**Impact**
Current figures, as at March 2022, show that the Service has not yet been fully recruited with the statutory requirement to have a full complement of employees in place by the Summer of 2022. In addition, the Service has not been fully rolled out into the Primary Care sector. The NWSSP integrated medium term plan (IMTP) for 2022-25 summarises the recruitment challenges and action to be taken across the whole organisation. However, we were also unable to identify a detailed plan or paper to identify the recruitment strategy or process to ensure remaining posts were filled prior to the Summer 2022. Whilst we can confirm that a risk register was in place for the Service, and was last updated in January 2022, we were unable to see an entry in regard of the Service not being fully recruited and compliant with statutory requirements by the Summer 2022.	Potential risk of: • Service is not operating effectively or in line with the UK Government requirements due to poor governance arrangements and/or lack of Medical Examiner training, potentially resulting in reputational damage to NWSSP or the NHS Wales health bodies it serves.

Recommendations	**Priority**
1.1 Management should establish whether a recruitment strategy has been formulated and implemented to ensure individuals are recruited into the remaining posts within the Service in order to meet the statutory requirements set out by the UK Government.	**Medium**
1.2 Management should ensure the risk register and assess the risk of vacancies remaining within the Service and the need to achieve full capacity to meet statutory requirements.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Agreed – a recruitment plan and strategy has been put in already in place and recruitment is underway to recruit to the full establishment for Medical Examiner Officers (completed May 2022) and Medical Examiners. Start dates will vary depending on notice periods required but all will be filled by September 2022 in order to meet the DHSC statutory phase deadline from April 2023.	30th September 2022	Lead ME and Lead MEO

1.2 Agreed – the risk has been added to the Risk Register (31/5/22) with mitigating actions included, i.e. recruit to full establishment by September 2022	31st May 2022	Programme Director

Matter Arising 2: Standard Operating Procedures (Operation)	**Impact**
The Service has in place 43 SOPs that had been developed and made available to staff via the SharePoint site. A review of a sample of SOPs identified the use of a document version management system in place to record the version, review date, issued and approving officers. However, this system was not evident on all documents, with a number of SOPs out of date for review, whilst others required updating to ensure the documents were fully complete. In addition, no timetable or register was in place to aid in the regular reviewing of SOPs.	Potential risk of: • Service is not operating effectively or in line with the UK Government requirements due to poor governance arrangements and/or lack of Medical Examiner training, potentially resulting in reputational damage to NWSSP or the NHS Wales health bodies it serves.
Recommendations	**Priority**
2.1 Management should undertake a review the SOPs to ensure: • all out of date procedures are promptly addressed; • the use of a document version management system is evident on all procedural documents for consistency; and • they reflect systems and processes currently in place.	**Medium**
2.2 Management should consider the introduction of a timetable to ensure the regular and timely reviewing of the SOPs.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**

2.1 Agreed – to ensure the management of SOPs, a Business Manager will be appointed to manage this process	30th June 2022	Lead MEO
2.2 Agreed – to ensure the regular and timely reviewing of SOPs, a standing item will be added to the Senior Management Team agenda	1st July 2022	Business Manager

Matter Arising 3: Key Performance Indicators (Design)		**Impact**
The *Implementing the Medical Examiner System Good Practice Guide* advises that key performance indicators are established to monitor the performance of the system, such as turnaround times, complaints, coroner concerns. A review of the Quarter 3 Service Performance Report 2021-22 did not include these performance indicators in the report.		Potential risk of: • Service is not operating effectively or in line with the UK Government requirements due to poor governance arrangements and/or lack of Medical Examiner training, potentially resulting in reputational damage to NWSSP or the NHS Wales health bodies it serves.
Recommendation		**Priority**
3.1 Management should include key performance indicator highlighted in the Good Practice Guidance within future quarterly service reports.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Agreed – the Quarterly Reports will be amended to capture the advised KPIs that fall within the remit of the Medical Examiners Service.	1st July 2022	Programme Director (Business Manager when appointed)

Matter Arising 4: Complaints Process (Design)	**Impact**
Whilst we can confirm contact details for key members of the Service were on the NHS Wales Medical Examiner website, we could not locate a direct link for a member of the public to submit a complaint. We feel the complaints procedure would be enhanced if this was in place.	Potential risk of: • Service is not operating effectively or in line with the UK Government requirements due to poor governance arrangements and/or lack of Medical Examiner training, potentially resulting in reputational damage to NWSSP or the NHS Wales health bodies it serves.
Recommendation	**Priority**
4.1 To further enhance the engagement of the Service, consideration should be given in providing guidance on how members of the public can submit a complaint on the NHS Wales Medical Examiner Service website.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
4.1 Agreed – a Complaints Procedure will be included in the Service Booklet and on the Service Web Site	1st July 2022	Programme Director

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. 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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Employment Services – Payroll
Final Internal Audit Report

June 2022

NHS Wales Shared Services Partnership

NWSSP Audit and Assurance

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

Contents

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Auditors:	Gareth Heaven, Audit Manager Adam Cranswick, Audit Manager
Executive sign-off:	Gareth Hardacre, Director of People, OD & Employment Services
Distribution:	Darren Rees, Deputy Director of Employment Services Stephen Withers, Head of Payroll Modernisation & Bursary
Committee:	Velindre University NHS Trust Audit Committee for NWSSP

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.

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Executive Summary

Purpose

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Payroll Services.

Overview

The design and operation of controls for the administration of Payroll Services are generally satisfactory. We have therefore concluded **Reasonable** assurance overall.

Findings identified this year are consistent with the previous audit, with no new issues to report.

There is one high priority matter arising relating to pension contribution rates which originates from the 2020/21 audit. Whilst action has been taken, sample testing identified that the issue remains. Further detail is provided at paragraph 2.23. We also identified two medium priority matters arising relating to:

- review of exception report; and
- timeliness of initiating action to recover overpayments.

Full details are provided in Appendix A.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved	⇔

Assurance summary[1]

	Assurance objectives	Assurance
1	Pre-employment checks are completed in a timely manner	Substantial
2	Gross payments to staff are timely and accurate	Reasonable
3	The establishment of the DHCW and NWSSP payrolls	Substantial
4	Overpayments are accurately recorded and recovered promptly	Reasonable
5	Implementation of previous internal audit report management actions	Reasonable

Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Exception Reporting	2	Design	Medium
2	Overpayments	4	Operation	Medium
3	Pension Contribution Rates	5	Design	High

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 A review of the Payroll Services function provided to NHS Wales health bodies by NHS Wales Shared Services Partnership (NWSSP) was completed in line with the 2021/22 Internal Audit Plan. The relevant lead for the assignment was the Director of People, Organisational Development & Employment Services.

1.2 Recruitment and Payroll Services activity significantly increased during the COVID-19 pandemic, with 33% more vacancies raised in 2021/22 compared to 2018/19, and a 19% increase in the number of staff processed by Payroll during the period April 2020 – December 2021.

1.3 The Payroll Service function was split across five teams at four sites:

Matrix House, Swansea	**Companies House, Cardiff**
Swansea Bay University Health Board (SBUHB)	Aneurin Bevan University Health Board (ABUHB)
Powys Teaching Health Board (PTHB)	Cardiff & Vale University Health Board (CVUHB)
Alder House, St Asaph	Cwm Taf University Health Board (CTUHB)
Betsi Cadwaladr University Health Board (BCUHB)	Public Health Wales (PHW)
Welsh Ambulance Service NHS Trust (WAST)	Velindre NHS Trust (VNHST)
Hafen Derwen, Carmarthen	Health Education & Improvement Wales (HEIW)
Hywel Dda University Health Board (HDUHB)	Digital Health & Care Wales (DHCW)
	NHS Wales Shared Services Partnership

1.4 The risks considered in the review were as follows:

- incomplete pre-employment checks potentially impacting on patient safety and/or resulting in non-compliance with the NHS Employment Standards;
- payments to staff are incorrect or not processed in a timely manner, potentially resulting in reputation damage to NWSSP and/or financial loss to customer organisations; and
- overpayments are not recovered resulting in financial loss to the customer organisation.

2. Detailed Audit Findings

Objective 1: Pre-employment checks are undertaken by NWSSP for new starters appointed via the TRAC system and are completed in a timely manner

2.1 Pre-employment checks should be completed for new starters in line with the NHS Employment Check Standards to verify that the individual meets the requirements of the role they have applied for. These checks are undertaken by NWSSP Recruitment Services on behalf of NHS Wales and recorded in the TRAC system, except for 'direct hires' and medical/dental staff which remain the responsibility of the appointing organisation.

2.2 Sample testing of new starters to confirm completion of pre-employment checks by NWSSP Recruitment Services identified no issues.

Conclusion:

2.3 Noting the above, we have concluded **Substantial** assurance for this objective.

Objective 2: Gross payments to staff are timely and accurate, with only employees of the organisation being paid

Starters, Leavers and Changes

2.4 A total sample 405 new starters, leavers and changes processed during the period February 2021 to January 2022 was verified to supporting documentation to confirm approval by the health body, the appropriateness and accuracy of processing by Payroll Services. No issues were identified. The previous audit highlighted the variation in enrolment, termination and change forms received by the Payroll Teams across Wales. There is also inconsistency in the use of Manager Self Service (MSS) within ESR, for example to process leavers and certain changes to assignment details. The same was observed this year, with 241 New Appointment Forms (NAF)/ Payroll Instruction Forms (PIF) and 94 manual forms identified within the sample.

2.5 Variation stems from legacy arrangements when Payroll services first transferred to NWSSP. The Payroll Modernisation Programme is exploring options for achieving standardisation of processes across NHS Wales and use of digital solutions to improve efficiency and drive cost savings. Recognising the work ongoing, no further recommendations are raised.

2.6 A new Microsoft Forms version of the NAF and PIF forms were introduced during 2021/22. Our sample included five instances where the Forms based NAF had been corrupted following the transfer of data to the new SharePoint system, so we were unable to verify the information in ESR to the source document to confirm accuracy. The validity of four of these new starters was confirmed as pre-employment checks had been completed. Management assured that this issue has been resolved with no further corrupted files identified.

Payroll Checking Processes

2.7 There are three elements to the payroll checking process:

- accuracy checks: checking the accuracy of data input into ESR, at the point of input
- completeness checks: period end checks to ensure that all starters, leavers, and changes processed on ESR during the period are supported by appropriate documentation
- exception reporting: using defined parameters to identify and investigate potential erroneous payments

2.8 Following input into ESR all forms (electronic or paper-based) should be signed as input and independently checked to confirm accuracy of processing. Our testing identified instances where the form had not been signed to evidence independent accuracy checking. We were advised that this is due to remote working arrangements and payroll documents being checked electronically. This will be addressed as part of the ongoing review of payroll checking processes (see paragraph 2.10 below). Consequently, no finding is raised.

2.9 The previous audit highlighted variation in the completeness checking arrangements across the five Payroll teams. The same was observed in this review, with some teams not doing completeness checks due to need to prioritise resources to manage the increased service demand. We were advised that reliance was placed on the effectiveness of the input accuracy checking process, and KPI data demonstrates a consistently high accuracy rate for 2021/22:

Payroll Accuracy	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
All Wales Average	99.94%	99.89%	99.82%	99.87%	99.87%	99.94%	99.90%	99.90%

Source: All Wales KPI NWSSP Payroll Accuracy Tracker 2021-22

2.10 We previously recommended that management explore options for automating the checking process to reduce the volume of manual checks required. At the time of reporting, management had commenced a review of payroll checking processes with a view to rationalising the checking requirements and achieving consistency across all teams. Recognising the accuracy rates and action ongoing to review existing arrangements, no further findings are raised.

2.11 Sample testing of 39 exception reports (three per organisation) identified instances four instances where these had not been evidenced as checked at all, 11 had only been partially checked and 13 had not been signed by a supervisor to independently confirm completion of checks. **[Matter Arising 1]**

Payroll Feeds and Data Flows

2.12 Walkthrough testing of payroll feeds and data flows observed satisfactory checking controls in place to confirm the completeness of data transfer into ESR.

2.13 In some cases manual timesheets / payroll returns (Powys, DHCW and PHW) and absence returns (Aneurin Bevan) continue to be submitted to Payroll for manual input into ESR. Sample testing to check the accuracy of processing identified no issues.

Covid Bonus Payment

2.14 In March 2021, the Welsh Government (WG) announced that a gross bonus payment of £735 would be made to staff working in the NHS in Wales that fell within the set criteria. Eligible current and former employees were identified from staff-in-post lists and cost analysis reports, with checks undertaken to ensure eligible individuals who had worked for more than one eligible organisation (both within and outside of NHS Wales) only received one payment. We were advised that the payments were input into ESR via dataload and subject to the standard payroll feed checking controls referred to at paragraph 2.10.

Conclusion:

2.15 We have concluded **Reasonable** assurance due to non-compliance with the exception reporting checking process.

Objective 3: The process for establishing the new Digital Health & Care Wales (DHCW) and NWSSP payrolls was robust, with checking arrangements to ensure the completeness and accuracy of employee payroll data transferred within the ESR system

2.16 Two new payrolls were created during 2021/22 for the newly established DHCW (April 2021) and the transfer of NWSSP employees from Velindre payroll to a new NWSSP payroll (June 2021). The IBM 'Management of Change' (MOCPD) process was followed and captured in a MOCPD project plan document first used for and updated to reflect lessons learned from the former Abertawe Bro Morgannwg / Cwm Taf University Health Boards boundary realignment in April 2019.

2.17 A review of the MOCPD process was undertaken to ensure the required steps had been completed to ensure the completeness and accuracy of employee data had been transferred. We can confirm that the MOCPD plans for the establishment of the DHCW and NWSSP payrolls had been signed and dated by the actioning officers and retained on file. In addition, a sample of key process steps was selected, and evidence provided to support the completion of the tasks to ensure the accuracy of data transfer to the new VPDs.

Conclusion:

2.18 We have concluded **Substantial** assurance for this objective.

Objective 4: Overpayments are accurately recorded and recovered promptly

2.19 The previous Payroll audit report (NWSSP-2021-08) highlighted an inconsistent approach across NHS Wales organisations and Payroll teams. An all-Wales Overpayments Policy has been drafted but has not yet been approved.

2.20 Overpayment registers are maintained for each health body. Sample testing of 60 overpayments for the period February 2021 to January 2022 noted that all had evidence on file to demonstrate action taken to recover monies. However, we identified 27 instances where there were delays of more than five weeks between

identification of the overpayment and initiating action to recover. **[Matter Arising 2]**

Conclusion:

2.21 We have concluded **Reasonable** assurance for this objective due to the delays in initiating action to recover overpayments.

Objective 5: Agreed management actions arising from the previous internal audit report have been implemented

2.22 Previous recommendations have been followed up as part of the current audit fieldwork set out under objectives 1-4 above, with the current status summarised in the table below. New recommendations have been raised where appropriate (detailed in Appendix A) and supersede those raised in the previous Payroll review (NWSSP-2021-08).

Ref	Finding	Priority	Status
1	Availability of Payroll Documentation	Medium	Implemented *Supporting documentation received for all starters/leavers/changes sampled*
2	New Appointment Form	Medium	Action Ongoing *See paragraph 2.6 above* *No further recommendations raised*
3	Timeliness & Accuracy of Processing	Medium	Implemented *No issues identified for the starters/leavers/changes sampled*
4	Pre-Employment Checks	Medium	Superseded *Risk related to COVID response period and is no longer prevalent*
5	Payroll Checking Processes	Medium	Action Ongoing *See paragraphs 2.10 – 2.11 above*
6	Exception Reporting	Medium	Previous Issue Not Addressed *See paragraph 2.11 above, and Matter Arising 1*
7	Overpayments	Low	Action Ongoing *See paragraphs 2.19 – 2.20 above, and Matter Arising 2*
8	Pension Contribution Rate	High	Previous Issue Not Addressed *See paragraphs 2.23-2.24 below, and Matter Arising 3*

2.23 Management advised that IBM released an *Automatic Pension Reassessment* release to resolve the system issue causing incorrect pension contribution rates however, this was unsuccessful. As a temporary measure, the Pensions team run monthly reports to identify where manual adjustments are required.

2.24 We sampled 30 employees enrolled on the NHS Pensions Scheme to establish whether the employee pension contribution rate stated on their December 2021

payslip was correct for their band and pay point. We noted eight instances where the pension contribution rate was incorrect. **[Matter Arising 3]**

Conclusion:

2.25 We have concluded **Reasonable** assurance for this objective, recognising that action is ongoing to address issues identified.

Issues Outside of the Control of NWSSP

The following issues have been identified which are outside of NWSSP control but are reported here for management information:

New Appointment Form & Payroll Instructions Form

2.26 Full implementation of the NAF and PIF forms needs to be progressed with customer organisations. These forms provide additional controls to improve data quality and reduce the risk of fraud, compared to paper-based forms.

Timely Notification of Leavers

2.27 Of the 135 terminations sampled, 19 were received by Payroll after the employee had left the organisation and resulted in four overpayments with the value of £6,344. Late notification of leavers results in overpayments, creating unnecessary additional work for the Payroll Teams and Finance Teams within the client organisations.

Appendix A: Management Action Plan

Matter Arising 1: Exception Reporting (Design)	**Impact**
A sample of 39 months (three per organisation) was reviewed for the period February 2021 to January 2022 to ensure exception reports had been produced and reviewed. Concluding testing, we identified the following: • four instances where exception reports had not been evidenced as checked at all; • 11 instances where exception reports had been partially checked; and • 13 instances where exception reports had not been signed by a supervisor to independently confirm completion of checks.	Potential risk of: • incomplete pre-employment checks potentially impacting on patient safety and/or resulting in non-compliance with the NHS Employment Standards • payments to staff are incorrect or not processed in a timely manner, potentially resulting in reputation damage to NWSSP and/or financial loss to customer organisations
Recommendation 1	**Priority**
1.1 Exception reports must be fully reviewed and evidenced as such, to ensure that erroneous payments are identified and prevented/recovered.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 We acknowledge the finding of the audit report, we have implemented a new checking process that has been adopted across Wales, it is embedded in the Payroll Process schedule and will be checked that all Exceptions reports are checking and signed by a member of the Payroll Team. We are piloting with the teams an automated checking report, whereby the information is extracted from all documents, NAF, PIF, EEF and match electronically with the data in ESR, this will produce a Power BI report of the checks undertaken for audit purposes that are correct, any discrepancy will be checked by the Team and probity to the process.	01/06/2022	**Head of Payroll Modernisation**

Matter Arising 2: Overpayments (Operation)		**Impact**
The previous Payroll audit report (NWSSP-2021-08) highlighted an inconsistent approach across NHS Wales organisations and Payroll teams. An all-Wales Overpayments Policy has been drafted but has not yet been approved. Overpayment registers are maintained for each health body. Sample testing of 60 overpayments for the period February 2021 to January 2022 noted that all had evidence on file to demonstrate action taken to recover monies. However, we identified 27 instances where there were delays of more than five weeks between identification of the overpayment and initiating action to recover.		Potential risk of: • overpayments are not recovered resulting in financial loss to the customer organisation
Recommendation 2		**Priority**
2.1 Management should ensure all overpayments are promptly actioned following notification from the client organisation.		**Medium**
2.2 Management should progress in agreeing and approving the drafted all-Wales Overpayments Policy to ensure a consistent approach is implemented across all Payroll Teams.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 We acknowledge the finding of the audit report, due to the unprecedented volume of work in the team, including the acknowledgement of audit of the increased workload of 18%. Staff in the overpayments team were diverted to ensure payrolls were completed. We are working with the Manager of the service to ensure that overpayments letters are expedited in future. It should be noted that where there has been an overpayment this is actioned at the point of discovery, so it does not perpetuate any further overpayments and any necessary changes are made in ESR, the delay here is on the administration side of issuing the letters.	30/06/2022	Head of Payroll Modernisation
2.2 We acknowledge the finding of the audit report, the All-Wales Overpayments Procedure has been completed, it has been out for consultation with the Finance Colleagues and Counterfraud and the details of the responses will be discussed on how to progress this.	30/06/2022	Head of Payroll Modernisation

Matter Arising 3: Pension Contribution Rates (Design)		**Impact**
A sample of 30 employees who were enrolled on the NHS Pensions Scheme were selected and tested to ensure their pension contribution listed on their payslip as of December 2021 accurately matched the contribution rate. Of the 30 employees tested, we noted that eight individual pension contribution rates were incorrect.		Potential risk of: • payments to staff are incorrect or not processed in a timely manner, resulting in reputation damage to NWSSP and/or financial loss to customer organisations
Recommendation 3		**Priority**
3.1 Management should ensure pension contribution rates are reviewed and promptly updated to reflect any changes following an in-year pay increase.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**

3.1 We acknowledge the finding of the audit report, a fix to this issue was deployed by IBM in RN469 Release 49.0.0.0 and 49.1.01.01 Automatic Pension Reassessment, however the fix deployed by IBM did not work, IBM are aware of this and due to the impending changes to the NHS Pensions Regulation, the system will be modified in October 2022 to accommodate this change. It should be noted that in October each year, there is an automatic reassessment of Pension Tiers undertaking in ESR. It is accepted by IBM and NHSBA Pensions Agency of this process. This process checks to see if staff have changed bands or have had additional enhancements, it then evaluates what pension tier they should be on and updates their record in ESR, it is not retrospective, the change is only updated from the date of assessment, where the tier has been changed there is no recovery of over or underpayments of Pension Contributions and this does not affect the employees' pension. Due to the changes in Pensions Legislation that is being implemented on 01.10.2022 This will include the fix to the Automatic Pension Reassessment process previously deployed. This process will review the Pension tier for each member of the NHS Pension scheme before every payroll run to check the correct status of the employee's tier banding to ensure they are correct, in the meantime the team has been reminded to check the Increment Report an action appropriately, once the fix is deployed it will eradicate the manual workaround mentioned. It should be noted that this finding does not affect any pensionable pay for members as stated in para two, when Staff retire their pension is based on their TPP not the % tier contribution.	01/07/2022 for the manual workaround 01/10/2022 for the automated IBM deployment	Head of Payroll Modernisation

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

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Final Head of Internal Audit Opinion & Annual Report 2021/2022

June 2022

NHS Wales Shared Services Partnership

Contents

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Author:	Head of Internal Audit
Executive Clearance	Head of Finance & Business Development
Audit Committee	July 2022

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1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

The Managing Director of NHS Wales Shared Services Partnership (NWSSP) is accountable to the Shared Services Partnership Committee (SSPC) for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

As a result of the continued impact of COVID-19 our audit programme has been subject to change during the year. In this report we have set out how the programme has changed and the impact of those changes on the Head of Internal Audit opinion.

1.2 Head of Internal Audit Opinion 2021-22

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Managing Director as Accountable Officer and the SSPC which underpin the assessment of the effectiveness of the system of internal control. The approved internal audit plan is biased towards risk and therefore NWSSP will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

The overall opinion for 2021/22 is that:

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.

1.3 Delivery of the Audit Plan

Due to the considerable impact of COVID-19 on NWSSP, the internal audit plan has needed to be agile and responsive to ensure that key developing risks are covered. As a result of this approach, and with the support of management, the plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by

the Audit Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2021/22 year was initially presented to the Committee in April 2022. Changes to the plan have been made during the course of the year and these changes have been reported to the Audit Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken other NHS Wales organisations, particularly, Digital Health & Care Wales (DHCW) that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors (in 2018), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work continues to 'generally conform' to the requirements of the Public Sector Internal Audit Standards for 2021/22. For this year, as in 2020/21, our QAIP has considered specifically the impact that COVID-19 has had on our audit approach and programmes. We are able to state that our service 'conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, and in part reflecting the impact of COVID-19, we also undertook a number of advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2021/22

Substantial Assurance	Reasonable Assurance
• Primary Care Services Contractor Payments • Legal & Risk Directorate • Welsh Infected Blood Support Service • Salary Sacrifice Scheme	• Procure to Pay • Payroll Services • Stores • Student Awards • Laundry Services • Medical Examiner
Limited Assurance	**Advisory/Non-Opinion**
• NWSSP Operational ICT Infrastructure	• Single Lead Employer • Capital Project Governance (Draft)
No Assurance	
• N/A	

Please note that our overall opinion has also taken into account both the number and significance of any audits that have been deferred during the course of the year (see section 5.7) and also other information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Managing Director of NHS Wales Shared Services Partnership is accountable to the Shared Services Partnership Committee (SSPC) for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;

- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Managing Director, on behalf of the Partnership Committee, through the Audit Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Shares Services Partnership Committee which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist NWSSP in the completion of its Annual Governance Statement and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2021/22 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations where appropriate. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight assurance domains that were used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of Opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

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

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there was one audit in 2021/22).

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2021/22 and reported to the Audit Committee has been aggregated at Section 5.

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

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).
- 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 (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of key meetings; meetings with Executive Directors, senior managers; the results of ad hoc work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the NHS Wales Shared Services Partnership.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively with robust control arrangements operating in some areas.

From the opinions issued during the year, four were allocated Substantial Assurance, six were allocated Reasonable Assurance and one was allocated Limited Assurance. No reports were allocated a 'no assurance' opinion. In addition, two advisory or non-opinion reports were also undertaken.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below.

NATIONAL AUDITS

The assurance ratings from the national transaction system audits are a key component of the overall NWSSP opinion.

- **Primary Care Services Contractor Payments** - This audit was given a Substantial Assurance rating overall. Three of the four areas, Pharmacy & Prescribing Services, General Dental Services and General Ophthalmic Services individually given substantial assurance with General Medical Services given reasonable assurance with a recommendation made in relation to the submission of capitation reports.

- **Procure To Pay** - The audit was given a reasonable assurance rating. Individual objectives each received either reasonable or substantial assurance, although a high priority recommendation rating was made relating to the need to establish the root causes of invoices on hold.

- **Payroll Services** - The audit was given a reasonable assurance rating. The audit highlighted that the design and operation of controls for the administration of Payroll Services were generally satisfactory. Findings identified in this year's audit are consistent with the previous audit, with no new issues reported. One high priority finding relating to pension contribution rates was again identified having also been noted in the 2020/21 audit. Whilst action has been taken, sample testing identified that the issue remained. The audit also identified two further medium priority matters arising relating to the review of exception reports and timeliness of initiating action to recover overpayments.

NWSSP AUDITS

The majority of these audits were given either Reasonable or Substantial Assurance, although one audit during 21/22 was given a Limited Assurance rating.

- **Legal & Risk Directorate Review** was given Substantial Assurance demonstrating a strong control environment in the areas covered.
- **Salary Sacrifice Scheme Audit** was given Substantial Assurance again demonstrating a strong control environment.
- **Wales Infected Blood Support Scheme** - Substantial Assurance was given to this audit covering the administration and management of the scheme including good progress with the implementation of previous recommendations.
- **Stores** – Reasonable Assurance was given to this audit covering adequacy of the systems and controls in place over the management of inventory at both NWSSP Stores and External Storage facilities.
- **Student Awards – Follow Up** – Reasonable Assurance – It was identified that progress has been made with five of the six previous recommendations made including the two high priority recommendations.
- **Laundry Service** – Reasonable Assurance - This baseline audit for the new national Laundry Service hosted by NWSSP covered a high-level overview of existing governance and management arrangements. This initial review has focussed on the arrangements in place at Llansamlet Laundry, with the recommendations made including formalising business continuity arrangements, pricing and invoicing arrangements, recording of absence and PADRs.
- **Medical Examiner Service** – Reasonable Assurance – The audit confirmed that the Medical Examiner Service has in place a formal structure with appropriate governance arrangements. Medium priority recommendations were raised in statutory staffing requirements, the updating of procedure documents and the inclusion of identified KPI's within quarterly returns.
- Limited assurance was given to the audit of **NWSSP Operational ICT Infrastructure**. The audit covered controls in place for the infrastructure (including the Core Hyper-V infrastructure and Telephony) used by NWSSP and did not include the management of national systems. A number of control weaknesses were identified including a lack of resilience and security issues with the telephony system, a number of old infrastructure items that contained vulnerabilities and a lack of visibility for NWSSP IT into the infrastructure and its management. Management have agreed actions to address the recommendations made, with a follow up audit has been included within the approved audit plan for 22/23 to review the implementation of agreed recommendations.

- Two non-opinion audits / advisory assignments were also undertaken during the year covering **Single Lead Employer** and **Major Capital Project Governance**.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

For the second year in a row, due to the impact of COVID-19, we are aware that it has been more difficult than usual for NHS organisations to implement recommendations to the timescales they had originally agreed. In addition, we also recognise that for new recommendations it may be more difficult to be precise on when exactly actions can be implemented by. However, it remains the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

Going forward, given that it is very likely that the number of outstanding recommendations will have grown during the course of the pandemic, audit committees will need to reflect on how best they will seek to address this position.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

As part of the governance arrangements within NWSSP an audit recommendation tracker was in operation during 2021/22. This is monitored and reported to Audit Committee on a regular basis, providing the ongoing position of recommendations implemented and the level of recommendations still to be actioned.

As part of the Internal Audit work during 2021/22 we followed up on recommendations made during a previous audits of both Student Awards and the Wales Infected Blood Support Scheme, and highlighted good progress having been made with the implementation of recommendations in booth audits.

2.4.4 Limitations to the Audit Opinion

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.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-19 on this year's (and to an extent last year's) programme makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2021/22 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of organisation's Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be

legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2021/22.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit & Risk Committee that it has conducted its audit at NHS Wales Shred Services Partnership in conformance with the Public Sector Internal Audit Standards for 2021/22.

Our conformance statement for 2021/22 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2021/22 which will be reported formally in the Summer of 2022; and
- the results of the work completed by Audit Wales.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2021/22 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the SSPC need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the

SSPC's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO NWSSP

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at Digital Health & Care Wales.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to NWSSP. These audits derived the following opinion ratings:

Audit	Opinion	Objective
Welsh Radiology Information System	Reasonable	To provide assurance over the adequacy of the processes in place in DHCW for the management of the WRIS and the data within it.
Data Centre Transition	Substantial	To evaluate and determine the adequacy of the processes in place in DHCW for the management of the Data Centre move and the current Data Centre Service.
Data Analytics (Information)	Reasonable	To provide assurance to DHCW that arrangements are in place to enable NHS Wales to maximise the use of analytics in an appropriate and secure manner.
System Development	Reasonable	To provide assurance over the adequacy of the processes in place in DHCW for securely developing and

		maintaining applications for NHS Wales.
GP System Procurement Project	Substantial	To provide assurance over the GP System Procurement project to ensure that appropriate project governance is in place, that stakeholders are fully engaged and that there is clarity over costs and benefits.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2022/23 operational audit plan.

The revised audit plan approved by the Committee in April 2021 contained 15 planned reviews. Changes have been made to the plan with two audits audit added and four deferred/cancelled. All these changes have been reported to and approved by the Audit Committee. As a result of these agreed changes, we have delivered 13 reviews.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the organisation. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed. The key performance indicators are summarised in the table below.

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2020/21	G	April	By 30 June	Not agreed	Draft plan	Final plan

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Total assignments reported against adjusted plan for 2020/21	G	*100%*	*100%*	*v>20%*	*10%<v< 20%*	*v<10%*
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	*92%*	*80%*	*v>20%*	*10%<v< 20%*	*v<10%*
Report turnaround: time taken for management response to draft report [15 working days]	G	*92%*	*80%*	*v>20%*	*10%<v< 20%*	*v<10%*
Report turnaround: time from management response to issue of final report [10 working days]	G	*100%*	*80%*	*v>20%*	*10%<v< 20%*	*v<10%*

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 33 audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings

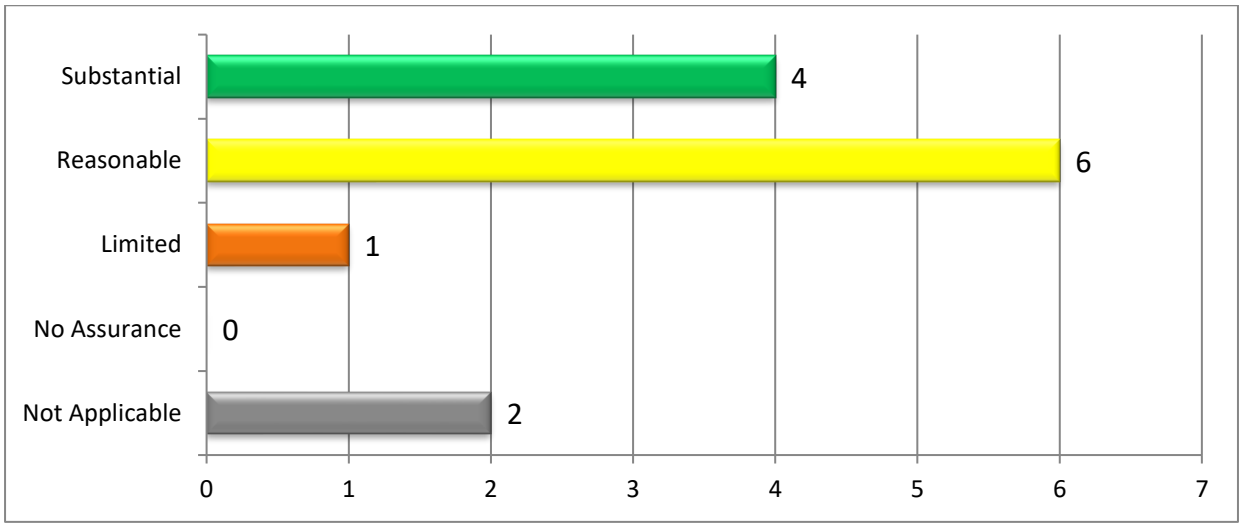

Figure 2 above does not include the audit ratings for the reviews undertaken at DHCW.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. In some cases, the impact of COVID-19 was the reason for the deferral or cancellation and in other cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Primary Care Services Contractor Payments	The overall objective of the review was to evaluate and determine the adequacy of controls in place to administer timely and accurate payments to primary care contractors.
Legal & Risk Directorate	The purpose of the review is to establish whether appropriate arrangements are in place for the

Review Title	Objective
	governance and performance and risk monitoring of the Legal and Risk Services Directorate.
Wales Infected Blood Support Service	The overall objective of this audit was to review the arrangements in place for the administration and management of the Wales Infected Blood Support Scheme (WIBSS).
Salary Sacrifice Scheme	The overall objective of this audit is to assess the adequacy and effectiveness of the arrangements in place for the administration of salary sacrifice schemes.

5.3 Reasonable Assurance (Yellow)

In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Procure to Pay	The purpose of the audit review was to evaluate and determine the adequacy of the systems and controls in place over the management of the NWSSP Procure to Pay (P2P) service.
Stores	To evaluate and determine the adequacy of the systems and controls in place over the management of inventory at both NWSSP Stores and External Storage facilities.
Student Awards	To assess progress in implementing the recommendations arising from the 2020/21 internal audit review (report NWSSP-2021-15 refers).
Laundry Services	To provide a baseline for the new national Laundry Service hosted by NWSSP since April 2021, and a high-level overview of existing governance and management arrangements, focusing on the Llansamlet Laundry.
Payroll	The overall objective of this audit was to evaluate and determine the adequacy of the systems and

Review Title	Objective
	controls in place for the management of Payroll Services.
Medical Examiner	The overall objective of this audit was to assess this new service, to provide a baseline position of the governance and management arrangements.

5.4 Limited Assurance (Amber)

In the following review areas the Board can take only **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.

Review Title	Objective
NWSSP ICT Operational Infrastructure	To evaluate the controls in place for the ICT Operational Infrastructure (including the Core Hyper-V infrastructure and Telephony) to ensure that it is secure, reliable and fit for future developments and needs.

5.5 No Assurance (Red)

No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate, but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Single Lead Employer	The overarching objective of the non-opinion review was to undertake a review of Phase 1 to identify improvements and to assist in ensuring that the Programme overall meets its objectives.
Project Governance	Advisory review covering the adequacy of arrangements for managing major capital projects.

5.7 Deferred Audits

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion. As there were audits deferred during the year, two audits were added to the plan as a result of discussion with Management. These adjustment to the plan were subject to approval at the Audit Committee during the year.

Review Title	
Counter Fraud	A review of certain fraud controls was included with the Procure to Pay Audit.
Agile Working Advisory	The current position with the ongoing developments and assessment of future agile working requirements.
Procurement Front Line Teams	Pressures with the Procurement function associated with the impact of the Covid-19 pandemic.
Decarbonisation	Deferred based on changes to national deadlines and requirements

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the NHJS Wales Shared Services Partnership to support delivery of the Internal Audit assignments undertaken within the 2021/22 plan.

James Johns

Pennaeth yr Archwiliad Mewnol/Head of Internal Audit

Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership

June 2022

Appendix A

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit

	Quality Manual. There is structured liaison with Audit Wales and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition, audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management, it would be discussed and will be escalated to Board level for resolution.

Appendix B - Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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

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Quality Assurance and Improvement Program 2021/22

Internal Audit Report

July 2022

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

Contents

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Executive sign off:	Neil Frow, Managing Director NWSSP
Distribution:	Audit Committee Chairs and Board Secretaries
Committee:	Velindre University NHS Trust Audit Committee for NWSSP 13 July 2022

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.

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 agreed audit brief and the Audit Charter, as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales 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 NHS Wales Shared Services Partnership 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

This paper sets out the Quality Assurance and Improvement Programme (QAIP) for 2021/22 and the approach and work for 2022/23.

The QAIP is a requirement of the Public Sector Internal Audit Standards (PSIAS).

2. Approach

The Audit & Assurance Service Quality Manual states:

"The Director of Audit & Assurance must develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity (Standard 1300). This should include internal and external assessments (standards 1311 and 1312)."

In 2018 we had the mandatory External Quality Assessment (EQA) which was undertaken by The Chartered Institute of Internal Auditors (the organisation that sets the International Standards for Internal Audit). As EQAs are required at least once every five years, we will need to have another one in place by March 2023 at the latest.

The internal assessments cover:

1. Quality Reviews - organisation focussed reviews to ensure each NHS organisation and Head of Internal Audit and the Specialist Services Unit (SSu) are covered (Section 2.1)
2. Internal Audit Quality Assurance Framework (IAQAF) (2.2)
3. EQA Action Plan (2.3)

In addition, there will be other information that supports the QAIP:

4. Results of Audit Satisfaction Surveys (a survey is sent after each audit) (2.4)
5. Key performance Indicator Outcomes (2.5)
6. Audit Committee assessments of their own effectiveness that include Internal Audit (2.6)
7. Audit Wales review (AW) (2.7)
8. Head of Internal Audit/Head of SSu 'Conformance Statements' (2.8)
9. Formal meetings with Chairs of Audit Committees and Board Secretaries (2.9)

Other relevant Information (2.10 & Sections 3.1 to 3.2).

2.1 Quality Reviews

A total of 25 audit files were reviewed. These were chosen from the list of completed outputs at 31 January 2022 (note: 25 out of 300 delivered audits for 2021/22 equates to 8.3%).

The sample of 25 covered:

- two reviews per Health Board and WAST (16 reviews),
- one review at PHW, Velindre University NHS Trust and HEIW (3 reviews)
- two reviews at DHCW and NWSSP (4 reviews) including one audit at each organisation that is used to inform the annual opinion work at other NHS Wales organisations
- two reviews of audits undertaken by our Capital & Estates team (2 reviews).

All four regional audit teams had files reviewed as did both of our specialist teams – Capital & Estates and Digital & IT.

There were three audits undertaken for WHSSC and EASC – none of these have been reviewed in 2021/22.

Details of the 25 audit files reviewed are shown in the following table.

No.	Health Body	Audit (code)	Team	Rating
1	Aneurin Bevan	Putting Things Right (AB-2122-11)	South East	Reasonable
2	Aneurin Bevan	Pathology (AB-2122-23)	South East	Reasonable
3	Betsi Cadwaladr	Standards of Business Conduct – Declarations (BCU-2122-6)	North Wales	Limited
4	Betsi Cadwaladr	Integrated Service Boards (BCU-2122-07)	North Wales	Limited
5	Cardiff & Vale	UHB Core Financial Systems (CVU-2122-03)	South Central	Substantial
6	Cardiff & Vale	Clinical Audit (CVU-2122-15)	South Central	Limited
7	Cwm Taf Morgannwg	Continuing Healthcare (CHC) (CTMU-2122-36)	South Central	Reasonable
8	Cwm Taf Morgannwg	Vaccinations (CTMU-2122-11)	South Central	Substantial
9	Hywel Dda	Financial Planning, Monitoring & Reporting (HDU-2122-04)	South West	Reasonable
10	Hywel Dda	Welsh Language Standards (HDU-2122-12)	South West	Limited
11	Powys	Access to Systems (PTHB-2122-13)	Digital & IT	Reasonable
12	Powys	Theatres Utilisation (PTHB-2122-15)	South Central	Reasonable
13	Swansea Bay	Procurement & Tendering (SB-2122-15)	South East	Limited
14	Swansea Bay	COVID-19 Review (Advisory) (SB-2122-09)	South East	N/A
15	WAST	Financial Planning & Budgetary Control (WAST-2122-02)	South East	Reasonable
16	WAST	Medicines Management – Controlled Drugs (WAST-2122-10)	South East	Reasonable
17	PHW	Screening Services	South Central	Substantial
18	Velindre	Infection Prevention & Control (VT-2122-10)	South East	Reasonable

19	HEIW	Recruitment	South Central	Reasonable
20	DHCW	Corporate Transitional Plan – Integration of Services (DHCW-2122-11)	South East	Reasonable
21	DHCW	Project Assurance (DHCW-2122-06) National audit	Digital & IT	Substantial
22	NWSSP	Stores (NWSSP-2122-04)	South West	Reasonable
23	NWSSP	Primary Care Services (NWSSP-2122-13) National audit	South West	Substantial
24	Aneurin Bevan	Tredegar Health & Wellbeing Centre (SSU-ABU-2122-01)	Capital & Estates	Reasonable
25	Swansea Bay	Waste Management (SSU-2122-SB-05)	Capital & Estates	Reasonable

The reviews comprise:

1). Checking that the audit file has completed correctly and fully

2). Reviewing evidence to support the completion of the checklist

3). Product reading of the final report/output

4). Follow-up questions with HIAs/Leads

5). Production of a summary note.

Overall, the results were positive and demonstrated a high level of quality consistent with recent years. However, in a small number of instances, discussions were needed with the Head of Internal Audit to confirm findings and minor exceptions were noted. The results of the reviews will continue to be built into both the 'TeamMate' audit software approach and our ongoing training around audit quality.

The exceptions, communicated to the Heads of Internal Audit/Head of Specialist Services in April 2022, are covered at Appendix C.

On the basis of the reviews undertaken, there were no specific matters that needed to be reported in the Annual Head of Internal Audit opinion in terms of compliance with the PSIAS.

2.2 Internal Audit Quality Assurance Framework (IAQAF)

One section of four has been reviewed, "Purpose & Positioning". See Appendix A for an explanation of this approach and Appendix B for the detailed assessment underpinning this review.

For this section, the review was undertaken by the Director of Audit & Assurance with support from the Heads of Internal Audit.

The section covers five areas, each with a number of good practice statements. For each area, Audit & Assurance needs to decide whether, in terms of the statements, it conforms fully, generally, partially or not at all. Conforming fully or

generally is considered appropriate to be able to state that the PSIAS are being complied with. The summary results are:

- Remit (4 statements) – 'fully conforms'
- Reporting Lines (7 statements) – 'fully conforms'
- Independence (9 statements) 'fully conforms'
- Risk Based Plan (2 statement) – 'fully conforms'
- Integration with other service providers (4 statements) – 'fully conforms'.

Despite being able to self-assess as fully conforming, we have identified three actions to support continuous improvement:

- updates have been made to our audit planning approach for 2022/23
- updates have been made to the text of the Audit Charter for 2022/23
- updating our audit strategy document to capture our IMTP and Quarterly Performance Review submissions.

The specific actions to address these points have been discussed and agreed with key stakeholders – Board Secretaries and Chairs of Audit Committees.

2.3 External Quality Assessment Follow-Up

In February and March 2018 Audit & Assurance Services were subject to a formal External Quality Assessment. This assessment is required by the PSIAS and was undertaken by The Chartered Institute of Internal Auditors (IIA). Their report was presented to the Velindre Audit Committee for Shared Services on 24 April 2018.

The assessment concluded that:

"It is our view that NWSSP Audit and Assurance Services conforms to all … 64 fundamental principles … and it is therefore appropriate for NWSSP Audit and Assurance Services to say in reports and other literature that it '**conforms to the IIA's professional standards and to PSIAS**.'

There were two specific areas of focus/recommendations from the 2018 EQA:

1). Audit coverage – links to strategic objectives and risks and other assurance providers

All Heads of Internal Audit focused on this during audit planning for 2021/22 as far as the impact of COVID-19 allowed, and we continued to work effectively with Audit Wales to understand the focus of each other's work. We also changed our planning approach for 2021/22 to reflect the fact we are no longer required to undertake any Welsh Government mandated work. There is still further work for some organisations to undertake to ensure that their Board Assurance Frameworks (BAF) clearly identify the work of other assurance providers and the strength of the first and second lines of defence. We included time within each

audit plan for 2021/22 (and for 2022/23) to consider the ongoing effectiveness of the BAF. We are also implementing a suite of Quality and Outcome focused KPIs for 2022/23 and beyond that will include measures such as the % of time spent on corporate risks.

2). Achieving efficiency in the audit methodology

As a part of our Integrated Medium-Term Plan (IMTP) for 2021/22 and 2022/23 we are developing a new Electronic Working Papers systems to support increased efficiency and effectiveness. Until we complete that work, we have decided not to change our audit methodology unless there are changes to the PSIAS that we need to respond to.

We will provide an update on our response to the EQA and our work on Quality KPIs in next year's QAIP.

2.4 Audit Satisfaction Surveys

Audit satisfaction surveys are sent out at the conclusion of each audit. Response rates are relatively low although they are improving, and they do differ by organisation. Copies of the survey are retained on the individual audit files. A summary of the response rates and findings are included in each Head of Internal Audit Opinion.

In addition, we receive feedback through regular meetings with both HB/Trust Executives and Audit Committees.

We continue to work with health bodies to improve the response rates to the surveys as this can be a key driver in helping to improve the focus and outcomes of audits.

2.5 Key Performance Indicators

At the end of May 2022 (when all Final opinions were issued), revised KPIs for 2021/22 showed:

KPI	SLA	Target	Overall
Audit plans agreed [2021/22]	√	100%	100%
Audit opinions/annual reports compiled [2021/22]	√	100%	100%
Audits reported over total planned audits *	√	95%	98%
Work in progress *	No	N/A	2%

Report turnaround fieldwork to draft reporting [10 days]	√	80%	95%
Report turnaround management response to draft report [15 days]	√	80%	70%
Report turnaround draft response to final reporting [10 days]	√	80%	99%

*Due to the impact of COVID-19 we delivered 304 outputs (Final and Draft reports). There were 58 reviews that were cancelled or postponed. In a few cases, work was in progress, but this was on the basis that the work would not form part of the 2021/22 annual opinions.

In 2021/22 we delivered 304 outputs (299 in 2020/21) to support the Head of Internal Audit Opinions and other reporting for the 13 NHS Bodies we audit (7 Health Boards, 3 Trusts, HEIW, DHCW, and NWSSP).

There were changes agreed to the plans of all NHS bodies during the course of the year with audits and reviews being added and removed. In all cases, these changes were approved by the relevant Audit Committee.

In terms of the delivery of the audit programme we are often asked to delay reviews until late in the financial year. We are happy to accommodate this, but it does mean that we sometimes need to use contractor staff to ensure delivery which does increase costs. The KPIs for each organisation are reported in each progress report and in their individual Head of Internal Audit Opinion.

2.6 Audit Committee self-assessments

Each year, Audit Committees will produce an annual report of their own activities and undertake a self-assessment against key criteria set out in the HFMA Audit Committee Handbook. Results of this work, which includes an assessment of Internal Audit, are used to help inform Audit & Assurance's forward strategy at both a Directorate and individual HB/Trust/SHA level.

2.7 Audit Wales review

Each year, Audit Wales undertakes an overview of Internal Audit as part of their work programme. In their Management Letter to NWSSP for 2021/22, Audit Wales have confirmed that they "did not identify any issues regarding (Internal Audit's) compliance with the PSIAS standards that would prevent us taking assurance from their work."

In addition, the Director of Audit & Assurance meets regularly with both Audit Wales NHS leads and the Velindre University NHS Trust audit team to ensure that

internal audit's work is co-ordinated, where appropriate, with the work of Audit Wales. Heads of Internal Audit also meet regularly with the relevant Audit Wales leads for each Health Board, Trust and Special Health Authority to ensure work is co-ordinated effectively.

2.8 Conformance self-assessments

Each year, all Heads of Internal Audit/SSu complete a self-assessment against the PSIAS which is submitted to the Director of Audit & Assurance for review. After review, the self-assessments are discussed with the relevant Head of Internal Audit/SSu if there are any matters requiring attention.

Overall, there are very few highlighted areas of 'partial compliance' (and none of 'does not comply') from the self-assessments either from ticking a specific box or from the narrative. This is in line with previous years and reflects, in part, the successful outcome of the External Quality Assessment in March 2018.

The only areas of identified partial conformance related to:

1). The HIA not interacting directly with the Board (function delegated to Audit Committee);

2). Still more to do on training & development, linked to better use of IT and data analytics;

3). Considering whether specialist teams need more of an understanding of the overall governance arrangements at each NHS Wales organisation; and

4). Assessing the costs of assurance in relation to the potential benefits.

In terms of actions against each of these areas we propose/are already doing:

1). The only action we take formally on this is to note it as the PSIAS assume 'delegation' of some key roles.

2). We continue to use all available non-pay funds for additional training and development (some teams and our Audit Leadership Team have had bespoke training and we have begun a process of 'Insight' training). We also recruited an additional IM&T auditor to increase our data and IM&T capacity and capability (now have a team of 3).

3). Beginning with the COVID-19 governance reviews in 2020 which were delivered through combined audit and specialist teams, we have built in more time for specialist staff to understand fully the wider governance and assurance arrangements at each NHS Wales organisation; and

4). In 2021/22 as part of a move to a more added value approach we have delivered a number of all-Wales summary reports to further the sharing of good practice and common issues. We are looking at introducing more outcome focused based KPIs and we will be undertaking specific work in a couple of areas to measure the cost and impact/benefits of assurance work. In addition, internal monitoring of the IMTP for 2022/23 within NWSSP will include a focus on costs versus benefits for all services/Directorates. To

support us with all this work we have appointed a Business Support Manager who joined us in May 2022.

2.9 Formal meetings with Chairs of Audit Committees and Board Secretaries

During 2021/22 the Director of Audit & Assurance met with the Board Secretaries and Chairs of Audit Committee groups on the following occasions:

- Board Secretaries: 30 April 2021, 30 July 2021, 24 September 2021, 22 October 2021, 19 November 2021, 28 January 2022, 18 February 2022, and 8 April 2022.
- Chairs of Audit Committee: 9 June 2021, 6 October 2021, and 9 February 2022.

Areas discussed included:

- Progress on the 2021/22 audit programmes
- Format of the annual opinion for 2021/22
- Summary Reports on areas such as IT Baseline Assessments, Control of Contractors, Fire Safety, and Water Management
- Changes to the approach for audit planning for 2021/22 and 2022/23
- Recommendation monitoring and tracking
- Quality based KPIs
- Themes emerging from audit work across NHS Wales
- 3rd Party assurances from within NHS Wales e.g. DHCW, NWSSP, WHSSC, and EASC
- Audit resources and the Service Level Agreement
- Internal Audit's IMTP.

The Director of Audit & Assurance also met with the Directors of Finance on 16 July 2021, 21 January 2022, and 18 March 2022. These meetings were focussed, in the main, on progress with the 2021/22 audit plans, IMTP targets and key messages/themes emerging from audit work.

To further strengthen the links between Audit & Assurance and the finance function across NHS Wales, the Director of Audit & Assurance is a member of the Finance Academy Governance Steering Group.

In addition, there is a small sub-group of Board Secretaries who meet regularly with the Director of Audit & Assurance and with Audit Wales to discuss and support areas of focus. Finally, a small governance steering group has been set up that brings together the Chair of the Board Secretaries, the Chair of the Directors of Finance and the Director of Audit & Assurance to ensure any cross-cutting themes/areas can be considered collectively.

Further meetings with these key peer groups are planned in 2022/23. In addition, the Director of Audit & Assurance has also met with a number of Chairs, Chief Executives, Finance Directors, Executive Directors and full Boards during the

course of the year.

2.10 Audit Approach

During 2021/22 we made a small number of changes to our audit approach. These covered:

- The process for forming the annual opinion for 2021/22, including the presentation of the opinion and annual report
- The process for putting together an annual plan for all NHS Wales organisations.

Due to the uncertainty around COVID-19 we prepared a number of papers for the Board Secretaries (as we did in 2020/21) on what our approach would be if we were unable to complete sufficient audit work to give a full annual opinion. Ultimately, we were able to complete sufficient audit work at each NHS Wales organisation to give a full annual opinion, so these contingency measures did not have to be implemented.

In terms of our approach for 2021/22 audit programmes we continued with the approach adopted in 2020/21 which focuses on six key components – some annual work that will support the effective delivery of an internal audit service, risk-based work, follow-up, national audits, work supporting key peer/stakeholder groups and Integrated Audit & Assurance plans for key capital/transformational schemes.

To support these changes to both the opinion and planning aspects of our work, the Director of Audit Assurance continued to work with the Board Secretaries sub-group. This group has proved effective in helping to bring forward the changes to the audit approach.

There were no other changes to our audit approach in 2021/22.

3. Other Quality Assurance and Improvement Areas

3.1 Wider role of Director of Audit & Assurance/Heads of Internal Audit

The Director of Audit & Assurance is an observer on the Public Sector Internal Audit Standards Advisory Board and a member of the Wales Public Sector Heads of Internal Audit Forum. He is also an Independent Member of the Audit Committee of Bristol City Council. One of the Heads of Internal Audit is a member of Caerwent Community Council in Monmouthshire.

3.2 QAIP Approach for 2022/23

The QAIP approach for 2022/23 will include (in addition to the standard areas):

1. Preparation for and the undertaking of the External Quality Assessment (EQA)
2. Follow up of previous QAIPs
3. Reporting on the implementation of the new set of quality based KPIs

Appendix A: IAQAF

HM Treasury has put together an Internal Audit Quality Assessment Framework (IAQAF) – published May 2013 – to "help evidence effective internal auditing in line with the Public Sector Internal Audit Standards. If the Standards are followed appropriately, this should enable internal auditors to state that their work is 'conducted in conformance with the International Standards for the Professional Practice of Internal Auditing."

The IAQAF is intended to apply to all government internal audit services where compliance with the Public Sector Internal Audit Standards (PSIAS) is required. The definition of an internal audit service will vary depending on the arrangements in place for the particular government body. For NWSSP, the appropriate definition is a group internal audit service with an overall assessment being made on the quality of the internal audit provided to the bodies that the group audits.

Where an internal audit service is provided by an integrated group the assessment should be performed on the group service as a whole, with specific reference to a representative sample of bodies to which the group service is provided. The results of the assessment should then be shared with each of the individual bodies that receive a service from the group.

The Framework has four sections reflecting four questions that the evaluation seeks to address:

- Purpose and positioning – Does the internal audit service have the appropriate status, clarity of role and independence to fulfil its professional remit?
- Structure and resources – Does the internal audit service have the appropriate structure and resources to deliver the expected service?
- Audit execution – Does the internal audit service have the processes to deliver an effective and efficient internal audit service?
- Impact – Has the internal audit service had a positive impact on the governance, risk and control environment within the organisation?

Each section is divided into several sub-sections covering key elements of an effective internal audit service as follows:

Purpose and positioning	**Structure and resources**	**Audit execution**	**Impact**
• Remit • Reporting lines • Independence • Risk based plan • Assurance strategy • Other assurance providers	• Competencies • Technical training & development • Resourcing • Performance management • Knowledge management	• Management of the IA function • Engagement planning • Engagement delivery • Reporting	• Standing and reputation of internal audit • Impact on organisational delivery • Impact on governance, risk, and control

For each sub-section a series of statements of good practice are provided as a guide in determining the performance of the service. Against this an assessment should be made as to the degree of conformance using the following scale, aligned with the PSIAS:

- **Fully Conforms** the reviewer concludes that the internal audit service fully complies with each of the statements of good practice.
- **Generally Conforms** means the reviewer has concluded that the relevant structures, policies, and procedures of the internal audit service, as well as the processes by which they are applied, at least comply with the requirements of the section in all material respects. For the sections and sub-sections, this means that there is general conformance to a majority of the individual statements of good practice, and at least partial conformance to the others, within the sub-section. As indicated above, general conformance does not require complete/perfect conformance
- **Partially Conforms** means the reviewer has concluded that the internal audit service falls short of achieving some elements of good practice but is aware of the areas for development. These will usually represent significant opportunities for improvement in delivering effective internal audit. Some deficiencies may be beyond the control of the service and may result in recommendations to senior management or the board of the organisation.
- **Does Not Conform** means the reviewer has concluded that the internal audit service is not aware of, is not making efforts to comply with, or is failing to achieve many/all of the objectives and good practice statements within the section or sub-section. These deficiencies will usually have a significant negative impact on the internal audit service's effectiveness and its potential to add value to the organisation. These will represent significant opportunities for improvement, potentially including actions by senior management or the board.
- An overall assessment of the performance of the internal audit service in conforming to good practice should be made using the same scale.

Appendix B: Purpose and Positioning

Does the internal audit service have the appropriate status, clarity of role and independence to fulfil its professional remit?

Remit		
Statements of good practice	**Assessment**	**Evidence**
An internal audit Charter defines the purpose, authority and responsibility, within the organisation, consistent with the Definition of Internal Auditing, the Code of Ethics and the Standards The internal audit Charter is approved by the AO and the Board and is regularly reviewed, and communicated to all senior management and other relevant people The Charter defines the nature and scope of the assurance and consulting services provided to the organisation (including any assurances provided to parties outside of the organisation) is such that it can provide independent and objective assurance and is not part of the direct control framework The Charter clearly defines internal audit's role in evaluating and	√ Fully conforms Generally conforms Partially conforms Does not conform Associated references PSIAS: Code of Ethics 1000 Purpose, Authority and Responsibility 1110 Organisational Independence 1210 Proficiency 2110 Governance 2120 Risk Management 2130 Control	Included in the Internal Audit Charter which is reviewed and updated (where appropriate) annually The Internal Audit Charter is approved by each Audit Committee who are delegated to approve on behalf of the Accountable Officer and the Board Included in the Internal Audit Charter. We do not provide third-party assurances outside of NHS Wales. As part of NWSSP we are independent of all other NHS organisations with the exception (technically) of Velindre University Hospitals NHS Trust as host to NWSSP, and NWSSP itself Included in the Internal Audit Charter. Counter-fraud is a separate function within NHS Wales, but we have a signed protocol for joint working and hold regular meetings with colleagues in Counter Fraud (and PPV for Health Boards)

contributing to the development of risk management, control and governance processes Internal audit's role in relation to any fraud-related / investigations work is clearly defined within the Charter.		

Reporting lines		
Statements of good practice	**Assessment**	**Evidence**
• The Board reviews and approves the appointment of the Chief Audit Executive (CAE) • Reporting lines for the CAE support independence, with functional reporting to the Board • The AO/Board agree the strategy/plans of the internal audit service	√ Fully conforms Generally conforms Partially conforms Does not conform Associated references PSIAS:	Formal appointments are made by the Director of Audit & Assurance as a part of his remit, but these are discussed and agreed beforehand with individual NHS organisations Reporting lines and access support independence and functional reporting The Audit Committee approves the annual Internal Audit plan Relevant Board/Senior Management Team meetings are attended <u>but</u> not every single Board/EMT is attended

• The CAE or their representative attend all Board and/or senior management meetings, particularly where key issues are discussed relating to governance, risk management or control across the department and its ALBs • The CAE meets regularly with the Accounting Officer • The AO/Board Chair routinely see and consider the outputs of the internal audit service • The Board is routinely updated with internal audit status and activity reports	1100 Independence and Objectivity 1110 Organisational Independence 1111 Direct Interaction with the Board 2010 Planning 2060 Reporting to Senior Management and the Board	Director of Audit & Assurance and Heads of Internal Audit have regular meetings with Directors of Governance (Board Secretary) and Audit Committee Chairs The Audit Committee receives all Internal Audit outputs, and our work is summarised in the Annual Governance Statement signed by the Chair of the Board and the Accountable Officer. A separate annual opinion/report is also produced for each NHS organisation Progress reports are produced for each Audit Committee and key messages are shared with the Boards

Independence			
Statements of good practice	**Assessment**		**Evidence**
Internal audit's position within the organisation is clearly established including authorisation for access to records, personnel and physical properties relevant to the	√	Fully conforms	Included in the Internal Audit Charter
		Generally conforms	
		Partially conforms	
		Does not conform	We have no Executive responsibilities in any organisation other than the

performance of engagements		Director of Audit & Assurance is part of NWSSP's Senior Leadership Group
The internal audit service is entirely free of executive responsibilities such that it can provide independent and objective assurance and is not part of the direct control framework	Associated references PSIAS: Code of Ethics 1100 Independence and Objectivity	Full disclosure undertaken annually Yes
Conflict of interests are identified, appropriately managed and avoided including those transferring to internal audit from elsewhere in the organisation	1110 Organisational Independence 1120 Individual Objectivity	Covered and monitored under the annual declarations of interest process Yes, this is reported in the progress reports, and we have a separate consulting protocol (updated February 2022)
Audit personnel are routinely rotated on assignments	1130 Impairment to Independence or Objectivity	Yes, this is built into the Protocol
Audit personnel do not have any conflicting operating responsibilities or interests		Yes, confirmed in the Audit Charter and Annual Report
Consultancy work that internal audit may undertake is clearly defined and agreed by the Audit and Risk Assurance Committee		This is built into the Internal Audit Charter and would be reported
Areas which have been the recipient of internal audit 'consultancy' work are subject to audit review by personnel independent of the consultancy work		
The CAE, at least annually, confirms to the Accounting Officer/Board		

the organisational independence of the internal audit activity The CAE notifies the appropriate parties if independence or objectivity is impaired in fact or appearance		

Risk based plan		
Statements of good practice	**Assessment**	**Evidence**
A risk based internal audit plan has been developed which: • considers the relative risk maturity of the organisation • considers the risk appetite as defined by management • includes an assessment of optimal resources and skills required to deliver both the audit assurance and consultancy work, including identification of specialist skills, which may be required • is clearly designed to enable the CAE to deliver an annual opinion on the effective of Governance, risk management and the system of control • has been approved by the Accounting Officer and Board • has been promulgated to all relevant parties	√ Fully conforms Generally conforms Partially conforms Does not conform Associated references PSIAS: 2010 Planning 2020 Communication and Approval 2030 Resource Management	Yes – as part of the planning process Yes – as part of the planning process Yes – as part of the planning process Yes – range of work and link to risks outlined in plan Yes – all audit plans are approved by the relevant Audit Committee Yes – as part of the audit management process Yes – noted in plan that it will be subject to review, and all changes are approved by the relevant Audit Committee Included in the IMTP and Quarterly Reviews

including members of the audit team, excluding any restricted information for senior managers only • is subject to regular review to ensure that it remains appropriate and current Either the audit plan or a separate audit strategy document should: • include an assessment of risks that the audit service itself faces in delivering the plan and plans for controlling and mitigating the risks identified • include consideration of if, and how, internal audit will rely on the assurance provided by other assurance providers • include an assessment of the range of audit techniques that have been selected as the most effective for delivering the audit objectives • set out how the internal audit service will measure its performance, quality assure itself and seek continuous improvement		Yes, in terms of Audit Wales, counter-fraud, HIW and other regulatory and statutory providers Yes, included in individual internal audit scopes Yes, KPIs are reported and QAIP process undertaken by Director of Audit & Assurance

Integration with other assurance providers		
Statements of good practice	**Assessment**	**Evidence**
• The internal audit service effectively co-ordinates with appropriate assurance providers to reduce the duplication and minimise gaps in the assurance framework	√ Fully conforms Generally conforms Partially conforms Does not conform	Ongoing liaison with Audit Wales, Counter-Fraud (through Protocol), PPV and HIW
• Internal Audit promote co-operation between internal and external audit (particularly as set out in the Good Practice Guide published by HM Treasury and National Audit Office)	Associated references PSIAS: 2050 Coordination	Yes, through regular meetings and Audit Wales undertaken an annual overview of Audit & Assurance Yes, work done at NWSSP, DHCW, WHSSC and EASC is reported in the annual Head of Internal Audit Opinions and Annual Reports
• When auditing shared service functions consideration is given to audit work being performed by other audit services such that duplication is minimised		N/A at this point – but a process would need to be developed if this were to happen
• When internal audit needs to work with other internal auditors from another organisation, the respective roles and responsibilities of the involved parties have been clearly defined and agreed with each Board		

Appendix C: Quality reviews 2021/22 Exceptions/Differences

Quality Reviews 2021/22 – Exceptions and differences noted

Independence, objectivity and competency (Q1 – 3)

No specific comments other than to note that external support was only used on a few of the audits. We currently have 3 auditors working with us on contract, all of whom have worked with us for some time and have relevant backgrounds. A number of other contractors who have worked with us during the year were successful in a recent round of appointments for both Principal Auditor and Audit Manager.

Engagement Planning (Q4 – 9)

Q5 – In a small number of instances the brief on file was the 'draft' rather than the 'final' but there was evidence that the HB/Trust had agreed the scope.

A number of audit files also had good planning aid documents for the areas under review which gave background on sometimes complex areas.

The consulting protocol had been completed where appropriate.

Performing the engagement (Q10 – 11)

Q10 – it was clear generally how the findings recorded on the file linked to the findings in the report (draft and final), for example where the number of issues recorded did not match the number of recommendations made in the report it was clear how they had been merged or where additional information had cleared the original finding. Evidence recorded on files was generally to a high standard. This was consistent with previous years.

In most instances, testing on the file was split and recorded by audit objective. However, in a few instances, all testing was done under one file section. While this still demonstrated that all the objectives had been covered it was less

Supervision and review (Q12 – 13)

Q13 – Head of Internal Audit final review was clear in all cases, this is consistent with 2020/21.

Q13 – There are small differences in the way each team uses the structure and steps to record evidence of work done and the findings e.g. the use of 'Current Issues' and 'Formulate Findings'. In addition, Teams have added additional schedules and matrixes where appropriate.

Reporting (Q14)

No specific comments other than to say I thought the quality of the reports was good and a number contained examples of good and comparative practice.

Completion (Q15 – 16)

Q15 – All teams now use the checklist to demonstrate that process and quality checks have been performed before the issue of the draft/final reports. In a few instances I think that files could have been signed-off as complete quicker than they were (after final report and the issue of a management feedback request).

Q16 – We have sought feedback for most reviews but only a couple had any evidence on file of the feedback. However, all reports do go through to Audit Committee which acts as a measure of the quality and relevance of our work and satisfaction surveys are included in each Head of Internal Audit and Annual Report. In addition, some teams now use Microsoft Forms to collect feedback but evidence of this being done was not on the TeamMate file – in all cases evidence to support the issue of the feedback form was provided separately.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

NHS WALES
Shared Services Partnership (NWSSP)

Counter Fraud Progress Report 01/04/2022 – 30/06/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of NWSSP from the 1st April 2022 to the 30th June 2022

The report's format has been adopted, in consultation with the Finance Director, to update the Audit and Assurance Committee about counter fraud referrals, investigations, activity and operational issues.

At 30th June 2022, **25** days of Counter Fraud work have been completed against the agreed 295 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used conducting ongoing fraud investigations; making initial assessments of enquiries referred to the department interviewing witnesses; preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response.

The breakdown of these days is as follows:

TYPE	Days
Proactive	16
Reactive	9

2. Progress

The Counter Fraud Annual Plan 2022/2023 and the Annual Counter Fraud report 2021/2022 have now both been completed and await approval from Executive Director of Finance.

Staffing

On the 1st April 2022 the new Counter Fraud Manager commenced employment with CAVUHB. This means that the CAV UHB Counter Fraud department now has a team of four personnel. Three are fully accredited (ACFS) the fourth member of the team is a fully qualified investigator joining from a police background and is currently undertaking his ACFS accreditation - the projected time for completion and subsequent nomination to the counter fraud authority is June 2022. The new Counter Fraud Manager is a fully accredited LCFS and qualified fraud investigator. As this team has the responsibility to provide a buy in Counter Fraud service for five other NHS organisations the above staffing levels allow for a provision of 75 days Counter Fraud work per annum from Cardiff and Vale UHB. On 1st June 2022 a new LCFS commenced secondment to NWSSP. The new LCFS is situated within the organisation and reports directly to it with no line management responsibility from CAVUHB. The new LCFS will, from this date take the lead for NWSSP Counter Fraud Work. The CAVUHB provision will remain at 75 days but will now act in support of the in-house provision.

Activity

Infrastructure/Annual Plan

During this reporting period, focus has been on developing the Counter Fraud Plan for 2022-2023. This plan is now aligned fully to the NHSCFA requirements as stipulated in Government Standard 13. The plan states proposed actions throughout the year. In tandem with investigation work required, the main focus of the CAVUHB team in the first quarter of the reporting period (April-June) has been to review and improve the Counter Fraud infrastructure. So far this has led to the following actions been undertaken -

a. The creation and implementation of a dedicated generic email address – the aim is for this to lead an additional reporting route open to staff that will

assist in recording activity generated as a result of awareness work. This will double as a dedicated incident reporting and logging tool. ***Complete***

b. The creation of a comprehensive activity database that will assist in maintaining a detailed record of work undertaken with a view to saving resource time in relation to corporate governance. ***Complete***

c. The creation of a new, up to date, interactive and dedicated Counter Fraud enquiry form that is available to all staff (click on following link Counter Fraud Enquiry Form) ***Complete***

d. Review of the Counter Fraud Bribery and Corruption Policy – this requires review and update. This is being undertaken by in-House LCFS (MW). ***Ongoing***

e. Review of CF Intranet Page – requires review and update. Enquiries undertaken with Comms Department. Development underway. This is now being taken on by in-house LCFS ***On-going***

f. Joint working protocol with Internal Audit agreed with Head of Internal Audit. ***Complete***

g. Review of Counter Fraud e-Learning arrangements – whilst eLearning available on ESR – not a mandatory module at this time. Liaison made with Workforce/OD and Learning Education and Development (LED) in order to make improvements in this area. Development underway of a dedicated Counter Fraud learning platform on 'Learning@Wales' site. This is being developed by the CAVUHB Counter Fraud Team and CAVUHB LED team. When complete all staff from NWSSP will have access to this and will be signposted accordingly. ***On-going***

h. In addition, the team have been liaising with relevant departments in relation to providing bespoke and general awareness sessions to staff in order to refresh knowledge of Fraud in NHS. ***On-going***

i. Work is underway to develop the communications strategy for the Counter Fraud Team. The aim, in the first instance, is to develop a modern and fit for purpose service that is appropriately communicated across the organisation by improving our use of Social Media, Data Systems (payslip, intranet news, screensaver messaging) and the use of all staff messaging in relation to presentations, surgeries, alerts and bulletins. This will be carried out in conjunction with in-house LCFS***. On-going***

Alerts/Bulletins

During this reporting period, **three fraud alerts** have been issued:

1. To all relevant staff in relation to mandate fraud (Appendix 1)
2. To all staff in relation to a prevalent scam in relation to Dell Computers. (Appendix 2)
3. To all staff in relation to a possible ESR phishing scam (Appendix 3)

Awareness Sessions

During this reporting period three awareness sessions have been delivered to NWSSP – distribution staff.

Further arrangements are underway to deliver sessions to staff in relation to general fraud awareness and mandate fraud.

Newsletters

During the reporting period one newsletter has been produced. (Appendix 4)

Fraud Prevention Notices and IBURN notices

During this reporting period one FPN has been issued by the NHS CFA. This was in relation to the risks associate with Credit Card terminal fraud taking place elsewhere in the NHS. A brief investigation carried out and assurance provided that the organisation does not operate Credit Card Terminals. Reported upon CLUE database accordingly.

During this reporting period one IBURN notice has been issued in relation to an Imposter acting as a consultant Doctor providing services externally to NHS providers. Whilst not directly impactive upon NWSSP enquiries carried out in relation whether services provided to NHS Wales with Accounts Payable team Negative result and recorded upon Clue accordingly.

Referrals/Enquiries

During this reporting period the CAVUHB CF team have received 3 referrals via the online enquiry form. These have all related to suspicious email activity. All information passed on to cyber security team and Action fraud accordingly.

Investigations

At 1st April 2022 there were no reported cases open in relation to NWSSP. During this reporting period however, an audit of open cases across all organisations that CAVUHB provide the CF service for has resulted in the identification of four investigations that have been referred to the team that have an impact/crossover with NWSSP. All of these investigations have been into suspicious claiming activity regarding the Student Nurse Bursary scheme. These investigations sit within the HEIW remit as they are the organisation that funds the process and are the end loser.

One of the cases has been closed with no further action being taken due to a lack of evidence.

In regard to two of the cases, these are now complete from a Counter Fraud perspective and the findings have been referred to the University of Wales Nursing Education directorate associate to the students involved. An internal investigation has been commenced with fitness to practice hearings to be scheduled. The monies involved are being recovered by way of an agreed repayment plan with the students. The finalised figures in relation to this are not yet available.

In regard of the final case, a full investigation is now complete with the subject being interviewed under caution on three occasions. A case file of evidence has been prepared and submitted to the Crown Prosecution service for the consideration to be given to whether they are prosecuted in relation to fraud related offences. The total amount provable in relation to this fraud is £736.

A fraud risk assessment into the area of Student Nurse Bursary awards application procedures has been commenced as a result. This will be reported upon when complete.

Other

No items to report.

Appendices

Appendix 1

Fraud Alert - Recent Mandate Fraud Risk

Appendix 2

Fraud Alert - Dell Scam Phone Call - N

Appendix 3

Fraud Alert ESR Email.pdf

Appendix 4

Fraud Newsletter May 2022.pdf

NHS WALES
SHARED SERVICES PARTNERSHIP

Annual Counter Fraud Report
01/04/2021- 31/03/2022

GARETH LAVINGTON
COUNTER FRAUD
CARDIFF & VALE UNIVERSITY HEALTH BOARD

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1. INTRODUCTION

This Counter Fraud Annual Report has been written in accordance with Welsh Government Directions on Fraud and Corruption, which requires Local Counter Fraud Specialists (LCFS') to provide a written report at least annually to NHS Wales Shared Services Partnership (NWSSP) on Counter Fraud work undertaken. All NHS organisations, in compliance to their service conditions of their NHS standard contract, must comply with the NHS Counter Fraud Authority's (NHSCFA's) fraud, bribery and corruption standards for providers.

This annual report will highlight the activities undertaken by the LCFS team, and demonstrate how they have delivered their counter fraud, bribery and corruption activities. Additionally, in compliance to the NHSCFA's standards for providers, this annual report will also document and present the following details,

- Days used to deliver counter fraud, bribery and corruption work
- The cost of counter fraud, bribery and corruption work carried out during the year
- Details of any risk based proactive exercises conducted during the year
- The number of information reports and cases recorded on the NHSCFA Case management system
- Number and type of sanctions imposed, including recoveries made

This report has been complimented throughout the year with detailed progress reports presented to the Audit Committee and additional briefings being presented to the Executive Director of Finance. Following acceptance and approval by the Audit Committee, this Counter Fraud Annual Report is distributed to the NHS Counter Fraud Service (Wales) and is available to the NHSCFA Quality Assurance Team for review if requested.

The NHSCFA is a Special Health Authority charged with identifying, investigating and preventing fraud within the NHS and the wider health groups. The legislation which created the NHSCFA transferred all functions and powers from NHS Protect to the NHSCFA. The NHSCFA is independent from other NHS bodies and is directly accountable to the Department of Health and Social Care (DHSC). For more information, the NHSCFA website is www.cfa.nhs.uk. For the purposes of this report, the term 'fraud' refers to a range of economic crimes, such as fraud, bribery and corruption or any other illegal acts committed by an individual or group to make a financial or professional gain, or to cause an economic loss.

2. SUMMARY OF COMPLIANCE

In January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the Government Functional Standard GovS 013: Counter Fraud. The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales DoF's meeting on 19th February 2021.

The LCFS' has demonstrated compliance towards the recognised standards as detailed below.

Compliance is Measured as follows:

Green – fully compliant

Amber – partially compliant

Red – non-compliant

(A comprehensive breakdown of the actions undertaken by the LCFS team in direct measurement against the Standard requirements for 2021-2022 will be recorded in the NHS CFA Functional Standard Return. This is due for completion by 31st May 2022. This document will be completed by the Counter Fraud Manager and is required to be submitted to the Director of Finance and the Audit Committee Chair for sign-off prior to submission to the NHS CFA. This document will be made available to the Audit and Assurance Committee upon sign -off.)

- Accountable Individual and Audit Assurance

  The LCFS' overall governance is held by the NWSSP ~~Executive~~ Director of Finance and Corporate Services . The LCFS' has ensured to notify him of any referrals received and regular updates are provided throughout the investigation process. Additional to this, the LCFS' makes sure to extend this exchange of information to ensure that where appropriate, the senior workforce members are briefed where aspects of a Counter Fraud

investigation may overlap with that of a disciplinary concern. During the course of the year regular updates are provided to the DoF, the Counter Fraud Champion and other senior managers where appropriate.

The LCFS is a member of the Audit Committee and as such provides regular progress reports of Counter Fraud work undertaken throughout the year. All quarterly progress reports have been provided and presented to committee. The Annual Report has now been completed and submitted. The Annual Plan has now been completed in draft form and awaits approval from DoF and Audit Committee. The Govt Standard Functional return has not yet been completed but the aim is to do so by 31st May 2022. There has been a delay in the reporting of in this end of year period due to the change of management within the counter fraud department.

GREEN

- Counter Fraud Bribery and Corruption Strategy / Policy and Response Plan

The organisation has a Counter Fraud, Bribery and Corruption Policy. This policy is due for review in April 2022. This review to ensure that it is fully aligned to the NHS CFA strategy. The policy is available to staff via the Intranet and has been promoted during fraud awareness work carried out by the team throughout the year. Further work will be carried out in the year ahead to ascertain if possible to make the relevant documents more visible. The LCFS team this reporting period has ensured to align its counter fraud, bribery and corruption work to the recent changes in NHSCFA counter fraud, bribery and corruption requirements.

GREEN

- Risk Assessment

The LCFS' team have, where appropriate continued to effectively work across the service to share expertise and guidance around fraud proofing, risks and vulnerability. Counter Fraud maintain a direct review and input role in relation to policy which aims to strengthen the wider practices to reducing the risk of fraud through poor policy or governance controls. Throughout the upcoming year this will be strengthened further with a full review into the relevant policies related to Counter Fraud Work. Where local risks are identified, assessment work is been carried out accordingly. During the course of the year work has been undertaken also in relation to a review of Mandate Fraud Risk, Invoice Fraud Risk, Supplier Fraud Risk (this has been informed by a Thematic Assessment exercise implemented by the NHS CFA.) Work has also been carried out in relation to Pre-employment checks involving the use of agency staff. This work is now complete and has been

reported earlier via the counter fraud progress reports. Due to the implementation of a new risk management reporting style adopted by the NHS CFA, a delay in training, and the service being stretched for a significant part of the year not all of this work has been recorded in the new format. All new risk work will now align to this methodology and be reported upon the CLUE case management system and locally through the AAC process, and recorded on the local risk register. Relationships and information sharing has continued throughout the year between LCFS and key contacts in key areas of risk including Workforce and OD, Procurement, and Internal Audit. A review of the joint working protocols in place between LCFS and these departments will take place throughout the year ahead.

AMBER

- Annual Action Plan

An annual action plan has been completed for the year ahead that has been produced in direct alignment to the new Government Standard 13. This document currently awaits agreement and sign off from the DoF and subsequent ratification by the Audit Committee. Progress of the LCFS teams work will be reported periodically at the Audit Committee. Due to the nature of Counter Fraud work the plan remains broad, flexible and subject to change throughout the year as new risks and requirements are identified.

GREEN

- Outcome Based Metrics

Throughout the year the work of the LCFS team has constantly been measured and statistics produced. This has been carried out in the areas of raising awareness, investigation, risk, awareness, strategic planning, sanctioning, and financial loss and recovery. The service has been successful in documenting some direct results e.g. reporting of management of investigation on CLUE, National Fraud Initiative reporting and feedback following awareness. However, there is little evidence of testing and reporting upon the effectiveness of counter fraud activity and work. Improvement is required in this area. Further work is being implemented in Q1 of the year ahead to routinely collect data in relation to areas that will assist in being able to directly measure the effectiveness of strategies implemented and work carried out. For example, the effectiveness of a new interactive internal Fraud Enquiry / Reporting tool being implemented, promoted and publicised, will be directly measured against a rise or fall in the amount of contact that is made by staff members that are automatically directed to a new dedicated email address. Further

monitoring of risk work carried out will be implemented to introduce periodic review in order to assess any savings made.

AMBER

- Reporting Routes

Staff have been made aware throughout the year of the reporting routes available to them. In the last year these included direct contact with the team via email, phone and in person, the use of the online CFA reporting tool, the National Reporting Hotline maintained by Crime stoppers, and an internal reporting form. All instances of fraud reporting have been initially assessed and those that are furthered to formal investigation have been recorded on the case management system (CLUE) and reviewed accordingly. New reporting methods are being introduced this year as laid out in the annual plan. Further work to signpost staff and others is required and the development of a fit for purpose communications strategy publicising and advertising the CF team and its work will aid in raising its profile.

AMBER

- Reporting Identified Loss

The CF team has reported all incidents of suspected fraud, bribery using the CLUE management system that was introduced on 9th April 2021. This reporting tool is used to record all investigations, sanctions, recoveries and losses and also has a mechanism to record system weakness and Local Proactive Exercise work. This system has been supervised by CFS Wales and all information has been used to inform progress reporting to Audit Committee and CFS Wales. In the upcoming year this will be added to with the reporting of savings made as a result of counter fraud work undertaken.

GREEN

- Access to trained investigators

At the start of the year the organisation employed three fully trained and accredited investigators that were supported by a full-time administrative support assistant. One of these investigators was off work on sickness leave and remained so throughout the year. The administrative support assistant left in September 2021. The team were joined by a further investigator in January 2022. This team member is at the time of reporting three quarters of the way into an accreditation qualification. This is due to be completed in

June 2022. The team have been under staffed for the majority of the year and have provided extra time and been bolstered throughout the year with assistance from the CFS Wales team and members of other NHS Wales teams on an ad hoc basis in order to ensure successful provision of the Counter Fraud Plan for 2021-2022.

GREEN

- Undertake Detection Activity

Where anomalies are identified through counter fraud work e.g. investigations, the CF team strives to carry out detection activity to assess whether there are any weaknesses present. Where this is the case corrective activity is proactively undertaken to mitigate the identified risk. Regular liaison takes place with internal audit in order to understand risks identified by them in order to identify and inform upon Fraud Risk. Data mining has also been undertaken within the context of the NFI database. The majority of matches have now been closed in relation to this years' exercise. No NFI investigations have identified fraud. All actions taken by the CF team in relation to work in this area are reported accordingly on CLUE inclusive of any recoveries made. There has been a lack of proactive detection work undertaken looking for outlying data that can inform on the occurrence of fraud. Improvement to be made in the upcoming year in carrying out informed detection data mining exercises into areas of locally identified risk and subsequent reporting and review to be carried out in line with Cabinet office supplied methodology and local risk procedures.

AMBER

- Access to and Completion of Training

Due to the COVID situation fraud awareness sessions to staff members have been significantly disrupted. However remotely delivered sessions have been created and delivered where possible. The plan for the year ahead is to get back to in room presenting alongside virtual presentation and to make sure that Fraud Awareness is mandatory at corporate induction. All wales fraud awareness training has remained available throughout via ESR but this is not a mandatory module. As a result, figures for completion among staff remain comparatively low against organisations where it is. This should be a priority objective for the upcoming year in order to improve fraud awareness and learning. A counter fraud newsletter has been published quarterly in order to keep staff appraised of ongoing issues. CF team staff have attended all sessions of training provided by CFS Wales and NHS CFA and a number of webinars from NHS CFA have also been

undertaken in relation to update training into areas such as risk assessment and CLUE implementation.

GREEN/AMBER

- Policies and Registers for Gifts and Hospitality and Conflicts of Interest

The organisation has in place policies and registers in compliance with this requirement. The register of Conflicts is managed by the Director of Governance and where appropriate liaison with CF can be sought.

GREEN

3. Allocation of Resources

At 31st March 2022 75 days of Counter Fraud work have been completed against the agreed 75 days in the Counter Fraud Annual Work-Plan for the 2021/22 financial year as shown below. The days have been used investigating allegations of fraud; interviewing witnesses; preparing, delivering and analysing the feedback from the fraud awareness presentations; preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; interviewing suspects; and carrying out a risk assessment work including an exercise on pre-employment checks conducted by agencies which supply staff to the organisation, and addressing the areas of risk raised in the CFA Thematic assessment document.

Strategic Requirements 12 Days

(inclusive of corporate governance undertaking, attendance of departmental team at staff training events, report writing, planning and attendance all wales meetings.)

Proactive Work 38 Days

(inclusive of fraud awareness sessions, and publicity work such as newsletters and bulletins, system weakness reviews and reporting, Local Proactive work eg pre-employment Risk Assessment. NHSCFA procurement exercise, and National Fraud Initiative work.)

Reactive Work 25 Days

(inclusive of the investigation of all referrals, preparation of reports for disciplinary processes.)

4. Summary of Costs

Proactive Costs	**£ 14,107**
Reactive Costs	**£ 7,268**
Total Costs	**£ 21,375**

5. Breakdown of Investigative work areas

There have been two referrals promoted to investigation during the reporting period. (1) Information was received that an employee of NWSSP was in receipt of overpayment of salary and was suspected of committing theft. The CF fraud investigation found no wrong doing on behalf of the subject and that they had contacted Payroll to inform previously but his was not noted. NFA. (2) Student bursary fraud – student nurse suspected of making false claims in relation to childcare arrangements. Case ongoing and file to be submitted to CPS for charging decision.

A brief summary of allegations received throughout the year is provided in the table below.

Offence	No. of Referrals	Type
False Representations	1	Student Bursary Fraud
Theft	1	Overpayment

6. Sanctions and Recoveries

During the financial year the team has achieved the following sanctions and recoveries.

Disciplinary Sanctions	**0**
Criminal Sanctions	**0**
Civil Sanctions	**0**
Recoveries	**NA**

In the upcoming year savings attributed to fraud risk identification and remedy will also be recorded.

7. Fraud Awareness

During the period 1st April 2021 – 31st March 2022 a total of 14 awareness sessions were delivered to 306 staff members across the organisation. The feedback from these presentations was positive.

8. Lines of Reporting

MD	Neil Frow
Director of Finance & Corporate Services	Andrew Butler
Head of Counter Fraud	Gareth Lavington
LCFS	Nigel Price
LCFS	Emily Thompson

LCFS	Henry Bales

9. Executive Sign Off / Declaration

I declare that the Counter Fraud work carried out on behalf of NWSSP for the year 2021/2022 has been reviewed against the NHSCFA requirements (as stipulated in the Government Functional Standard 13). The ratings that have been achieved are reported above and meet that standards set as shown.

Head of Counter Fraud: Gareth Lavington
~~Executive~~ Director Finance & Corporate Services : Andry ~~ew~~ Butler
Date: 8/7/ 2022

NHS WALES
Shared Services Partnership

COUNTER FRAUD PLAN
2022/2023

Mark Weston
Counter Fraud Manager
NHS Wales Shared Service Partnership

This document is prepared by Mark Weston Counter Fraud Manager, NHS Wales Shared Service Partnership and Gareth Lavington Counter Fraud Manager for Cardiff and Vale UHB in order to comply with Government Functional Standards and the recommendations of the NHS Counter Fraud Authority for NHS Bodies (Wales) and has been approved by the Director of Finance as below.

Workplan prepared by:

Counter Fraud Manager – Mark Weston and Gareth Lavington

Workplan agreed by:

Andrew Butler - Executive Director of Finance and Corporate Services

Date:

WORKPLAN 2022-2023

Background

On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales DoF's meeting on 19th February 2021.

The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and will be responsible for ensuring the effective implementation of the NHS Counter Fraud Requirements. The requirements have superseded our own fraud, bribery and corruption standards for providers, commissioners and NHS bodies in England and Wales. The NHSCFA is required to provide assurance to the Cabinet Office of NHS compliance with the Functional Standard. This will be accomplished by the receipt and validation by the NHSCFA of the Counter Fraud Functional Standard Return submitted by organisations providing any NHS funded services. Deadline for submission of this document in relation to this plan is 31/05/2023. The NHSCFA Quality Assurance Programme will enable the analysis of performance of the Counter Fraud team against each requirement. They will provide a grading of compliance in relation to all areas of the functional standards. (Green, Amber or Red)

NHS Wales Shared Services Partnership (NWSSP) now directly employs its own dedicated full time and professionally accredited Local Counter Fraud Specialist (LCFS) to manage and deliver the local counter fraud service for NWSSP. This will ensure that NWSSP follows the Welsh Government Directions on Countering Fraud, Bribery and Corruption within the NHS in Wales and the standards set by the NHSCFA are achieved. The additional full-time resource commenced on 6th June 2022. NWSSP continue to obtain additional resources of accredited NHS Local Counter Fraud Specialists (LCFS) from Cardiff and Vale University Health Board. These arrangements will also ensure that the organisations resources remain resilient to the risk of fraud, bribery and corruption. An Annual Work-Plan is compiled by the Counter Fraud Manager that is agreed by Executive Director of Finance and submitted to the Audit Committee for approval at the commencement of each financial year. The Workplan provided below formulates Local Counter

Fraud arrangements for NWSSP for 2022-2023. The tasks outlined will be considered and reviewed dynamically throughout the year as the need arises. The effectiveness of the plan will be reported in the end of year Annual Report to Audit Committee and in the NHSCFA Functional Return as referred to above.

This organisation's Work-Plan for the first time will directly mirror GovS:13 Standard (Counter Fraud) in order to bring the organisations provision into line with the NHSCFA Counter Fraud Bribery and Corruption Strategy. This in turn supports the objectives set by the Welsh Government.

Taking a risk-based approach to planning local counter fraud work

Locally investigators are in the best position to identify and understand the counter fraud requirements for their organisation. Successful implementation of counter fraud policy relies on the work of the Local Counter fraud Specialist (LCFS).

The counter fraud work-plan should be tailor-made and specific to the NHS organisation, for example, carrying out local proactive exercises identified in the course of investigations, or analysis of referrals may show the need for more work on preventing fraud or highlight that awareness is needed in a particular department or staff group.

Meeting key personnel in the organisation and using the information from staff surveys are important methods for forming action plans. The responses may also reveal areas of risk highlighting a need for pro-active prevention or detection work. Any risks which are identified by the LCFS will be recorded in line with local procedures adopted for such by the organisation, shared with the Internal Audit department and reported to the DoF and Audit Committee. This aims to provide another level of assurance that the risk will be **owned** and managed. While every effort will be made to identify local risks, it is important that information from outside the organisation is also considered; for example, NHS CFA fraud alerts, and fraud prevention notices. Information received from external sources will be assessed and any risks locally identified will be targeted as a result.

To help organisations take a risk-based approach to counter fraud work and planning, the NHSCFA has issued up to date risk assessment advice and training. This helps the LCFS when assessing the counter fraud arrangements at their own organisation. This provides direction in risk assessment work and provides a basis of measuring local risks using a dedicating risk matrix scoring

system and template. Results of all local risk work carried out by the Counter Fraud Team will be reported through the quality assurance process to NHS CFA, managed on the CLUE case management system and will be locally reported to the Audit Committee

Outcomes/Results

Accurate records of counter fraud work are crucial. They inform upon the effectiveness of work undertaken, assist in the planning of future work and help to identify strengths and weaknesses within the organisation. Accurate records of all work undertaken by the Counter Fraud team for this upcoming year will be kept and updated. These results will be reflected in the quarterly progress reports and end of year annual report.

The Counter Fraud team are aware of the importance of liaison with External Auditors when planning Local Counter Fraud work in order to prevent duplication of effort. There are some elements of the Counter-Fraud Work-Plan which External Auditors may review on a risk basis as part of their own reviews of Governance Arrangements, e.g., Whistle-Blowing arrangements, Declaration of Interests, Gifts and Hospitality. External Auditors will certainly be seeking to gain assurance that Counter Fraud arrangements are robust and the Counter Fraud team, will maintain a close working relationship with Audit Wales as required.

Resource Provision

Resource Provision for NHSWSSP	Days Planned 22 / 23
Counter Fraud Manager and LCFS provision by CAVUHB	75
NHSWSSP Counter Fraud Manager* (commenced 6/6/22)	167
Total	**242**

Resource by Activity

Activity	Days Planned 22 / 23				
	C&V Resource		NWSSP Manager		
Proactive	50	+	100	=	150
Reactive	25	+	67	=	92
Total	75		167	=	**242**

With the move to the GovS:13 taking place and the previous 4 standards of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account are now obsolete, the methodology to be adopted in breaking down resource time spent by activity area is simplified into Proactive and Reactive areas. Generally Proactive work will involve activities such as fraud awareness, corporate induction, creating e-learning modules, local proactive exercises involving risk assessment. Reactive work will involve activities such as, investigation into referrals received, carrying out system weakness analysis as a result of investigation findings.

NHSCFA states that Proactive work should not be absorbed by Reactive activity or *vice versa* and to this end NHSCFA strongly encourages Proactive work to be 'ring-fenced'. However due to the dynamic nature of the Counter Fraud environment the plan is intended to be flexible to the needs of the service, so may be subject to review and change where service priorities and risk require. If this occurs then careful consideration will be given to any changes made and this will be reported in progress reports to the DoF and the Audit and Assurance Committee. Any changes to the overall days provided or in regard to the areas planned for will be reported in the end of year report.

Work Plan Objectives

A work plan with matching tasks/objectives is set out below for each NHS requirement area. Each task/objective relates to a specific standard of compliance or fraud risk area; the work plan has been formulated to support the mitigation of the risk of fraud to the organisation and to ensure compliance with the NHSCFA/Gov requirements.

Gov s013 / NHS Requirement	Objective	Proposed Delivery
1: Accountable individual NHS Requirement 1A: A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. N.B. 'Equivalent body' may include, but is not limited to, the board of directors, the board of trustees or the governing body. Oversight of counter fraud, bribery and corruption work	Counter Fraud Manager (CFM) to hold regular scheduled meetings with Director of Finance (DoF) - objectives to be reviewed and work to date evaluated. During these meetings ongoing work involving investigations, the promotion of fraud awareness, fraud proofing and risk assessments, policy considerations and Counter Fraud communication strategy to be discussed. The DoF to act as the link between the Audit and Assurance Committee (AAC) and Senior Leadership Group to allow key risks to be identified, managed, and mitigated. CFM to produce the SSP Counter Fraud Annual Report & Workplan which is to be agreed with the DoF and ratified by the Audit Committee. CFM to provide quarterly progress reports to Dof and AAC and to present these quarterly at AAC. Checks to be carried out by CFM that nominations to NHSCFA are correct, up to date and in order. Where necessary and appropriate Counter Fraud Manager (CFM) will seek to hold regular one to one meetings with the Audit Committee Chair, Counter Fraud Champion. In addition to this CFM to attend pre-audit committee meetings with Independent Members of the Audit Committee.	Ongoing throughout the Year Q4 Q1 As required

Gov s013 / NHS Requirement	Objective	Proposed Delivery
should not be delegated to an individual below this level of seniority in the organisation NHS Requirement 1B: The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The Counter Fraud Champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and	Counter Fraud to remain a standing agenda item at AAC. Counter Fraud Manager to provide written and oral reports to this forum, annually and progressively throughout the year. CFM to report to DoF and AAC any matters arising from NHSCFA in relation to thematic assessment exercises, matters arising out of Fraud Prevention Notices and national exercises. CFM to liaise regularly with internal partners, such as Internal Audit, HR, Information Governance and Communication Department to develop and maintain fit for purpose infrastructure providing a firm foundation for the Counter Fraud provision. CFM and Counter Fraud Champion to meet fortnightly to discuss all aspects of Counter Fraud work. CFM to carry out annual reporting to NHSCFA in the form of the NHS CFA Functional Standard return and to subsequently address any issues rising from the results of this assessment.	Ongoing throughout the year Throughout the year addressing matters arising as necessary Throughout the year Throughout the year Q1

Gov s013 / NHS Requirement	Objective	Proposed Delivery
details corrective action where standards have not been met.		
2: Counter fraud bribery and corruption strategy NHS Requirement 2: The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks. **(The organisation may have its own counter fraud, bribery and corruption strategy, however, this must be aligned to and referenced to the NHSCFA counter fraud, bribery and corruption strategy)**	CFM to verify that the organisational Counter Fraud Bribery and Corruption Policy is in place and review to check that in date and fit for purpose. CFM to ascertain whether the local policy is properly aligned to the current NHS CFA Strategy. CFM to ensure that work planned for in the Annual Counter Fraud Plan and that work carried out is aligned to the NHS CFA strategy and that the objectives are being met. CFM to provide assurance that counter fraud provision is resourced by way of qualified, nominated and accredited Counter Fraud Specialists and to ensure that this is maintained.	Q1 & Q2 Q1 Continual Monitoring
3: Fraud bribery and corruption risk assessment NHS Requirement 3:	Counter Fraud Department to carry out risk analysis in line with the Government Counter Fraud Profession (GCFP) fraud risk methodology. Locally identified risk to be recorded in line with the organisations Risk Management Policy and entered on to the	Dynamic – throughout the year as the need arises

Gov s013 / NHS Requirement	Objective	Proposed Delivery
The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.	appropriate risk registers. All risks identified to be assessed and remedial action identified and reported to key stakeholders. All matters arising to be reported to DoF and AAC by way of counter fraud progress reporting. Counter Fraud department to develop a fraud risk profile upon the CLUE case management system in order to effectively evaluate, evidence and measure the effectiveness of counter fraud risk assessment work with a view to reducing fraud to an absolute minimum. Local Proactive exercises to be undertaken by LCFS as the need arises throughout the year as a result of local identification or if informed by CFA Fraud Prevention Notices and national exercises. All risk analysis work to be subject to timed ongoing review to assess if recommendations acted upon. CF manager to explore with Corporate Governance the preferred method of reporting and recording risk, including the maintenance of a register review. (To compliment the recording upon CLUE) Where resource implications are present priority to be given to those areas identified as higher risk.	Dynamic – throughout the year as the need arises Ongoing throughout the Year Ongoing throughout the Year Q1& Q2

Gov s013 / NHS Requirement	Objective	Proposed Delivery
4: Policy and response plan NHS Requirement 4: The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured.	CF Manager to establish/review existing counter fraud bribery and corruption policy, update and amend as appropriate. Counter Fraud team to promote awareness of the policy at presentations and through newsletters. CF team to utilise staff surveys to evaluate if staff are aware of the policy and how and where to locate it. Also establish that they are aware of the correct procedures associated with reporting fraud, bribery and corruption.	Q1 & Q2 Throughout the Year Q3 & Q4
5: Annual action plan NHS Requirement 5: The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).	CF Manager to complete annual CF fraud workplan detailing planned actions for the coming year. Where possible actions to be given a proposed action time period. CF Manager to ensure the plan is agreed by DoF, ratified by AAC and is informed by national and local risk and is aligned to organisational objectives and CFA Strategy. CF Manager to ensure that the provision of the CF function is written into the overall organisation plan.	Q4 (Due to change of manager 22/23 plan provided Q1 as agreed by AAC) Q1 Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF manager to provide quarterly reports to AAC. CF manager to provide quarterly statistics to Counter Fraud Service Wales. CF manager to provide annual report measuring the effectiveness of the plan.	Throughout the Year Q4
6: Outcome-based metrics NHS Requirement 6: The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	The new contact, enquiry and reporting methods being developed by the CF team will benefit from the automatic facility of analytical data collection. This will be utilised as an important tool to measure the effectiveness of the actions and work undertaken by the CF Team. Where necessary regular review will be used to inform change. Data will be collected in relation to the amount of fraud awareness work is carried out. In turn the effectiveness of these actions will be measured by how many enquiries/actions are generated on a newly developed internal interactive Counter Fraud Enquiry/Referral Form. A new local incident reporting form is to be created in order that all enquiries made to the team are recorded and have an audit trail not just those that are logged on the CLUE system, providing a clearer picture of the work generated as a result of the fraud awareness work undertaken by the CF team.	Q1 Development and Implementation Q1 Development and Implementation Data collection throughout the year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	The development of a generic email account will take place in order to assist in the process of this.	Q1 Development and Implementation
	Interactive feedback forms will be developed and utilised to measure the effectiveness of the service supplied by the CF team throughout the year.	Data collection throughout the year
	Locally and nationally informed risk assessments will be recorded according to local policy and using the CLUE case management system and will and a suitable review date added to check upon progress of recommended remedial action. These items will also be shared automatically with the Internal audit department and reported to the AAC.	Q1 development and implementation
	All investigations will be recorded and Managed on the CLUE case management system and reported to AAC via the Audit Committee quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.	Throughout the Year
	All losses, recoveries, outcomes, decisions and criminal, disciplinary and professional sanction will be recorded on the CLUE system and reported to AAC via the Audit Committee quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.	Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
7: Reporting routes for staff, contractors and members of the public NHS Requirement 7: The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system. The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.	CF team to undertake a project of assessing the current infrastructure in place for the reporting of concerns and making of general enquiries from all groups. This will involve infrastructure development to include the creation a dedicated Counter Fraud Enquiry email address, the development of interactive referral/awareness request forms available internally to provide a dedicated route of reporting and enquiry to staff (incorporating an anonymised version to provide assurance to the reporter), liaison with the Communications Department in order to ensure that this process and route is promoted in the most effective way in order to give the CF Fraud team have a brand identity and presence. CF manager to arrange and meet with Communications team in order to discuss the creation of a dedicated CF page on the organisation's intranet. Ongoing review of the effectiveness of the work undertaken via data analytics and where necessary remedial action to take place dynamically throughout the year.	Q1 & Q2 Implementation Q1 & Q2 Q1/Q2 Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	Continuance of promotion of the National Fraud Reporting Line and the National Fraud Reporting tool as managed by the NHSCFA. Ongoing events throughout the year such as half-day events at key premises promoting the reporting methods available to all groups. E.g. SSP HQ.	Throughout the Year Throughout the Year
8: Report identified loss NHS Requirement 8: The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises	CF team to make full use of the CLUE case management system for recording and managing Investigations, System Weakness reporting, and Local Proactive exercise reporting. CF Manager to ensure that all members of CF team are suitably trained and qualified to access the CLUE case management system. H Bales (C&VUHB) to be added upon accreditation as ACFS. CF Manager to supervise the reporting of cases on CLUE ensuring that all referrals are suitably recorded and investigated CF manager to oversee live investigations on CLUE. CF manager to supervise the recording of all proactive work carried by way of Local Proactive exercise/System Weakness reporting. CF manager to provide direction to IO concerning case management where necessary.	Ongoing throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF manager to ensure that all outcomes by way of sanction, recovery and loss are suitably recorded and reported to DoF and AAC at progress updates and at year end in Annual report.	
9: Access to trained investigators NHS Requirement 9: The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account. The organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and	The organisation has recently obtained additional resources of a dedicated full time and fully accredited Counter Fraud Manager (CFM). This position is a long term (three years) secondment from the NHS CFS Wales Team and will be directly employed by NWSSP. The CFM will be responsible for all management of Counter Fraud Work from date of commencement (6th June 2022). The organisation will continue to utilise the services from the C&V Counter Fraud Team with 75 days annually (0.3 WTE). The organisation currently therefore employs/has access to provision from four fully accredited, nominated, and qualified LCFS (1.3 WTE). The team has a further member who is currently undertaking ACFS training course. Target date for accreditation July 2022. Nomination to CFA to follow accreditation and to be actioned by CF manager. All members work on a full-time basis but resources from C&V are limited to 0.3 WTE).	Ongoing throughout The year Ongoing Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
maintaining up to date knowledge of legal and procedural requirements.	All staff members of the CF team are skilled and trained in criminal investigation and fully up to date with their knowledge of relevant legislation such as PACE, CPIA, DPA, HRA, GDPR, offence legislation. All staff will keep abreast of changes and updates to legislation and undertake training as necessary. All staff will continue to develop professionally, attending appropriate training sessions provided by NHSCFA to enhance their knowledge and skills as well as attending regional forums hosted by NHSCFA and NHS CFS Wales. CF team will undertake continuing professional development opportunities associated with role throughout the year as they become available. All staff to maintain full compliance with mandatory training/e learning as measured on the ESR system. CF team to maintain the appropriate standards of confidentiality and security as well as having access to the tools and resources necessary to professionally carry out their role (inclusive of secure access to relevant IT systems, data systems and access to NHS Wales) All training and development to be recorded on ESR and referenced during annual staff appraisals.	Ongoing Throughout the Year Ongoing Throughout the year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
10: Undertake detection activity NHS Requirement 10: The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.	CF team to assess the work already completed in relation to the Thematic Assessment exercise published by the NHS CFA in 2020. Any work left incomplete to be carried out in period stated. CF team to undertake national exercise work as it is published by NHS CFA throughout the year. CF team to react appropriately to the issue of FPN's from NHS CFA. CF team to react appropriately to fraud alerts raised by other Health Boards and Special Health Authorities. CF team will undertake Local Proactive Exercises (LPE's) in response to locally identified risk with a view to identifying if fraud has occurred. Remedial action will be reported as appropriate and any necessary investigative action undertaken. CF Manager to interact with key managers and stakeholder groups such as NWSSP Payroll Services, Corporate Finance, Information Governance, Communications Department and HR to foster relationships improve awareness of CF department and function. CF Manager to agree to a joint working protocol with Internal Audit and to meet with Head of IA on a	Q1 & Q2 Throughout the Year Throughout the Year Throughout the year (with the aim of scheduling regular quarterly catch ups.)

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	quarterly basis to discuss ongoing areas of mutual concern. CF team will engage with investigators from other organisations and agencies where necessary (including police, UKBA, DWP, HMRC, local authorities, regulatory and professional bodies, complying with relevant legislation and organisational policies when countering fraud bribery and corruption. CF team to make use of NFI database to assist in countering fraud, bribery and corruption within NHS and other organisations.	Quarterly and as required Throughout the Year As required
11: Access to and completion of training NHS Requirement 11: The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work.	CF manager to ascertain whether CF awareness training is a standing item on all corporate inductions to new employees. If not, then meetings with Workforce OD and Educational Development to be held to drive the initiative forward. CF team to develop/maintain an up-to-date e-learning module for staff to undertake. CF team to develop awareness of the Counter Fraud Department team through all available avenues. To include but not limited to • Digital banners on organisation intranet site	Q1 Q1 & Q2 Development and implementation to take place Q1

Gov s013 / NHS Requirement	Objective	Proposed Delivery
Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.	• Regular publishing of Counter Fraud news items via Counter Fraud Newsletter • Regular messaging across available social media systems • All staff email bulletins to advise of fraud alerts • Ad hoc and bespoke fraud awareness training for different staff cohorts throughout the organisation • The use of a Counter Fraud Awareness staffed stand at impactive sites around the organisational estate in order to provide face to face contact with staff promoting the work of the team and its function CF team to be fully conversant with the use of the NHSCFA 'ngage' tool in accessing materials and literature suitable for dissemination organisation wide. CF team to fully participate in National Counter Fraud Week initiative.	Delivery throughout the Year Throughout the year
12: Policies and registers for gifts and hospitality and COI. NHS Requirement 12: The organisation has a managing conflicts of interest policy and registers that include gifts	CF manager to assess whether a conflicts of interest/business conduct policy is in place and is in date. CF team to assess whether a register for conflicts of interest, gifts and hospitality is in place and in date and being utilised effectively.	Q1 & Q2 Q1 & Q2

Gov s013 / NHS Requirement	Objective	Proposed Delivery
and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the policy are regularly tested	CF fraud team to raise awareness of the registers and policies by way of fraud awareness sessions and news bulletins/letters. CF manager to provide a presence and input into relevant policy review, and to record and document changes highlighted through Counter Fraud review.	Throughout the Year As required

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	13 July 2022
AGENDA ITEM	
PREPARED BY	Peter Stephenson, Head of Finance and Business Development
PRESENTED BY	Andy Butler, Director of Finance and Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Final Annual Governance Statement 2021-22

PURPOSE

To present the Final Annual Governance Statement (AGS) to the Committee, for assurance purposes.

1. BACKGROUND

The Annual Governance Statement is a mandatory requirement. It provides assurance that NWSSP has a generally sound system of internal control that supports the achievement of its policies, aims and objectives, and provides detail of any significant internal control issues.

The Statement must be signed off by the Managing Director as the accountable officer and approved by the Shared Services Partnership Committee (SSPC). As a hosted organisation, NWSSP's annual governance statement forms part of the Velindre University NHS Trust's annual report and accounts. The external auditor will report on inconsistencies between information in the Statement and their knowledge of the governance arrangements for NWSSP.

The Head of Internal Audit provides an annual opinion to the accounting officer and the Velindre University NHS Trust Audit Committee for NWSSP on the adequacy and effectiveness of the risk management, control, and governance processes to support the Statement.

2. TIMELINE FOR APPROVAL

The timeline for approving the statement is as follows:

Version	Approved
1	**Velindre Integrated Governance Group April 2022**
2	**SLG 28 April 2022 draft for endorsement**
3	**SSPC 19 May 2022 final for endorsement**
4	**SLG 26 May 2022 final for endorsement**
5	**Audit Committee 13 July 2022 for final approval**

3. GOVERNANCE & RISK

The Managing Director of NWSSP, as head of the Senior Management Team, reports to the Chair and is responsible for the overall performance of NWSSP. The Managing Director is the designated Accountable Officer for NWSSP and is accountable through the leadership of the Senior Management Team.

The Managing Director is accountable to the Shared Services Partnership Committee (SSPC) in relation to those functions delegated to him by the SSPC. The Managing Director is also accountable to the Chief Executive of Velindre NHS Trust in respect of the hosting arrangements supporting the operation of NWSSP.

Section 4 of the SSPC Standing Orders states that:

> *"With regard to its role in providing advice to both Velindre Trust Board and the SSPC, the Audit Committee will comment specifically upon:*
>
> - *The adequacy of the organisation's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement ....."*

4. RECOMMENDATION

The Audit Committee are asked to:

- **APPROVE** the Final Annual Governance Statement.

Annual Governance Statement 2021/2022

NHS Wales Shared Services Partnership

Version	Approved
1	Velindre Integrated Governance Group April 2022
2	SLG 28 April 2022 draft for endorsement
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CONTENTS

ANNUAL GOVERNANCE STATEMENT 2021/2022

1. SCOPE OF RESPONSIBILITY

As Accounting Officer, the Managing Director has responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which he is personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

Governance comprises the arrangements put in place to ensure that the intended outcomes for stakeholders are defined and achieved. Effective governance is paramount to the successful and safe operation of NHS Wales Shared Services Partnership's (NWSSP) services. This is achieved through a combination of "hard" systems and processes including standing orders, policies, protocols, and processes; and "soft" characteristics of effective leadership and high standards of behaviour (Nolan principles).

The NWSSP Managing Director is accountable to the Shared Services Partnership Committee (SSPC) in relation to those functions delegated to it. The Managing Director is also accountable to the Chief Executive of Velindre University NHS Trust (the Trust) in respect of the hosting arrangements supporting the operation of NWSSP.

The Chief Executive of the Trust is responsible for the overall performance of the executive functions of the Trust and is the designated Accountable Officer for the Trust. As the host organisation, the Chief Executive (and the Trust Board) has a legitimate interest in the activities of NWSSP and has certain statutory responsibilities as the legal entity hosting NWSSP.

The Managing Director (as the Accountable Officer for NWSSP) and the Chief Executive of the Trust (as the Accountable Officer for the Trust) shall be responsible for meeting all the responsibilities of their roles, as set out in their respective Accountable Officer Memoranda. Both Accountable Officers co-operate with each other to ensure that full accountability for the activities of NWSSP and the Trust is afforded to the Welsh Government Ministers/Cabinet Secretary whilst minimising duplication.

The Governance Structure for NWSSP is presented in Figure 1 below:

Figure 1 –NWSSP's Governance Structure

Organisation map

Underpinned through the overarching Velindre University NHS Trust legal and assurance framework

2. GOVERNANCE FRAMEWORK

NWSSP currently has two main Committees that have key roles in relation to the Governance and Assurance Framework. Both Committees undertake scrutiny, development discussions, and assess current risks and monitor performance in relation to the diverse number of services provided by NWSSP to NHS Wales.

2.1 Shared Services Partnership Committee (SSPC)

The SSPC was established in accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and the functions of managing and providing shared services (professional, technical, and administrative services) to the NHS in Wales is included within the Velindre National Health Service Trust (Establishment) (Amendment) Order 2012.

The composition of the SSPC includes an Independent Chair, the Managing Director of Shared Services, and either the Chief Executive of each partner organisation in NHS Wales or a nominated executive representative who acts on behalf of the respective Health Body.

At a local level, NHS Wales organisations must agree Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out within the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, into day-to-day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a scheme of delegations to officers and others; and Standing Financial Instructions, they provide the regulatory framework for the business conduct of NWSSP and define its way of working. These documents, accompanied by relevant Trust policies and NWSSP's corporate protocols, approved by the SLG, provide NWSSP's Governance Framework.

Health Boards, NHS Trusts and the two Special Health Authorities (Health Education and Improvement Wales (HEIW) and Digital Health & Care Wales (DHCW)) have collaborated over the operational arrangements for the provision of shared services and have an agreed Memorandum of Co-

operation to ensure that the arrangements operate effectively through collective decision making in accordance with the policy and strategy set out above, determined by the SSPC.

Whilst the SSPC acts on behalf of all NHS organisations in undertaking its functions, the responsibility for the exercise of NWSSP functions is a shared responsibility of all NHS bodies in Wales.

NWSSP's governance arrangements are summarised below.

Figure 2: Summary of Governance Arrangements

The SSPC has in place a robust Governance and Accountability Framework for NWSSP including:

- Standing Orders;
- Hosting Agreement;
- Interface Agreement between the Chief Executive Velindre University NHS Trust and Managing Director of NWSSP; and
- Accountability Agreement between the SSPC Chair and the Managing Director of NWSSP.

These documents, together with the Memorandum of Co-operation form the basis upon which the SSPC's Governance and Accountability Framework is developed. Together with the Trust's Values and Standards of Behaviour framework, this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

The Membership of the SSPC during the year ended 31 March 2022 is outlined in Figure 3 below. Membership was originally designed to be the Chief Executives of each Health Board and Trust but nominated deputies are allowed to attend and vote, provided they are an Executive Director of their own organisation.

Figure 3: Table of Members of the NHS Wales Shared Services Partnership Committee during 2021/2022

Name	**Position**	**Organisation**	**Full/Part Year**
Margaret Foster* (Chair)	*Independent Member*	*NHS Wales Shared Services Partnership*	*Part Year*
Tracy Myhill ** (Chair)	*Independent Member*	*NHS Wales Shared Services Partnership*	*Part Year*
Huw Thomas (Vice Chair)	*Director of Finance*	*Hywel Dda UHB*	*Full Year*
Neil Frow	*Managing Director of NWSSP*	*NHS Wales Shared Services Partnership*	*Full Year*
Geraint Evans	*Director of Workforce and OD*	*Aneurin Bevan UHB*	*Part Year*
Sarah Simmonds***	*Director of Workforce and OD*	*Aneurin Bevan UHB*	*Part Year*
Jo Whitehead	*Chief Executive*	*Betsi Cadwaladr UHB*	*Full Year*
Catherine Phillips	*Director of Finance*	*Cardiff and Vale UHB*	*Full Year*
Hywel Daniel	*Director of Workforce & OD*	*Cwm Taf Morgannwg UHB*	*Full Year*
Claire Osmundsen-Little	*Director of Finance*	*Digital Health and Care Wales*	*Full Year*
Eifion Williams	*Director of Finance*	*HEIW*	*Part Year*
Rhiannon Beckett ****	*Interim Director of Finance*	*HEIW*	*Part Year*
Pete Hopgood	*Director of Finance*	*Powys THB*	*Full Year*
Helen Bushell	*Board Secretary*	*Public Health Wales NHS Trust*	*Full Year*
Debbie Eyitayo	*Director of Workforce and OD*	*Swansea Bay UHB*	*Full Year*
Steve Ham	*Chief Executive*	*Velindre University NHS Trust*	*Full Year*
Chris Turley	*Director of Finance*	*Welsh Ambulance Services NHS Trust*	*Full Year*

**Until 30 November 2021*
***With effect from 1 December 2021*
**** Replaced Geraint Evans with effect from 23 September 2021*
***** Replaced Eifion Williams with effect from 20 January 2022*

The composition of the Committee also requires the attendance of the following: Deputy Director of Finance, Welsh Government, Director of Finance & Corporate Services, NWSSP, Director of People & Organisational Development, NWSSP, Medical Director, NWSSP, Director of Planning, Performance, and Informatics, NWSSP and Head of Finance & Business Development, NWSSP as governance support. Trade Unions are also invited to the meetings.

Figure 4 – Attendance at the Meetings of the NHS Wales Shared Services Partnership Committee during 2021/2022

Organisation	20/05/ 2021	22/07/ 2021	23/09/ 2021	18/11/ 2021	20/01/ 2022	24/03/ 2022
Aneurin Bevan UHB	✓	✓	✓	✓	✓	x
Betsi Cadwaladr UHB	✓**	✓*	✓**	✓**	✓**	✓**
Cardiff and Vale UHB	✓	✓	✓**	✓**	x	✓**
Cwm Taf UHB	✓	✓	✓	✓	✓	✓
DHCW	✓	✓	✓	✓	✓*	✓
HEIW	x	✓	✓	✓**	✓	✓
Hywel Dda UHB	✓	✓	✓**	✓	✓	✓
Powys Teaching Health Board	✓	✓	x	✓	x	✓
Public Health Wales Trust	x	x	✓**	✓**	✓**	✓**
Swansea Bay UHB	✓**	✓**	✓**	✓**	✓**	✓
Velindre University NHS Trust	✓*	x	✓	x	x	x
Welsh Ambulance Service Trust	✓	x	x	✓	x	✓**
Welsh Government	✓	✓	✓	✓	✓	✓
Trade Union	x	✓	✓	x	x	x
Chair	✓	✓	✓	✓	✓	✓
Accountable Officer	✓	✓	✓	✓	✓	✓

✓ Denotes the nominated member was present

✓**Denotes the nominated member was not present and that an alternative Executive Director attended on their behalf*

✓** *Denotes that the nominated member was not present and that while a deputy did attend, they were not an Executive Member of their Board.*

X Denotes Health Body not represented

No meetings of the SSPC were cancelled during 2021/22 due to the pandemic but all meetings were held virtually. In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. As a result of the public health risk linked to the pandemic there have been limitations on public gatherings and has not therefore been possible to allow the public to attend meetings of our board and committees during the year. We did not receive any requests from the public to attend the SSPC but to ensure business was conducted in as open and transparent manner as possible during this time the following actions were taken:

- The dates of all meetings are published on the NWSSP website prior to the start of the financial year;
- The agenda is published in English and Welsh at least seven days prior to the meeting;
- All papers are published in English on the website, and minutes are also provided in Welsh, shortly after the meeting has taken place.

The purpose of the SSPC is set out below:

- To set the policy and strategy for NWSSP;
- To monitor the delivery of shared services through the Managing Director of NWSSP;
- To seek to improve the approach to delivering shared services which are effective, efficient and provide value for money for NHS Wales and Welsh Government;
- To ensure the efficient and effective leadership, direction, and control of NWSSP; and
- To ensure a strong focus on delivering savings that can be re-invested in direct patient care.

The SSPC monitors performance monthly against key performance indicators. For any indicators assessed as being below target, reasons for current performance are identified and included in the report along with any remedial actions to improve performance. These are presented to the SSPC by the relevant Director. Deep Dive sessions are a standing item on the agenda to learn more about the risks and issues of directorates within NWSSP.

The SSPC ensures that NWSSP consistently followed the principles of good governance applicable to NHS organisations, including the oversight and development of systems and processes for financial control, organisational control, governance, and risk management. The SSPC assesses strategic and corporate risks through the Corporate Risk Register.

2.2 SSPC Performance

During 2021/2022, the SSPC approved an annual forward plan of business, including:

- Regular assessment and review of:
  - Finance, Workforce and Performance information;
  - Corporate Risk Register;
  - Welsh Risk Pool;
  - Programme Management office updates.
- Annual review and/or approval of:
  - Integrated Medium-Term Plan;
  - Annual Governance Statement;
  - Audit Wales Management Letter;
  - Annual Review;
  - Standing Orders and Standing Financial Instructions;
  - Service Level Agreements.
- Deep Dives into:
  - Use of IP5;
  - National Primary Care Programme;
  - Foundational Economy;
  - Decarbonisation;
  - HCS support to Booster Campaign;
  - Procurement National Operating Model; and
  - Recruitment Modernisation Programme.

2.3 Velindre Audit Committee for NWSSP

The primary role of the Velindre University NHS Trust Audit Committee for Shared Services (Audit Committee) has been to review and report upon the adequacy and effective operation of NWSSP's overall governance and internal control system. This includes risk management, operational and compliance controls, together with the related assurances that underpin the delivery of NWSSP's objectives. This role is set out clearly in the Audit Committee's terms of reference, which were revised in April 2021 to ensure these key functions were embedded within the standing orders and governance arrangements.

The Audit Committee reviews the effective local operation of internal and external audit, as well as the Counter Fraud Service. In addition, it ensures that a professional relationship is maintained between the external and internal auditors so that assurance resource is effectively used.

The Audit Committee supports the SSPC in its decision-making and in discharging its accountabilities for securing the achievement of NWSSP's objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Audit Committee attendees during 2021/2022 comprised of three Independent Members of Velindre University NHS Trust supported by representatives of both Internal and External Audit and Senior Officers of NWSSP and Velindre University NHS Trust.

Figure 5 - Composition of the Velindre University NHS Trust Audit Committee for NWSSP during 2021/22

In Attendance	April 2021	June 2021	October 2021	January 2022	Total
Members					
Martin Veale, Chair & Independent Member	✓	✓	✓	✓	**4/4**
Gareth Jones, Independent Member	✓	✓	✓	✓	**4/4**
Janet Pickles, Independent Member	X	✓			**1/2**
Vicky Morris, Independent Member				✓	**1/1**
Audit Wales					
Audit Team Representative	✓	✓	✓	✓	**4/4**
NWSSP Audit Service					
Director of Audit & Assurance	✓	✓	✓	✓	**4/4**
Head of Internal Audit	✓	✓	✓	✓	**4/4**
Counter Fraud Services					
Local Counter Fraud Specialist	✓	✓	✓	✓	**4/4**
NWSSP					
Margaret Foster, Chair NWSSP (to 30/11/2021)	✓	✓	✓		**3/3**
Tracy Myhill, Chair NWSSP (from 01/12/2021)				x	**0/1**
Neil Frow, Managing Director	✓	✓	✓	✓	**4/4**
Andy Butler, Director of Finance & Corporate Services	✓	✓	✓	✓	**4/4**
Peter Stephenson, Head of Finance & Business Development	✓	✓	✓	✓	**4/4**
Carly Wilce Interim Corporate Services Manager	✓	✓	✓	✓	**4/4**
Velindre University NHS Trust					
Mark Osland/Matthew Bunce, Director of Finance	✓	✓	✓	✓	**4/4**
Lauren Fear Director of Corporate Governance	✓	x	✓	✓	**3/4**

The Audit Committee met formally on four occasions during the year with the majority of members attending regularly and all meetings were quorate. An Audit Committee Highlight Report is reported to the SSPC after each Audit Committee meeting.

2.4 Reviewing Effectiveness of Audit Committee

The Audit Committee completes an annual committee effectiveness survey evaluating the performance and effectiveness of:

- the Audit Committee members and Chair;
- the quality of the reports presented to Committee; and
- the effectiveness of the Committee secretariat.

The survey questionnaire comprises self-assessment questions intended to assist the Audit Committee in assessing their effectiveness with a view to identifying potential areas for development going forward. A survey undertaken during July 2021, had a 60% response rate (nine responses received) and identified the following:

- Very positive responses received from participants in regard to the Chairing of the Audit Committee;
- The atmosphere at meetings is conducive to open and productive debate;
- All members and attendees' behaviour are courteous and professional;
- The majority of participants have found virtual meetings a positive experience;
- Members agree the Audit Committee meets sufficiently frequently to deal with planned matters and enough time is allowed for questions and discussions;
- All respondents agreed that the Audit Committee is provided with sufficient authority and resources in order to perform its role effectively; and
- The vast majority of responses indicated that the reports received by the Audit Committee are timely and have the right format and content, which enables the Audit Committee to enhance its internal control and risk management responsibilities.

2.5 Sub-Groups and Advisory Groups

The SSPC is supported by two advisory groups:

- **Welsh Risk Pool Committee**
  - Reimburse losses over £25,000 incurred by Welsh NHS bodies arising out of negligence;
  - Provide oversight of the GP Indemnity Scheme;
  - Funded through the NWSSP allocation supplemented by a risk sharing agreement with health boards and trusts ;
  - Oversees the work and expenditure of the Welsh Risk Pool; and
  - Helps promote best clinical practice and lessons learnt from clinical incidents.

- **Local Partnership Forum (LPF)**
  - Formal mechanism for consultation and engagement between NWSSP and the relevant Trade Unions. The LPF facilitates an open forum in which parties can engage with each other to inform debate and seek to agree local priorities on workforce and health service issues.

2.6 Senior Leadership Group (SLG)

The Managing Director leads the SLG and reports to the Chair of the SSPC on the overall performance of NWSSP. The Managing Director is the designated Accountable Officer for NWSSP and is accountable, through the leadership of the Senior Leadership Group, for:

- The performance and delivery of NWSSP through the preparation of the annually updated Integrated Medium-Term Plan (IMTP) based on the policies and strategy set by the SSPC and the preparation of Service Improvement plans;
- Leading the SLG to deliver the IMTP and Service Improvement Plans;
- Establishing an appropriate Scheme of Delegation for the SLG; and
- Ensuring that adequate internal controls and procedures are in place to ensure that delegated functions are exercised properly and prudently.

The SLG is responsible for determining NWSSP policy, setting the strategic direction and aims to ensure that there is effective internal control, and ensuring high standards of governance and behaviour. In addition, the SLG is responsible for ensuring that NWSSP is responsive to the needs of NHS Wales organisations.

The SLG comprises:

Figure 7 – Composition of the SLG at NWSSP during 2021/2022

Name	Designation
Neil Frow	Managing Director
Andy Butler	Director of Finance and Corporate Services
Gareth Hardacre	Director of People, Organisational Development and Employment Services
Jonathan Irvine	Director of Procurement Services
Simon Cookson	Director of Audit and Assurance
Mark Harris	Director of Legal and Risk Services
Andrew Evans	Director of Primary Care Services
Neil Davies	Director of Specialist Estates
Professor Malcolm Lewis OBE	Medical Director (until 30/09/21)
Dr Ruth Alcolado	Medical Director (wef 01/10/21)
Alison Ramsey	Director of Planning, Performance & Informatics
Colin Powell	Director of Pharmacy Technical Services
Alwyn Hockin	Trade Union Representative

In 2020/21 the SLG was supported by a Planning and Response Group to meet the challenges arising from the COVID-19 outbreak. In addition to the

core members of the SLG, the Planning and Response Group includes representation from Trade Unions, Communications, the Surgical Materials Testing Laboratory, and a number of Deputy Directors to provide an operational perspective. In 2021/22 the Group was stood back up between December 2021 and February 2022 in response to the potential threat from the Omicron variant.

3. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to the achievement of the policies, aims and objectives of NWSSP. Therefore, it can only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks, evaluate the likelihood of those risks being realised and the impact they would have, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in NWSSP for the year ending 31 March 2022 and up to the date of approval of the Trust Annual Report and Accounts.

3.1 External Audit

NWSSP's external auditors are Audit Wales. The Audit Committee has worked constructively with Audit Wales and the areas examined in the 2021/22 financial year included:

- Position Statements (to every meeting);
- NWSSP Nationally Hosted NHS IT Systems Assurance Report;
- Management Letter 2020/21;
- Stock/Inventories Report; and
- Assurance Arrangements 2021/22.

The work of external audit is monitored by the Audit Committee through regular progress reports. Their work is considered timely and professional. The recommendations made are relevant and helpful in our overall assurance and governance arrangements and in minimising risk. There are clear and open relationships with officers and the reports produced are comprehensive and well presented.

In addition to internal NWSSP issues, the Audit Committee has been kept appraised by our external auditors of developments across NHS Wales and elsewhere in the public sector. These discussions have been helpful in extending the Audit Committee's awareness of the wider context of our work.

3.2 Internal Audit

The Audit Committee regularly reviewed and considered the work and findings of the internal audit team. The Director of Audit and Assurance and the relevant Heads of Internal Audit attend meetings to discuss their work

and present their findings. The Audit Committee are satisfied with the liaison and coordination between the external and internal auditors.

Quarterly returns providing assurance on any audit areas assessed as having "no assurance" or "limited assurance" were issued to Welsh Government in accordance with the instruction received from Dr Andrew Goodall, Chief Executive NHS Wales/Director General in July 2016. During 2021/22 one internal audit report (ICT Operational Infrastructure) was rated as limited assurance. There were no reports that received a "no assurance" rating.

For both internal and external audit, the Audit Committee have ensured that management actions agreed in response to reported weaknesses were implemented in a timely manner. Any planned revisions to agreed timescales for implementation of action plans requires Audit Committee approval. A separate report on the position with implementation of audit recommendations is monitored at each Audit Committee and is also taken for action at each monthly meeting of the SLG.

Reports were timely and enabled the Audit Committee to understand operational and financial risks. In addition, the internal auditors have provided valuable benchmarking information relating to best practice across NHS Wales.

3.3 Counter Fraud

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

Regular reports were received by the Audit Committee to monitor progress against the agreed Counter Fraud Plan, including the following reports:

- Progress Update at each meeting
- Annual Report 2020-21
- Counter Fraud Work Plan 2021-22.

As part of its work, Counter Fraud has a regular annual programme of raising fraud awareness for which a number of days are then allocated and included as part of an agreed Work-Plan which is signed off by the Director of Finance and Corporate Services annually.

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. During 2021/22, these sessions have been provided virtually.

In addition to this and in an attempt to promote an Anti-Fraud Culture within NWSSP, a quarterly newsletter is produced which is available to all staff on the intranet and all successful prosecutions are publicised in order to obtain the maximum deterrent effect.

Although the Work Plan for 2021/22 was signed off at the Audit Committee, it was recognised and recorded that the days being made available through the Local Counter Fraud Specialist were considered insufficient to address the fraud risk within NWSSP. This was in part due to the long-term sickness absence of the Manager of the Counter Fraud Service and also due to the increase in size and complexity of NWSSP, with significant expenditure undertaken to support the response to the pandemic. The plan was therefore approved with the contingency that additional resource could be provided by the Counter Fraud Service Wales team and Internal Audit as appropriate. Going forward, NWSSP intends to recruit its own dedicated LCFS to complement the service currently received from the Cardiff & Vale Team.

3.4 Integrated Governance

The Audit Committee is responsible for the maintenance and effective system of integrated governance. It has maintained oversight of the whole process by seeking specific reports on assurance, which include:

- The Quality Assurance and Improvement Plan arising from the 2020-21 Internal Audit self-assessment;
- Tracking of Audit Recommendations;
- Corporate Risk Register;
- Directorate Assurance Maps; and
- Governance Matters report on single tender actions, declarations of interest, gifts and hospitality received and declined.

During 2021/22, the Audit Committee reported any areas of concern to the SSPC and played a proactive role in communicating suggested amendments to governance procedures and the Corporate Risk Register.

3.5 Quality

During 2021/22, the SSPC has given attention to assuring the quality of services by including a section on "Quality, Safety and Patient Experience" as one of the core considerations on the committee report template when drafting reports for SSPC meetings.

Since the start of the 2021/22 financial year, the Velindre Quality and Safety Committee gives over part of its meetings to NWSSP issues and particularly those relating to the Temporary Medicines Unit. An assurance report is produced following this meeting for review at the SSPC.

In addition, quality of service provision is a core feature of the discussions undertaken between NWSSP and the Health Boards and Trusts during quarterly review meetings with the relevant Directors.

Procurement Services maintains certification to a number of international and national standards including ISO 9001 Quality Management, BS ISO 45001 Occupational Health & Safety and Customer Service Excellence. The

Regional Stores are also accredited to the food hygiene STS Code of Practice & Technical Standard for the Public Sector. In 2021 our certifications were extended to include our new IP5 Newport Store with a successful audit against the ISO 9001 Quality Management Standard and BS ISO 45001 Occupational Health & Safety Standard. Also achieving transition from OHSAS 18001 to the international standard ISO 45001.

In January 2022 our independent audit against the Customer Service Excellence standard confirmed ongoing compliance and identified seven areas of exceptional 'Compliance Plus'. Our Quality Plan includes objectives that will see us utilise these recognised Standards to standardise practice across our logistics and materials management functions, building on the foundations already created and supporting our plans for service development and modernisation.

3.6 Looking Ahead

As a result of its work during the year the Audit Committee is satisfied that NWSSP has appropriate and robust internal controls in place and that the systems of governance incorporated in the Standing Orders are fully embedded within the Organisation.

Looking forward to 2022-23 the Audit Committee will continue to explore the financial, management, governance and quality issues that are an essential component of the success of NWSSP.

Specifically, the Audit Committee will:

- Continue to examine the governance and internal controls of NWSSP;
- Monitor closely risks faced by NWSSP and also by its major providers;
- Work closely with the Chairs of Audit Committee group on issues arising from financial governance matters affecting NHS Wales and the broader public sector community;
- Work closely with external and internal auditors on issues arising from both the current and future agenda for NWSSP;
- Ensure the SSPC is kept aware of its work including both positive and adverse developments; and
- Request and review a number of deep dives into specific areas to ensure that it provides adequate assurance to both the Audit Committee and the SSPC.

4. CAPACITY TO HANDLE RISK

The need to continue to respond to, and recover from, the COVID-19 pandemic presents a number of challenges to the organisation. A number of new and emerging risks were identified, not least in the areas of Recruitment and Payroll where a significant and sustained increase in demand for services has impacted performance. NWSSP continues to work closely with a wide range of partners, including the Welsh Government as it continues with its response, and planning into the recovery phase.

The identified COVID risks were recorded in a separate risk register which was reported primarily to the Planning and Response Group, but also each and every meeting of the SLG, the SSPC and the Audit Committee. There are currently no red-rated COVID risks, other than the impact on Recruitment and Payroll services as previously highlighted.

In addition to the risks arising as a result of the COVID-19 pandemic there are other risks facing the organisation. The organisations risk profile relating to non-COVID-19 risks has included three red-rated risks in the 2021/22 financial year as follows:

- Plans for the replacement of the GP Payments system – this is no longer a red risk as at 31 March 2022;
- The impact on Employment Services and particularly Recruitment and Payroll of the response to recovering from the pandemic and a resultant significant increase in demand for these services from NHS Wales organisations; and
- The inflationary pressures, particularly on fuel and energy, as a result of the situation in Ukraine.

The SSPC has overall responsibility and authority for NWSSP's Risk Management programme through the receipt and evaluation of reports indicating the status and progress of risk management activities.

The Lead Director for risk is the Director of Finance and Corporate Services who is responsible for establishing the policy framework and systems and processes needed for the management of risks within the organisation.

The Trust has an approved strategy for risk management and NWSSP has a risk management protocol in line with its host's strategy providing a clear systematic approach to the management of risk within NWSSP. The Risk Protocol was re-approved by the Audit Committee in June 2021.

NWSSP seeks to integrate risk management processes so that it is not seen as a separate function but rather an integral part of the day-to-day management activities of the organisation including financial, health and safety and environmental functions.

The Corporate Risk Register is reviewed monthly by the SLG who ensure that key risks are aligned to delivery and are considered and scrutinised by the SLG as a whole. The register is divided into two sections as follows:

- Risks for Action – this includes all risks where further action is required to achieve the target score. The focus of attention for these risks should be on ensuring timely completion of required actions; and

- Risks for Monitoring – this is for risks that have achieved their target score, but which need to remain on the Corporate Risk Register due to their potential impact on the organisation as a whole. For these

risks the focus is on monitoring both any changes in the nature of the risk (e.g. due to external environmental changes) and on ensuring that existing controls and actions remain effective (e.g. through assurance mapping).

It is the responsibility of each Director and Head of Service to ensure that risk is addressed within each of the locations relevant to their Directorates. It is also important that an effective feedback mechanism operates across NWSSP so that frontline risks are escalated to the attention of Directors.

Each Director is required to provide a regular update on the status of their directorate specific risk registers during quarterly review meetings with the Managing Director. All risks categorised as being red within individual directorate registers trigger an automatic referral for review by the SLG, and if deemed appropriate the risk is added to the NWSSP Corporate Risk Register.

Assurance maps are updated at least annually for each of the directorates to provide a view on how the key operational, or business-as-usual risks are being mitigated. The Audit Committee review all assurance maps annually.

A Risk Appetite statement has also been documented and approved by the Audit Committee. This covers nine specific aspects of NWSSP activity with a separate appetite score for each. The operationalisation of the risk appetite is through the target scores in the corporate and directorate risk registers. The Risk Appetite was reviewed again by the Audit Committee in June 2021.

NWSSP's approach to risk management therefore ensures that:

- Leadership is given to the risk management process;
- Staff are trained on how to identify and manage risk;
- Risks are identified, assessed, and prioritised ensuring that appropriate mitigating actions are outlined on the risk register;
- The effectiveness of key controls is regularly assured; and
- There is full compliance with the Orange Book on Management of Risk.

5. THE RISK AND CONTROL FRAMEWORK

NWSSP's commitment to the principle that risk is managed effectively means a continued focus to ensure that:

- There is compliance with legislative requirements where non-compliance would pose a serious risk;
- All sources and consequences of risk are identified, and risks are assessed and either eliminated or minimised; information concerning risk is shared with staff across NWSSP and with Partner organisations through the SSPC and the Audit Committee;

- Damage and injuries are minimised, and staff health and wellbeing is optimised; and
- Lessons are learnt from compliments, incidents, and claims in order to share best practice and reduce the likelihood of reoccurrence.

5.1 Corporate Risk Framework

The detailed procedures for the management of corporate risk have been outlined above. Generally, to mitigate against potential risks concerning governance, NWSSP is proactive in reviewing its governance procedures and ensuring that risk management is embedded throughout its activities, including:

- NWSSP is governed by Standing Orders and Standing Financial Instructions which are reviewed on an annual basis;
- The SSPC and Audit Committee both have forward work plans for committee business which provide an assurance framework for compliance with legislative and regulatory requirements;
- The effectiveness of governance structures is regularly reviewed including through self-effectiveness surveys;
- The front cover pro-forma for reports for the SSPC includes a summary impact analysis section to be completed prior to submission. This provides a summary of potential implications relating to equality and diversity, legal implications, quality, safety and patient experience, risks and assurance, Wellbeing of Future Generations, Health and Care Standards and workforce;
- The Service Level Agreements in place with NHS Wales organisations set out the operational arrangements for NWSSP's services to them and are reviewed on an annual basis;
- NWSSP complete the Welsh Government's Health and Care Standards framework and ensure that Theme 2 Safe Care provides a clear picture of NWSSP's approach to health, safety, and risk management; and
- The responsibilities of Directors are reviewed at annual Performance and Development Reviews (PADRs).

5.2 Policies and Procedures

NWSSP follows the policies and procedures of the Trust as the host organisation. In addition, a number of workforce policies have been developed and promulgated on a consistent all-Wales basis through the Welsh Partnership Forum and these apply to all staff within NWSSP.

All staff are aware of and have access to the internal Intranet where the policies and procedures are available. In a number of instances supplementary guidance has been provided. The Trust ensures that NWSSP have access to all the Trust's policies and procedures and that any amendments to the policies are made known as they are agreed. NWSSP participate in the development and revision of workforce policies and procedures with the host organisation and has established procedures for staff consultation.

The SSPC will where appropriate develop its own protocols or amend policies if applicable to the business functions of NWSSP. The Managing Director and other designated officers of NWSSP are included on the Trust Scheme of Delegation.

During the 2020/21 year, the continuing need to respond urgently to meet the unprecedented demand for Personal Protective Equipment (PPE) and other medical devices and consumables, required significant amendment to the existing Scheme of Delegation that forms part of the Standing Orders for NWSSP. The delegated authorisation limits for the Chair and Managing Director for COVID 19 were increased to £5M from 30 March 2020, and this higher limit remained in force until June 2021 when it expired. However, contracts and orders for COVID expenditure more than £5M still require approval of the Velindre Trust Board, which for expedience may need to be through the existing mechanism of Chair's action. Welsh Government approval is still required on all orders over £1m or advanced payments worth 25% or more of the contract value. Following concerns over the Omicron variant prior to Christmas 2021, the £5m limit was re-instated until 30 June 2022.

5.3 Information Governance

NWSSP has established arrangements for Information Governance to ensure that information is managed in line with the relevant ethical law and legislation, applicable regulations and takes guidance, when required from the Information Commissioner's Office (ICO). This includes established laws including Data Protection Legislation, Common Law Duty of Confidentiality, the Human Rights Act, the Caldicott Report, and specific Records Management Principles. The implementation of the General Data Protection Regulations in May 2018 increased the responsibilities to ensure that the data that NWSSP collects, and its subsequent processing, is for compatible purposes, and it remains secure and confidential whilst in its custody.

The Director of Finance and Corporate Services is the designated Senior Information Risk Owner (SIRO) in relation to Information Governance for NWSSP. NWSSP has an Information Governance Manager who has the objective of facilitating the effective use of controls and mechanisms to ensure that staff comply with Information Governance fundamental principles and procedures. This work includes awareness by delivery of an online core skills training framework eLearning module on Information Governance, classroom-based training (when possible) for identified high risk staff groups, developing, and reviewing policies and protocols to safeguard information, and advising on and investigating Information Governance breaches reported on the Datix incident reporting system.

The Information Governance Manager is responsible for the continuing delivery of an enhanced culture of confidentiality. This includes the presence of a relevant section on the intranet and a dedicated contact point for any requests for advice, training, or work.

NWSSP has an Information Governance Steering Group (IGSG) that comprises representatives from each directorate who undertake the role of Information Asset Administrators for NWSSP. The IGSG discusses quarterly issues such as GDPR and Data Protection Legislation, the Freedom of Information Act, Information Asset Ownership, Information Governance Breaches, Records Management, training compliance, new guidance documentation and training materials, areas of concern and latest new information and law.

NWSSP has a suite of protocols and guidance documents used in training and awareness for all staff on the importance of confidentiality and to ensure that all areas are accounted for. These include email and password good practice guides, summarised protocols, and general guidance for staff. There is also a documented Privacy Impact Assessment (or "Privacy by Design") process in place to ensure consideration of Information Governance principles during the early stages of new projects, processes or work streams proposing to use identifiable information in some form.

NWSSP has developed an Integrated Impact Assessment process to include broader legislative and regulatory assurance requirements, and the pro-forma includes the need to consider the impact of the protected characteristics (including race, gender, and religion) on the various types of Information Governance protocols.

The Information Governance Manager attends various meetings including the Trust IG and IM&T Committee and the NHS Wales Information Governance Management Advisory Group (IGMAG) hosted by NHS Wales Informatics, attended by all NHS Wales Health Bodies.

An annual report is produced on Information Governance within NWSSP. This was submitted to the SLG in April 2021.

5.4 Counter Fraud

Counter Fraud support is incorporated within the hosting agreement with the Trust. Under this agreement, local Counter Fraud Services are provided to NWSSP by Cardiff and Vale UHB.

In addition, NWSSP lead the NHS Wales Counter Fraud Steering Group (CFSG), facilitated by Welsh Government, which works in collaboration with the NHS Counter Fraud Authority in NHS England to develop and strengthen counter fraud services across NHS Wales. The Director of Finance and Corporate Services chairs the group.

The Group has a documented NHS Fighting Fraud Strategy for Wales with an accompanying action plan which is reviewed at the quarterly meetings of the CFSG. Work has also been undertaken to improve and enhance the quarterly reporting of both the Local Counter Fraud Specialists, and the Counter Fraud Services Wales Team. Reports are submitted to the meetings of the CFSG and are then shared with both Welsh Government and the Directors of Finance Group for NHS Wales.

During 2020/21 the Group received and considered a report "Raising our Game" which was produced by Audit Wales, and which assessed the counter-fraud arrangements in place across NHS Wales and both local and central government. While the findings of the review were largely positive, there were some recommendations for all sectors, and actions to respond to these recommendations have been incorporated into a combined action plan which also includes the required actions from the Fighting Fraud Strategy.

5.5 Internal Audit

The NWSSP hosting agreement provides that the SSPC will establish an effective internal audit as a key source of its internal assurance arrangements, in accordance with the Public Internal Auditing Standards.

Accordingly, for NWSSP, an internal audit strategy has been approved by the Audit Committee which provides coverage across NWSSP functions and processes sufficient to assure the Managing Director of NWSSP and in turn the SSPC and the Trust as host organisation, on the framework of internal control operating within NWSSP.

The delivery of the audit plan for NWSSP culminates in the provision of a Head of Internal Audit opinion on the governance, risk and control processes operating within NWSSP. The opinion forms a key source of assurance for the Managing Director when reporting to the SSPC and partner organisations.

5.6 Integrated Medium-Term Plan (IMTP)

The Plan is approved by the SSPC and performance against the plan is monitored throughout the year. The 2021-2024 plan was submitted to Welsh Government in accordance with required timescales, and the current 2022-2025 plan has similarly met the required Welsh Government deadlines.

Significant work has been undertaken to revise the performance framework to ensure that it is fully integrated with the key priorities in the plan. The majority of performance targets for 2021/22 were achieved and progress against each of these is reported to the SLG and the SSPC. There is also regular reporting to Welsh Government requirement on progress against the plan through Joint Executive Team (JET) meetings.

The planning process includes substantial engagement with key stakeholders, both internally and across NHS Wales and the wider public sector, in both virtual team events and on a one-to-one basis.

5.7 Health and Care Standards for NHS Wales

The Standards for Health Service in Wales provide a framework for consistent standards of practice and delivery across the NHS in Wales, and for continuous improvement. In accordance with the programme of internal audits, the process is tested and is an integral part of the organisation's assurance framework process.

The Health and Care Standards Framework comprises seven main themes and sub criteria against which NHS bodies need to demonstrate compliance.

The process for undertaking the annual self-assessments is:

- The Corporate Services Manager undertakes an initial evaluation;
- A draft self-assessment is then presented to the SLG for discussion and further consultation is undertaken at Directorate level;
- Feedback from each Directorate is reviewed and incorporated into the self-assessment pro-forma and is then re-presented to SLG for final approval
- Once approved, it is presented to the SSPC, Audit Committee and the Trust Quality and Safety Committee.

Each theme is assessed and given an overall self-assessment rating of between 1 and 5. As a largely non-clinical service provider, not all of the sub-criteria are applicable. This process is shortly to complete for the 2021/22 financial year.

A summary of the self-assessment ratings is outlined below:

Figure 9 – Self- Assessments Rating Against the Health and Care Standards 2021/2022

Theme	Executive Lead	2021/22 Self-Assessment Rating	2020/21 Self-Assessment Rating
Governance, Leadership and Accountability	Senior Management Team	TBC	4
Staying Healthy	Director of Workforce and Organisational Development	TBC	4
Safe Care	Director of Finance and Corporate Services Director of Specialist Estates	TBC	4

Theme	Executive Lead	2021/22 Self-Assessment Rating	2020/21 Self-Assessment Rating
Effective Care	Senior Management Team	TBC	4
Dignified Care	Not applicable	Not applicable	Not applicable
Timely Care	Not applicable	Not applicable	Not applicable
Individual Care	Senior Management Team	TBC	4
Staff and Resources	Director of Workforce and Organisational Development	TBC	4

The overall rating against the mandatory Governance, Leadership, and accountability module and the seven themes within the Health and Care Standards reflects NWSSP's overall compliance against the standards and has been rated as a TBC as outlined below:

Figure 10 – NWSSP's Overall Self-Assessment Score Health and Care Standards 2021/2022

Assessment Level	1 We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve	2 We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action	3 We are developing plans and processes and can demonstrate progress with some of our key areas for improvement	4 We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business	5 We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from
Rating				✓	

6. MANDATORY DISCLOSURES

In addition to the need to report against delivery of the Standards for Health Services in Wales, NWSSP is also required to report that arrangements are in place to manage and respond to the following governance issues:

6.1 Equality, Diversity and Human Rights

NWSSP is committed to eliminating discrimination, valuing diversity, and promoting inclusion and equality of opportunity in everything it does. NWSSP's priority is to develop a culture that values each person for the contribution they can make to the services provided for NHS Wales. As a non-statutory hosted organisation within the Trust, NWSSP is required to adhere to the Trust Equality and Diversity Policy, Strategic Equality Plan and Objectives, which set out the Trust's commitment and legislative requirements to promote inclusion.

NWSSP are a core participant of the NHS Wales Equality Leadership Group (ELG), who work in partnership with colleagues across NHS Wales and the wider public sector, to collaborate on events, facilitate workshops, deliver, and undertake training sessions, issue communications and articles relating to equality, diversity, and inclusion, together with the promotion of dignity and respect for all. NWSSP is proactive in supporting NHS Wales organisations with completion of their submission for all-Wales services, such as Procurement and Recruitment. We host a range of staff networks and we are developing our inclusion offering for our workforce.

The process for undertaking Equality Integrated Impact Assessments (EQIIA) has matured, and considers the needs of the protected characteristics identified under the Equality Act 2010, the Public Sector Equality Duty in Wales and the Human Rights Act 1998, whilst recognising the potential impacts from key enablers such as Well-being of Future Generations (Wales) Act 2015, incorporating Environmental Sustainability, Modern Slavery Act 2015 incorporating Ethical Employment in Supply Chains Code of Practice 2017, Welsh Language, Information Governance and Health and Safety.

With effect from March 31st, 2021, the Socio-Economic Duty placed a legal responsibility on NHS bodies when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. A presentation on this topic was given by two lawyers from our Legal & Risk Directorate to the April 2021 Informal SLG.

Personal data in relation to equality and diversity is captured on the Electronic Staff Record (ESR) system and staff are responsible for updating their own personal records using the Electronic Staff Record Self-Service. This includes ethnicity; nationality, country of birth, religious belief, sexual orientation, and Welsh language competencies. The NHS Jobs All-Wales recruitment service, run by NWSSP adheres to all of the practices and principles in accordance with the Equality Act and quality checks the adverts and supporting information to ensure no discriminatory elements are present.

NWSSP has a statutory and mandatory induction programme for its workforce, including the NHS Wales "Treat Me Fairly" e-learning module, which forms part of a national training package and the statistical data captured for NWSSP completion contributes to the overall figure for NHS Wales. A Core Skills for Managers Training Programme is provided, and

the Managing Conflict module includes an awareness session on Dignity at Work.

6.2 Welsh Language

NWSSP is committed to ensuring that the Welsh and English languages are treated equally in the services provided to the public and NHS partner organisations in Wales. This is in accordance with the current Trust Welsh Language Scheme, Welsh Language Act 1993, the Welsh Language Measure (Wales) 2011 and the Welsh Language Standards [No7.] Regulations 2018.

The work of NWSSP in relation to Welsh language delivery and performance is reported to the Welsh Government and the Welsh Language Commissioner within the Annual Performance Report. This work is largely undertaken by the Welsh Language Officer and a team of Translators.

These posts enable compliance with the current obligations under the Welsh Language Scheme and in meeting the requirements of the Welsh Language Standards. This has significantly increased the demand for translation services in the following areas:

- Service Delivery Standards;
- Policy Making Standards;
- Operational Standards;
- Record Keeping Standards; and
- Supplementary Standards.

NWSSP has made significant progress in developing and growing its Welsh language services by successfully offering all staff the opportunity to learn Welsh at work. The NWSSP website is bilingual and there has been investment in the development of a candidate interface on the TRAC recruitment system. NWSSP also offer language services to other organisations and have delivered translation and other language services to Public Health Wales, HEIW, and NWIS over recent years.

An annual report on performance with Welsh Language services is also produced and was submitted to the SLG in August 2021 and to the SSPC in September 2021.

6.3 Handling Complaints and Concerns

NWSSP is committed to the delivery of high-quality services to its customers. The NWSSP Issues and Complaints Management Protocol is reviewed annually. The Protocol aligns with the Velindre University NHS Trust Handling Concerns Policy, the Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 and Putting Things Right Guidance.

During 2021-22, 100 complaints have been received, of which:

- 98 complaints responded to within 30 working days (98%); and
- 2 complaints responded to outside of 30 working days (2%).

The total number of complaints received represents a significant increase on the total for the previous financial year (59). 86 of the current year complaints relate to Employment Services, with the vast majority of these being received over the summer of 2021. These coincided with the surge in demand on Employment Services from the rest of NHS Wales as organisations sought to take on large numbers of additional staff to boost the recovery from the pandemic and to undertake vaccination campaigns. Measures taken by management to improve the situation in Recruitment and Payroll in particular have produced a huge decline in complaints received over recent months.

As detailed above, 98% of the complaints received were responded to within the 30-working day target. This is a significant increase in performance compared to 69% compliance during 2020-21, and 84% of these were responded to and closed down within 24 hours of receipt of the complaint.

6.4 Freedom of Information Requests

The Freedom of Information Act (FOIA) 2000 gives the UK public the right of access to a variety of information held by public bodies and provides commitment to greater openness and transparency in the public sector, especially for those who are accountable for decisions made on behalf of patients and service users.

Figure 12 – Freedom of Information Requests 2020-21

There were 83 requests received within NWSSP during 2021/22, seven of which were answered slightly over the deadline for compliance, but this was due to the complexity of the information requested within those requests and the far-ranging input required by other parties to agree the information to be supplied. Two are currently on-going but are on track to be completed within the 20-day target.

FOI Breakdown
74 answered within the 20-day target
2 currently on-going but within target
7 responded to outside of the deadline

6.5 Data Security and Governance

In 2021/22, there were 40 (2020/21 34) information governance breaches reported within NWSSP; these included issues with mis-sending of email and records management. The majority of these were down to human error and despite education effectively provided to ensure awareness of confidentiality and effective breach reporting, unfortunately errors can happen.

All breaches are recorded in the Datix risk management software and investigated in accordance with the Information Governance and Confidentiality Breach Reporting protocols, which comply with the General Data Protection Regulation (GDPR). The protocols encourage staff to report those breaches that originate outside the organisation for recording purposes.

From this, the Information Governance Manager writes quarterly reports including relevant recommendations and any areas for improvement to minimise the possibility of further breaches. Members of the Information Governance Steering Group are required to report on any incidents in their areas to include lessons learned and any changes that have been made since an incident was reported.

There was one Information Governance breach referred to the Information Commissioner's Office (ICO) for further investigation, but the ICO were content to close the case with no further action being taken.

6.6 ISO14001 – Environmental Management and Carbon Reduction

NWSSP is committed to managing its environmental impact, reducing its carbon footprint, and integrating the sustainable development principle into day-to-day business. NWSSP successfully implemented ISO14001 as its Environmental Management System (EMS), in accordance with Welsh Government requirements and have successfully maintained certification since August 2014, through the operation of the Plan, Do, Check, Act model of continuous improvement.

The ISO14001:2015 Standard, places greater emphasis on protection of the environment, continuous improvement through a risk process-based approach and commitment to top-down leadership, whilst managing the needs and expectations of interested parties and demonstrating sound environmental performance, through controlling the impact of activities, products, or services on the environment. NWSSP is committed to environmental improvement and operates a comprehensive EMS in order to facilitate and achieve the Environmental Policy. NWSSP successfully achieved its recertification of the ISO 14001:2015 standard in August and September of 2021 with British Assessment Bureau (BAB). We are currently awaiting dates from BAB for the first annual surveillance audits, but we anticipate a summertime review.

Carbon Footprint

We committed to reducing our carbon footprint by implementing various environmental initiatives and efficiencies at our sites within the scope of our ISO14001:2015 certification. As part of our commitment to reduce our contribution to climate change, a target of 3% reduction in our carbon emissions (year on year, from a baseline of carbon footprint established in 2016-17), was agreed and this was reflected within our Environmental Sustainability Objectives.

In 2021-22 we saw a continuance of COVID-19 restrictions and this meant that many of our staff were working from home, thereby significantly reducing carbon emissions through not commuting to work, albeit that these savings are difficult to measure within NWSSP.

Despite this, all of our sites remained operational and therefore all required heating and lighting. Activity in IP5 and Stores, to respond to the needs of NHS Wales and others in battling the impact of the pandemic, particularly with regards to the provision of medical equipment and PPE, significantly increased for the period. The provision of electric vehicles charging points at many sites has also increased the amount of electricity used, albeit that this is green electricity, and the provision of this facility has benefits in making electric cars and fleet vehicles more attractive to NHS Wales and its staff, thus reducing emissions from fossil fuels. However, the benefits from this fossil fuel reduction are impossible to measure for NWSSP, particularly as this facility is available to all NHS Wales staff.

In light of these challenges, NWSSP has still been able to demonstrate significant overall reductions in energy usage where it is possible to directly compare with the previous year, achieving an **overall reduction of 3.15%** in carbon emissions.

	Target	2017-18	2018-19	2019-20	2020-21	2021-22	Achieved
Electricity CO2e	**3%** ↓	18% ↓	11.5 % ↓	27% ↓	15% ↓	4.4% ↑	x
Gas CO2e	**3%** ↓	7% ↓	38% ↓	35 % ↑	32% ↓	12% ↓	✓
Water CO2e	**3%** ↓	9% ↓	6% ↑	50% ↓	46% ↓	13.3 % ↑	x
Overall Carbon Footprint	**3.78%** ↓	**5%** ↓	**11.3%** ↓	**12%** ↓	**16.2%** ↓	**3.1%** ↓	✓

Decarbonisation Action Plan

The NHS Wales Decarbonisation Strategic Delivery Plan (2021-2030) was published in March 2021 and provides a detailed road map for NHS Wales, built around 46 initiatives each of which has been assessed for the potential to help facilitate or directly reduce carbon emissions.

NWSSP led the development and publication of the Strategic Plan which sets out the NHS Wales response to the 2030 net zero ambitions. The organisation has an All-Wales lead role in Buildings, Transport, Procurement, Estates Planning and Land Use but also has responsibilities across other activity streams at both a national and local level due to our significant direct influence on key aspects of the Plan.

NWSSP has also developed its own action plan which was summarised in the IMTP for 2022-25 and progress reporting will be integrated into the IMTP monitoring process. This plan sets out how the organisation will be decarbonising our own activities. Key actions include reducing the impact of our buildings, fleet, and new laundry service, as well as working with staff to help raise the profile of decarbonisation across the organisation. This was submitted to Welsh Government at the end of March 2022 after being signed off by the SLG and reported to the SSPC.

6.7 Business Continuity Planning/Emergency Preparedness

During 2020/21 and the initial response to COVID, NWSSP Business Continuity processes were immediately implemented. This included the establishment of a Planning and Response Group, comprising the SLG plus representatives from the Trade Unions, Surgical and Materials Testing Laboratory, Deputy Directors, and Communications. In 2021/22 the Group has continued to meet as required and in particular during the period from December 2021 to February 2022, when the Omicron variant looked as though it may significantly impact services.

Staff have continued to work from home where possible and have been provided with the IT equipment to enable them to do so effectively. For staff who were required, or preferred to attend NWSSP sites, safe systems of working were implemented and enhanced to keep them as safe as possible, and in compliance with national guidance. Staff welfare is safeguarded, whether working from home or a NWSSP site, through employee support programmes including a network of Mental Health First Aiders across NWSSP who provide a point of contact for employees who are experiencing a mental health issue or emotional distress.

In addition, the NWSSP Mental Health Support Group is a virtual online group open to all colleagues and provides a supporting community where other individuals facing similar struggles can come together to find support, resources, and self-help tools. NWSSP has signed an employer pledge with Time to Change Wales; the first national campaign to end stigma and discrimination faced by people with mental health problems, which is delivered by two of Wales's leading mental health charities, Hafal and Mind Cymru.

Notwithstanding COVID-19, NWSSP is proactive in reviewing the capability of the organisation to continue to deliver products or services at acceptable predefined levels following a disruptive incident. NWSSP recognise its contribution in supporting NHS Wales to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care, in accordance with requirement for NHS bodies to be classed as a Category 1 responders deemed as being at the core of the response to most emergencies under the Civil Contingencies Act (2004).

As a hosted organisation under the Trust, NWSSP is required to take note of their Business Continuity Management Policy and ensure that NWSSP has effective strategies in place for:

- People – the loss of personnel due to sickness or pandemic;
- Premises – denial of access to normal places of work;
- Information Management and Technology and communications/ICT equipment issues; and
- Suppliers internal and external to the organisation.

NWSSP is committed to ensuring that it meets all legal and regulatory requirements and has processes in place to identify, assess, and implement applicable legislation and regulation requirements related to the continuity of operations and the interests of key stakeholders.

NWSSP has a network of BCP Champions who meet bi-monthly and who represent all directorates and major teams. The Group was refreshed in August 2021, and is chaired by the Director of Planning, Performance, and Informatics. In addition to continuing to respond to the issues caused by the pandemic, BCP measures were implemented in February 2022 due to Storm Eunice. Lessons learned from the response to the storm have been documented and formally considered by the BCP Champions.

At the end of the 2021 calendar year, NWSSP were requested to complete the Welsh Government Health Emergency Planning Report for the first time. This provides assurance over the measures in place within NWSSP to cope with and respond to major disruptive incidents and reaffirmed the robust arrangements in place within the Supply Chain and Health Courier Services who are well versed in this area. It did however identify the need to ensure that the rest of NWSSP was appropriately trained, communicated with, and engaged with key external stakeholders where appropriate. An Action Plan has been developed to address these requirements.

Cyber Security

NWSSP continues to work towards implementing the Cyber Security Framework in order to address the specific needs of the service. This is an ongoing plan covering the areas of Identify, Protect, Detect, Respond and Recover. NWSSP have already started a number of work streams including Information Workflows and Governance, Awareness and Training, Procurement of Professional Incident Response Capability, Protective Technology through the SIEM Procurement Project and Business Continuity Planning workshops across the whole of the whole of NWSSP. NWSSP have also recently implemented a robust new virtualised infrastructure based on the tenets of the framework in order to provide a safe and secure environment for NWSSP business systems.

During 2021/22 the Information Security team has been strengthened with the recruitment of an assistant to the Information Security Officer, with the whole team now reporting to the newly appointed Chief Digital Officer, who in turn reports to the Director of Planning, Performance & Informatics. During the year phishing campaigns have been run and heighted concerns over cyber security due to the war in Ukraine have led to action cards being

updated and staff reminded of required practice when dealing with IT systems and responding to e-mails and other forms of contact.

6.8 UK Corporate Governance Code

NWSSP operates within the scope of the Trust governance arrangements. The Trust undertook an assessment against the main principles of the UK Corporate Governance Code as they relate to an NHS public sector organisation in Wales. This assessment was informed by the Trust's assessment against the "Governance, Leadership and Accountability" theme of the Health and Care Standards undertaken by the Board. The Trust is clear that it is complying with the main principles of the Code, is following the spirit of the Code to good effect and is conducting its business openly and in line with the Code. The Board recognises that not all reporting elements of the Code are outlined in this Governance Statement but are reported more fully in the Trust's wider Annual Report. NWSSP have also completed the self-assessment on the "Governance, Leadership and Accountability" theme of the Health and Care Standards with a positive maturity rating of 4.

6.9 NHS Pension Scheme

As an employer hosted by the Trust and as the payroll function for NHS Wales, there are robust control measures in place to ensure that all employer obligations contained within the Scheme regulations for staff entitled to membership of the NHS Pension Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

7. MANAGING DIRECTOR'S OVERALL REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the Directors and Heads of Service within NWSSP who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

As Accountable Officer I have overall responsibility for risk management and report to the SSPC regarding the effectiveness of risk management across NWSSP. My advice to the SSPC is informed by reports on internal controls received from all its committees and in particular the Audit Committee.

Each of the Committees have considered a range of reports relating to their areas of business during the last year, which have included a comprehensive range of internal and external audit reports and reports on professional standards from other regulatory bodies. The Committees have also considered and advised on areas for local and national strategic

developments and a potential expansion of the services provided by NWSSP. Each Committee develops an annual report of its business and the areas that it has covered during the last year and these are reported in public to the Trust and Health Boards.

Internal Audit Opinion

Internal Audit provide me and the SSPC through the Audit Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with Public Sector Internal Audit Standards by the Audit and Assurance function within NWSSP.

The scope of this work is agreed with the Audit Committee and is focussed on significant risk areas and local improvement priorities. The overall opinion of the Head of Internal Audit on governance, risk management and control is a function of this risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The programme has been impacted by the need to respond to COVID-19 with some audits deferred as the organisation responded to the pandemic. The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion, the Head of Internal Audit has considered the impact of the audits that have not been fully completed.

The Head of Internal Audit opinion for 2021/2022 was that the Partnership Committee can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively:

RATING	INDICATOR	DEFINITION
Reasonable assurance	 - + Yellow	The Committee 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 reaching this overarching opinion the Head of Internal Audit has identified that the assurance domains relevant to NWSSP have all been assessed as providing reasonable assurance. During the year, there was one internal audit report (ICT Operational Infrastructure) which was issued with a rating of limited assurance. All other reports were either substantial or reasonable assurance or were issued as advisory reports.

Financial Control

NWSSP was established by Welsh Government to provide a range of support services to the NHS in Wales. As Managing Director and Accountable Officer, I retain overall accountability in relation to the financial management of NWSSP and report to the Chair of the SSPC.

NWSSP Financial Control Overview

There are four key elements to the Financial Control environment for NWSSP as follows:

- **Governance Procedures** – As a hosted organisation NWSSP operates under the Governance Framework of the Trust. These procedures include the Standing Orders for the regulation of proceedings and business. The statutory requirements have been translated into day-to-day operating practice, and, together with the Scheme of Reservation and Delegation of Powers and Standing Financial Instructions (SFIs), provide the regulatory framework for the business conduct of the Trust. These arrangements are supported by detailed financial operating procedures covering the whole of the Trust and also local procedures specific to NWSSP. During the pandemic, the governance arrangements have been enhanced through the establishment of a Finance Governance Committee. This continues to meet as and when required to consider and approve large scale and urgent requisitions. Membership of the Committee includes senior finance staff from NWSSP, the Velindre Director of Finance and an independent member of the Board, representatives from Counter Fraud, Accounts Payable and Legal and Risk Services. The Committee is chaired by the Director of Audit and Assurance Services, and Procurement colleagues attend the Committee to give background and context to specific requisitions.

- **Budgets and Plan Objectives** – Clarity is provided to operational functions through approved objectives and annual budgets. Performance is measured against these during the year.

- **Service Level Agreements (SLAs) –** NWSSP has SLAs in place with all customer organisations and with certain key suppliers. This ensures clarity of expectations in terms of service delivery, mutual obligations, and an understanding of the key performance indicators. Annual review of the SLAs ensures that they remain current and take account of service developments.

- **Reporting** – NWSSP has a broad range of financial and performance reports in place to ensure that the effectiveness of service provision and associated controls can be monitored, and remedial action taken as and when required.

Through this structure NWSSP has maintained effective financial control which has been reviewed and accepted as appropriate by both the Internal and External Auditors.

CONCLUSION

As indicated throughout this statement and the Annual Report the need to plan and respond to the COVID-19 pandemic has had a significant impact on the organisation, the wider NHS, and society as a whole. It has required a dynamic response which has presented a number of opportunities in addition the risks. The need to respond and recover from the pandemic were with the organisation and wider society throughout 2021/22 and will continue into 2022/23 and possibly beyond. I will ensure our Governance Framework considers and responds to this need.

This Governance Statement indicates that NWSSP has continued to make progress and mature as an organisation during 2021/22 and that it is further developing and embedding good governance and appropriate controls throughout the organisation. NWSSP has received positive feedback from Internal Audit on the assurance framework and this, in conjunction with other sources of assurance, leads me to conclude that it has a robust system of control.

Looking forward – for the period 2022/23:

I confirm that I am aware of my on-going responsibilities and accountability to you, to ensure compliance in all areas as outlined in the above statements continues to be discharged for the financial year 2022/23.

Signed by:

Managing Director – NHS Wales Shared Services Partnership

Date:

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	13 July 2022
AGENDA ITEM	6.2
PREPARED BY	Carly Wilce, Corporate Services Manager
PRESENTED BY	Andy Butler, Director of Finance and Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Governance Matters
PURPOSE The purpose of this paper is to provide the Audit Committee with a brief update on governance developments within NWSSP.	

1. STANDING ORDERS AND FINANCIAL INSTRUCTIONS (SOs and SFIs)

There is one item that we need to bring to the Committee's attention concerning the use of a private laundry service.

At the start of the pandemic, the Hywel Dda Laundry subcontracted work to a private provider, as there were problems in meeting demand due to staff sickness. At the time, this was intended to be a short-term arrangement and normal procurement procedures were not followed due to the urgency caused by the pandemic. Although the Hywel Dda Laundry transferred to NWSSP responsibility in October 2021, the Laundry Manager continued to use Hywel Dda systems for ordering goods and services, which included the continuation of the arrangement with the private laundry. From January 2022, the Laundry Manager was requested to use NWSSP systems for ordering, and after a number of weeks, the arrangement was identified and the Laundry were requested to desist from placing work with them which they have now done. The value of the work subcontracted was £115k through Hywel Dda systems, and £44k following the transfer to using NWSSP systems. This latter figure may increase as we understand there may be some outstanding invoices to come.

So, in summary, this does represent a breach of Standing Financial Instructions, but the breach occurred whilst the Laundry was owned and operated by Hywel Dda UHB, and immediately we became aware of the situation, the arrangement was stopped. We will be contacting the Health Board to advise them of this breach.

2. CONTRACTS FOR NWSSP

The table overleaf summarises contracting activity undertaken during the period **21 March 2022 to 20 June 2022**. A summary of activity for the period is set out in **Appendix A**.

Description	No.
File Note	**10**
Invitation to competitive quote of value between £5,000 and £25,000 (exclusive of VAT)	**9**
Invitation to competitive tender of value between £25,000 and the prevailing OJEU threshold (exclusive of VAT)	**2**
Single Tender Actions	**3**
Single Quotation Actions	**2**
Direct Call Off against National Framework Agreement	**2**
Invitation to competitive tender of value exceeding prevailing OJEU threshold (exclusive of VAT)	**0**
Contract Extensions	**1**
Total	**29**

3. NWSSP PROCUREMENT SERVICES ALL WALES CONTRACTING ACTIVITY

During the period **16 March 2022 to 26 May 2022**, activity against **19 contracts** have been completed. This includes **4** contracts at the **briefing** stage and **9** contracts at the **ratification** stage. In addition to this activity, **6 extensions** have been actioned against contracts. A summary of activity for the period is set out in **Appendix B**.

4. GIFTS, HOSPITALITY & SPONSORSHIP

There have been **3** declarations as to Gifts, Hospitality or Sponsorship made since the last Audit Committee meeting. These are as follows:

- Funding from RLDatix to support the recruitment and training of a post within the Once for Wales Concerns Management System Central Team. Funding will cover twelve months of Band 7 post with a small surplus to cover travel and subsistence. Total value of £55k covering the period Dec22 to Nov23.;
- Funding from RLDatix to facilitate travel and accommodation for two members of staff to travel to Edinburgh to present to the forum on the Once for Wales programme, value of £500; and
- Golf event 22 September 2022, registration, breakfast and tee off and hot buffet and awards ceremony. This offer was declined.

5. WELSH GOVERNMENT QUARTERLY UPDATE

On a quarterly basis, we issue a letter to Judith Paget at Welsh Government to confirm any Audit Reports which have achieved limited or no assurance. We were pleased to submit a nil return to the latest report, for the last quarter.

6. RECOMMENDATIONS

The Committee is asked to **NOTE** the report.

APPENDIX A - NWSSP Contracting Activity Undertaken (21/03/2022 to 20/06/2022)

No.	Trust	Division	Procurement Ref No	Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required
1.	VEL	NWSSP	NWSSP-STA-962	23/03/2022	Single Tender Action	To provide expert advice on the planning and implementation of circular zero-waste zero-carbon approach to sustainable textile use for NWSSP	Revolution Zero	£99,988.40	Attempts to find competition in this market area have failed as Revolution Zero is the only supplier able to provide the circular 'cradle to grave' solution. Furthermore, they have the infrastructure required to deliver all aspects of the requirement from design, manufacturing, decontamination/clean room specialists, through to disposal in this field.	Endorsed	No action required
2.	VEL	TMU	NWSSP-STA-939	29/03/2022	Single Tender Action	Consumables relating to pharmaceutical Compounding Equipment	B Braun	£72,000.00	This supplier is responsible for manufacture of pharmaceutical compounding equipment and associated disposable items currently used within the CIVAS@IP5 service. This is to allow ongoing purchase of items compatible with the current equipment which has been validated and approved for use via the internal supplier and item approval process in line with EU Good Manufacturing Practice guidelines	Endorsed	Market review to ensure no new entrants or better alternative product in market prior to any future procurements.

No.	Trust	Division	Procurement Ref No	Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required
3.	VEL	TMU	NWSSP-STA-940	29/03/2022	Single Tender Action	Consumables relating to pharmaceutical Compounding Equipment	Feel Assured	£72,000.00	This supplier is responsible for manufacture of pharmaceutical compounding equipment and associated disposable items currently used within the CIVAS@IP5 service. This is to allow ongoing purchase of items compatible with the current equipment which has been validated and approved for use via the internal supplier and item approval process in line with EU Good Manufacturing Practice guidelines	Endorsed	Market review to ensure no new entrants or better alternative product in market prior to any future procurements.
4.	VEL	NWSSP	NWSSP-SQA-969	25/03/2022	Single Quotation Action	The short-term continuation of facilities management services for the Matrix House Building	Facilities Service Group	£22,560.45	Upon purchase of Matrix House the facilities management company services were continued until 31/08/2022 to allow for a procurement exercise to be undertaken.	Endorsed	Future requirement being investigated by Mark Roscrow.
5.	VEL	SMTL	NWSSP-SQA-983	30/03/2022	Single Quotation Action	Provision of Lab Testing	4ward testing laboratories	£14,400	The supplier is the only UKAS accredited testing laboratory offering EN 14683:2019 Medical Face Masks in the UK.	Endorsed	No action required

No.	Trust	Division	Procurement Ref No	Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required
6.	VEL	PCS	NWSSP-RFQ-946	10/03/2022	Request for Quote	Plural Sight Enterprise Licenses	Pluralsight	£15,750.00	Awarded to lowest price quotation.	Endorsed	No action required
7.	VEL	Finance Academy	NWSSP-RFQ-964	23./02/2022	Request for Quote	Finance Academy Spring Conference	Glamorgan County Cricket Club	£7,800.00	Awarded to lowest price quotation.	Endorsed	No action required
8.	VEL	Procurement	NWSSP-RFQ-966	23/03/2022	Request for Quote	PRO TABLET	Computacentre UK ltd	£12,268.83	Awarded to lowest price quotation.	Endorsed	No action required
9.	VEL	HCS	NWSSP-RFQ-970	25/03/2022	Request for Quote	Driver Assessments	Esitu Solutions Ltd	£24,995.00	Awarded to lowest price quotation.	Endorsed	No action required
10.	VEL	NWSSP	NWSSP-RFQ-1007	26/05/2022	Request for Quote	Security Service for Matrix House	Securitas Security Services Ltd	£9,190.44	Awarded to lowest price quotation.	Endorsed	Short term agreement before full procurement exercise can be undertaken
11.	VEL	NWSSP	NWSSP-MQ-314555	31/03/2022	Multiquote	Customer Service Excellence Standard certification	Assessment Services	£5,568.85	MEAT evaluation utilised	Endorsed	No action required
12.	VEL	Laundry	NWSSP-MQ-RA315440	23/03/2022	Multiquote	Laundry Transport Mobile Sanitising Fogging Units	LTD Worldwide	£14,985.00	MEAT evaluation utilised	Endorsed	No action required
13.	VEL	HCS	NWSSP-MQ-RA316152	31/03/2022	Multiquote	Mobile Phones for HCS	Incom Telecommunications	£21,560.00	MEAT evaluation utilised	Endorsed	No action required
14.	VEL	Finance Academy	NWSSP-MQ-RA317443	01/07/2022	Multiquote	Provision of Graduate Scheme Assessment Centre	Eliesha Training Ltd	Upto £25000	MEAT evaluation utilised	Endorsed	No action required

No.	Trust	Division	Procurement Ref No	Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required
15.	VEL	Corporate	NWSSP-DCO-820	08/03/2022	Direct call off	Welsh Language Translation	Trosol	Upto £50,000	External provider of Welsh Language Translation required to support NWSSP	Endorsed	Procurement to support renewal activity
16.		Corporate	NWSSP-DCO-821	01/04/2022	Direct call off	Insurance for Matrix House	A J Gallagher	£5,544.47	Building insurance for Matrix House	Endorsed	No action required
17.	VEL	PCS	NWSSP-MIN-91798	01/01/2022	Mini Competition	Fixed Term Appointment	IDPP Consulting	£59,555	Primary Care Services Additional Non Clinical Staff	Endorsed	No action required
18.	VEL	Corporate	NWSSP-MINI-50146	30/05/2022	Mini Competition	Provision of Multi-functional Devices for Companies House	Konica Minolta	£33,942.90	Printers required on 3rd and 4th Floor of Companies House, Cardiff.	Endorsed	No action required
19.	VEL	HCS	VEL-NWSSP-FN- 130	25/01/2022	File Note	2 x Mobile Welfare Units at Picketston Storage & Distribution	CITY HIRE GORSEINON LTD TA CITY LOO HIRE	£36,760	Welfare units required during Covid, Due to circumstances, there is still an ongoing requirement	Competition not sought in accordance with SFI'S.	Service and Procurement meeting to be arranged to support
20.	VEL	Corporate	VEL-NWSSP-FN136	17/06/2022	File Note	MFD for CH	Konica Minolta	£4,907.58	The supplier was not forthcoming regarding the proposed request to extend the existing MFD contract by 6 months, despite being approached by Procurement in advance. As a result of this delay in communication, the contract expired late December 2021. However, discussions took place directly between BSM and the	Extended without appropriate authorisation	Competitive tender carried out for future requirement

No.	Trust	Division	Procurement Ref No	Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required
									supplier resulting in a 6-month extension to the contract with the aim of achieving business continuity		
21.	VEL	Workforce	VEL-NWSSP-FN-138	23/02/2022	File Note	City And guildes Kineo Ltd . Scorm (elearning) course file is required for Aseptic Non Touch Technique (ANTT) Course	City & Guilds Kineo Ltd	£16,200.00	SQA submitted 1 day prior to agreement needed to commence. No time for Procurement Service to support delivery of a formal process hence FN process applied	Competition not sought in accordance with SFI'S.	Service and Procurement meeting to be arranged to support
22.	VEL	SES	VEL-NWSSP-FN-139	17/03/2022	File Note	Purchase of access to an online library containing information from HSE, British standards, trade associations and legal organisations.	Barbour EHS Ltd	£9,941.26	Only 2 providers are able to conduct the service however competition was not sought.	Competition not sought in accordance with SFI'S.	Service and Procurement meeting to be arranged to support
23.	VEL	SMTL	VEL-NWSSP-FN-140	17/03/2022	File Note	TESTING OF 3 SETS OF FACE MASKS TO EN 14683:2019+ AC2019	4Ward Testing	£7,076.55	Service did not seek competition in accordance with SFI's.	Competition not sought in accordance with SFI'S.	Service and Procurement meeting to be arranged to support
24.	VEL	Corporate	VEL-NWSSP-FN-141	17/03/2021	File Note	Production of 2 short videos for Welsh language awareness for corporate induction	Webber Design LTD	£5,000.00	Competition was not sought due to needing to spend non-recurrent funding by the end of the financial year.	Competition not sought in accordance with SFI'S.	Service and Procurement meeting to be arranged to support. Further training to be provided for future.

No.	Trust	Division	Procurement Ref No	Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required
25.	VEL	Corporate	NWSSP-FN-146	14/06/2022	File Note	Welsh Courses on behalf of the NHS Wales	Learn Welsh Glamorgan	£18,000.00	Due to Covid-19 pressures the contract was extended without authorisation/	Extended without appropriate authorisation.	There is work being undertaken to ensure compliance for 2023/24 courses through a compliant framework.
26.	VEL	Welsh Risk Pool	NWSSP-FN-147	30/05/2022	File Note	Prompt Maternity Foundation 2021	The PROMPT Maternity Foundation (PMF)	£5,000.00	Welsh Government dictate that the supplier's training is facilitated.	Competition not sought in accordance with SFI'S	Service and Procurement meeting to be arranged to support. Further training to be provided for future.
27.	VEL	Workforce	VEL-NWSSP-FN-107	30/05/2022	File Note	Continuation of support and maintenance for Zylab.system contract ID 02088 008 & 02088 006	Zylab System	£9,640.00	Continuation of support and maintenance for Zylab.system. We have contract ID 02088 008 & 02088 006 with Commercial IT which continues and other suppliers were approached but Commercial support our existing systems so to avoid disruption to service must remain with Zylab.	Competition not sought in accordance with SFI'S	Service and Procurement meeting to be arranged to support
28.	VEL	PCS	NWSSP-FN-149	13/06/2022	File Note	Internal Auditor training	Wales Quality Centre	£5,500.00	Requesters did not realise the procurement process was to be followed for the total figure for the training as they were requesting 3 separate training sessions over the year.	Competition not sought in accordance with SFI'S	Procurement has met with service to offer training.

No.	Trust	Division	Procurement Ref No	Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required
29.	VEL	Finance	NWSSP/FINACC/OJEU/41647	25/05/2022	Contract Extension	Contract for the Provision of Graduate Financial Management Trainee Scheme	HTFT Partnership Limited	Cost will be between £196,429 to £471,430 ex VAT (With extensions between £327,382 to £785,717)	Extended for 1 year. 1 year extension option remaining	Endorsed	No action required

APPENDIX B - All Wales Contracting Activity In Progress (16/03/2022 - 26/05/2022)

No.	Contract Title	Doc Type	Total Value	JI approval <£750K	WG approval >£500k	NF approval £750-£1M	Chair Approval £1M+
1.	Electricity Electricity supply - over & sub 100kW sites Contract period 1/4/15 – 30/9/22 extension 1/10/22 - 31/3/25	extension	£404,193,000	16/03/2022	original approval applies 26/2/14	06/04/2022	06/04/2022
2.	Construction Frameworks for SBU HDDA these frameworks will fulfil the Health Board business case submissions based on each contracting authority's long-term strategic plan, and the need to react to urgent minor works projects Contract period: April 22-March 25	ratification	£44,000,000	17/03/2022	04/05/2022	06/05/2022	06/05/2022
3.	Printer Consumables The supply of various printer consumables such as toner cartridges throughout NHS Wales Contract period 01/04/2022 - 31/03/2023	ratification	£1,500,000	CS 22/03/22	12/04/2022	21/04/2022	21/04/2022
4.	General Waste & Recycling Services collection and disposal of non-hazardous general waste including food waste for Swansea Bay UHB, Cwm Taf Morgannwg UHB, Velindre University NHS Trust, HEIW and Welsh Blood Service sites. Contract period 5 years (+ 3 yr extension option)	briefing	£24,000,000	CS 25/03/22	03/05/2022	n/a	n/a
5.	Cardiology Radiology Endoscopy Surgical urology consumables A Framework Agreement covering all NHS Wales bodies for the supply of the following Interventional products to four specialist areas Cardiology, Radiology, Endoscopy and Surgical Urology Contract period – 4 years (1/4/22-31/3/26)	ratification	£127,324,916	25/03/2022	13/04/2022	21/04/2022	21/04/2022
6.	Provision of Post Graduate Modules in Genomics Education and Training Services Develop internationally recognised medical and public health genomics services in Wales – that are innovative, responsive and well-connected to the major genetics and genomics initiatives that are evolving worldwide Contract period 1/11/22 – 31/7/26 (2 yr extension option)	briefing	£1,169,600	12/04/2022	04/05/2022	n/a	n/a
7.	MVCs & IP5 Clin waste collection Clinical Waste Collection & Disposal at South Wales & North Wales Field Hospitals, Mass Vaccination Centres/Testing Centres & Pathology Laboratories at IP5 Contract period 01/06/2022 – 31/05/2023 (+2 yr extension option)	ratification	£ 2,643,549	13/04/2022	12/05/2022	13/05/2022	sent to TM 13/5
8.	Proprietary Drugs Proprietary Drugs to purchase for use by All Wales hospital pharmacy departments, as requested by the All Wales Drug Contracting Committee Contract period 01/07/2022 to 30/06/2024 (+2 years extension)	ratification	£385,849,378	13/04/2022	10/05/2022	20/05/2022	sent to TM 20/5
9.	Provision of Rating Consultants for 2023 Non-Domestic Rating Revaluation	briefing	nil	12/04/2022	08/06/22	n/a	n/a

	to secure specialist professional services to support the 2023 Non-Domestic Rating Revaluation on behalf of NHS Wales. The intention is to appoint an all-Wales rating consultant(s) in time for when the new list is published in October 2022 so that rateable values can be checked, manifest errors corrected and allow and any appeals to be prepared and submitted in an expeditious manner following the 1st April 2023. Contract period 1/10/22-30/9/27 (+2 yr extension option)						
10.	Pest control services The provision of both regular and ad-hoc pest control services as required by the Health Boards/Trusts in NHS Wales. Contract period 01/05/2022 – 30/04/2024 +1yr extension)	ratification	£555,000	12/04/2022	06/05/2022	n/a	n/a
11.	Laundry detergent The five Laundry Processing Units (LPU's) were previously operated by Local Health Boards and as such made their own provisions for products used within the laundry such as soap and detergent. The creation of the All-Wales service allowed synergy and standardisation in service provision and delivery in areas such as procurement of goods and services Contract period 1/9/22-31/8/27 (+2yr extension option)	briefing	£1,960,000	12/04/2022	06/05/2022	n/a	n/a
12.	Electrosurgical Instrumentation Provision of Electrosurgical Instrumentation products Contract period 1/5/22 – 31/5/26	ratification	£3,130,957	26/04/2022	25/05/2022	25/05/22	Sent to TM 25/5
13.	Proton beam therapy. commission Proton Beam Therapy (PBT) from the Rutherford Cancer Centre in Newport for the population of south west, mid and south east Wales. The procurement exercise was completed between May and October 2018. In November 2018, the Joint Committee approved a recommendation that the Rutherford Cancer Centre (RCC) could be commissioned by WHSSC to provide PBT for adult patients (aged 25 years and older) in Wales referred via the approved pathway. Contract period 9/4/19 – 8/4/23	extension	£700,000	28/04/2022	original approval applies 18/12/18	n/a	n/a
14.	Haulage set up and maint of specialist vehicles The contract is for the Haulage, Set Up and Maintenance of specialist Vehicles, owned or leased by participating Health Boards/Trusts Contract period 01/05/19-30/4/23	extension	£1,265,290	21/04/2022	original approval applies 19/2/19	27/04/2022	28/04/2022
15.	Electricity supply Electricity supply - over & sub 100kW sites Contract period 1/4/15 – 30/9/22 extension 1/10/22 - 31/3/25	Extension amended	£404,193,000	06/05/2022	original approval applies 26/2/14	09/05/2022	sent to TM 9/5
16.	Culture Media and Consumables For the provision of culture plated and bottled media as well antibiotic sensitivity testing discs for Microbiology Laboratories Contract period 1/6/22-31/5/24 (2 year extension option)	ratification	£3,860,300	17/05/2022	08/06/22	Sent to NF 8/6	
17.	E-Expenses Management System deliver an all-Wales E-expenses Management System for NHS staff in Wales. The system integrates with ESR, enables NWSSP to provide Duty of Care checks on	extension	£888,480	18/05/2022	original approval applies		n/a

	registered vehicles and allows users to submit expenses through an app on their mobile phones Contract period 5/8/19-4/8/23						
18.	Generic Drugs Injections infusions Generic Drugs - Injections/Infusions Items to purchase for use by All Wales hospital pharmacy departments, Contract period 01/07/2022 to 30/06/2024 (2 years)	ratification	£33,199,632	26/05/2022	09/06/22	Sent to NF 9/6	
19.	Heparins Heparins & Anticoagulants purchased by hospital Pharmacy Departments Contract period 1/7/20-30/6/23	extension	£23,131,266	08/06/22	Original approval applies 15/4/20	Sent to NF 9/6	

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	13 July 2022
AGENDA ITEM	6.3
PREPARED BY	Jane Tyler, Senior Finance and Business Partner
PRESENTED BY	Andy Butler, Director of Finance and Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Stock write off

PURPOSE
To seek permission to request Welsh Government permission to write off of stock

Introduction

Audit Committee members will be aware that NWSSP has been requested by Welsh Government to hold the equivalent of 16 weeks of PPE stock, based on the usage during the peak of the pandemic. A consequence of such a policy is that certain stock will go out of date and will need to be written down in the accounts.

During April 2022 it was identified that a number of test kits had passed their use by dates and could no longer be issued. The test kits were originally purchased by NHS Wales on 7th April 2020 at cost £5.246m for 16,000 packs of 25. Funding for the purchase was provided by Welsh Government.

During 2020/21 2,225 packs were issued and at 31/3/21 13,787 packs remained in stores and were valued at £4,251,085. In September 2021 Welsh Government requested that 12,000 packs be donated to Namibia with the balance held in case required in Wales. The balance of 1,838 packs at a value of £602,680.20 are now out of date and cannot be used.

It should be noted that stock monitoring procedures have been updated and amended to review slow moving stock as a result of the additional stockholdings being held.

The issue was identified at the time the Annual Accounts were being prepared and after the previous Audit Committee. Following discussions

with Welsh Government it was agreed that the stocks should be written down in the 2021/22 accounts and funding cover would be provided.

Chapter 6 of the Manual for Accounts stipulates that:

> *'NHS Wales health bodies do not have unlimited powers to make special payments or to write-off losses. They must obtain the written approval of the Welsh Government H&SSG Finance Director before writing-off a loss or making, or undertaking to make, any special payment that exceeds their delegated limit.'*
>
> *Annex 4 to Chapter 6 sets out the delegated limits above which Health bodies need to obtain WG approval for the write off of the loss. The delegated limit in is* ***£250,000***

It has been agreed that such requests to Welsh Government seeking approval to write off stock should be approved by the Audit Committee. We have therefore prepared the attached checklist and request the Audit Committee's permission to submit it to Welsh Government.

Recommendation

The Audit Committee is asked to review the attached losses form and provide permission to seek formal approval from Welsh Government to write off the loss.

NHS Wales Shared Services Partnership

Checklist to be used when compiling the summary of the case

Category – Type of case – Rapid Test Kit Write Off Reference number – NWSSP/Stock Adjustment/002 Health Body (name and code) – RQF- NHS Wales Shared Services Partnership hosted by Velindre University NHS Trust
1. Record the amount involved and the reasons why the loss arose. ***Menarini Rapid Test Kits were purchase by NHS Wales on 7th April 2020 at cost £5.246m for 16,000 packs of 25).*** ***During 2020/21 2,225 packs were issued and at 31/3/21 13,787 packs remained in stores and were valued at £4,251,085.*** ***Post year end 51 packs were returned – revised balance 13,838*** ***In September 2021 WG requested that 12,000 packs be donated to Namibia with the balance held in case required in Wales*** ***The balance of 1,838 packs at a value of £602,680.20 are now out of date and cannot be used***
2. Detail the background of case giving full reason why payment is necessary. Have other alternatives to the payment been investigated? If not, why not? If so, provide details. ***As above***
3. **Was fraud involved?** If so complete a fraud report and ensure that the LCFS, the relevant NHS CFS Wales team, Internal and External Auditors, and where relevant the police, are informed of the fraud in accordance with Welsh Government Directions to NHS Wales health bodies on Counter Fraud Measures and using the reporting system as specified by the NHS CFS Wales. Enter dates of completion of fraud report. ***N/A***
4. **Was theft or criminal damage involved?** If so have the police been informed? If not, give the reasons why not? All security related incidents must be reported to the Local Security Management Specialist once trained, accredited and in place in accordance with forthcoming guidance issued by NHS Security Management Service. ***N/A***

5. **For abandoned works**, were detailed specifications identified before the scheme went ahead? How did the projected work compare to these detailed specifications? At what level, by whom, and why was the scheme approved? Why was the scheme abandoned and by whom? Could the scheme have been aborted earlier? Was the scheme joint financed? If so, was any agreement signed? Was legal advice taken in the drawing up of an agreement? Is the other party prepared to pay half of the costs of the scheme?

N/A

6. **For Bad Debts and Claims Abandoned.** Were invoices raised on a regular basis? Was the debt monitored and chased regularly? Were services withdrawn upon continued non-payment? Enclose report showing when invoices were raised and where relevant paid.

   For cases involving businesses – has the business gone into liquidation/receivership? If so, are you listed as a creditor and do you have confirmation of this from the liquidator /receiver? If not, why not? Are any dividends being paid out? Was the financial integrity of the business looked into before goods or services were supplied? If not, why not and have procedures been revised to ensure this is carried out in the future?

N/A

7. **For rental cases only** - did the tenant enter into lease agreements prior to occupation? If not, why not? If the lease was faulty investigate whether action can be taken against legal advisors who drew up the agreement? Provide an analysis of rent and services charges.

N/A

8. **For private patients** cases was an undertaking to pay signed? If not, why not? Was a full estimate of potential costs given and full deposit taken to cover these costs? If not, why not?

   For overseas private patient's cases – have the relevant embassies been contacted for payment (if applicable)? For overseas visitors, are robust procedures in place in the NHS Body to identify and charge liable overseas visitors? If not, why not? Was the overseas visitor informed that he/she would be liable to pay for the full cost of treatment? Was treatment, in a clinical opinion, immediately necessary or urgent? If treatment was not urgent why was it given before obtaining a sizeable deposit?

N/A

9. **Stores (only)** - Are any linen losses calculated at 50% of the replacement value? Is this in accordance with the guidance? Is the total loss more than 5% of the total stock value? Confirm that the loss has been valued at book value less net disposal proceeds.

N/A

10. **For extra contractual payments to contractors.** Have other alternatives to the payment been investigated? If not, why not? If so, provide details. Provide detailed calculations on which the payment is based.

N/A

11. **For ex gratia payments.** Have other options been considered? If not, why not? Explain why an ex gratia payment offers the best value for money. Confirm that the proposed payment does not place the claimant in a better position than if the error had not occurred? If it does, why? In cases of hardship record what evidence exists on this? Provide detailed calculations to support the proposed payment and demonstrate why the proposed sum is in accordance with the relevant paragraphs of this guidance.

    For settlements on termination of employment, has relevant central guidance on such payments been followed in all respects? If not, why not?

    For clinical negligence and personal injury cases has the relevant central guidance for such cases been followed in all respects? If not, why not?

N/A

12. Is the value of the loss reduced by insurance? If so, record the value of the gross loss and the value of the amount recovered by insurance.

No

13. Have all reasonable steps been taken to recover the loss? Provide details of the attempts that have been made to recover the loss or explain why no action has been taken. Has appropriate legal advice been sought? If not, why not? If advice has been sought, what recommendations were made and have these been followed? If not, why not?

Confirmation has been received from Welsh Government that funding will be provided in full and there will be no impact on the financial position of NWSSP/ Velindre University NHS Trust

14. Identify any failings in the actions of employees, including supervisors. Having considered this, is there a need for disciplinary action? Record what action has been taken or is proposed, or if no action is to be taken, explain why. Include dates, names of individuals and positions.

N/A

15. Was there any apparent breakdown of procedures? Detail weakness or fault in system of control or supervision.

N/A

16. What proposed improvements have been put forward to correct defects in the existing systems or procedures? Include the timetable for implementation of the improvements. What monitoring measures have been introduced to ensure the improvements are working effectively?

The monthly stores movement reports have been in place for many years and identify for all stock lines in each store the stock on hand, minimum and maximum stock levels (to drive reorders) and the issues by month in the current and previous years, including trend activity. All Warehouse managers are required to review and action any required changes to manage slow moving stocks.

In addition, we now have in place a date life monitoring system for PPE stocks separately. This additional monitoring is required because we hold significant stocks of some PPE items and the same PPE item may be held on a number of different stocklines due to different suppliers or pack sizes and therefore reorder levels are not set in the system and stock codes must be managed in groups. This monitoring captures for all of the stock held in bulk the actual date life for each product and ensures that the oldest stocks can be identified for transfer to pick and issue before products with a longer life.

17. Is it necessary to inform the board/chief executive? If not, why not?

Yes – Managing Director and Audit Committee members have been informed

18. Do your SFIs require a Board report for this case? If so, please enclose the report. If not, consider whether in the light of this case your SFIs should be amended to require a Board report in such cases.

Form submitted to Audit Committee. A further update on stocks will be provided to the Audit Committee at the next meeting in July

19. Having completed the above steps, detail the general lessons that can be drawn from this case. If a system weakness has been identified which has possible implications across the NHS the LCFS or the NHS CFS Wales should report the problem to NHS Protect using either the intranet fraud prevention referral system for fraud or the Area Security Management Specialist for security matters so that measures can be taken nationally to amend policy or systems.

N/A

20. Please give details of name and position of person forwarding this case for Welsh Government approval (if applicable). Give the date when this case was first brought to the attention of the Welsh Government H&SSG FD (if applicable).

    Name - Andy Butler

    Position - Director of Finance & Corporate Services, NWSSP – May 2022

    Date Welsh Government H&SSG FD notified – Jackie Salmon – May 2022

21. I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above and on the attached case summary are complete and accurate, and that all aspects of the checklist have been properly considered and actioned.

    Signed by - Andy Butler

22. I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that write off of this loss offers the best value for money for this case.

    This case is novel, contentious or repercussive and I therefore request formal approval from the Welsh Government H&SSG FD

    Signed by - Jane Tyler Date – 27.06..2022

Countersigned by – Andy Butler Date – 27.06. .2022 **Please note this section must be signed by two senior officers in accordance with the delegated limits set by the board. Please print names and position held in the organisation.** Name - Neil Frow Position held – Managing Director, NWSSP Countersigned by – Position held - Chair, NWSSP

MEETING	NWSSP Audit Committee
DATE	13 July 2022
PREPARED BY	Carly Wilce, Corporate Services Manager
PRESENTED BY	Peter Stephenson, Head of Finance & Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance & Corporate Services

TITLE OF REPORT

Conflict of Interests Declarations July 2022

PURPOSE OF REPORT

The purpose of this report is to provide the Audit Committee with a record of Directors Interests and a summary of the completion rates for each service for Conflicts of Interest as at July 2022.

1. BACKGROUND

The Velindre University NHS Trust Standards of Behaviour Framework outlines arrangements within the organisation to ensure that staff comply with requirements, including recording and declaring potential conflicts of interest. It is important to note that any private interest(s) does not conflict with NHS duties.

The Nolan Principles on Public Life were established in 1994 and have recently been extended to define public office as applying to all those involved in the delivery of public services. The seven principles are as follows:

1. **Selflessness** - You should take decisions solely in terms of the public interest. You must not act in order to gain financial or other material benefit for family or friends.
2. **Integrity** - You should not place yourself under any financial or other obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties

3. **Objectivity** - You must make decisions solely on merit when carrying out public business (including the awarding of contracts)
4. **Accountability** - You are accountable for your decisions and actions to the public. Consider issues on their merits, taking account of the views of others and ensure the organisation uses resources prudently and in accordance with the law.
5. **Openness** - You should be as open as possible about all decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest demands.
6. **Honesty** - You have a duty to act honestly. Declare private interests relating to public duties and take steps to resolve any conflicts arising in a way that protects the public interest.
7. **Leadership** - Holders of public office should promote and support the foregoing principles by leadership and example.

It is the responsibility of all individuals to ensure that they are familiar with the requirements of Nolan Principles and every public body should develop Codes of Conduct for staff and Independent Members, which reflect these Nolan Principles and its shared values. The guidance in terms of disclosing potential conflicts of interest is to err on the side of caution and disclose more rather than less. What is important is whether a relationship could be perceived as a conflict of interest, whether or not it actually is. Guidance had been revised to require staff to highlight any family relationships in their declarations made, in accordance with our Managing Personal Relationships at Work Protocol.

2. DECLARING CONFLICTS OF INTEREST

At April's Senior Leadership Group meeting, it was formally agreed that NWSSP would proceed to implement a lifetime declaration approach. All employees regardless of their banding will be required to complete the exercise, in line with best practice and to improve compliance rates. Members of Senior Leadership Group will still be required to complete an annual declaration and the details of which will be made publicly available on our website. Once a declaration has been submitted, staff will only need to revisit their declaration if their circumstances change. Staff are asked to complete the exercise via ESR, however for those who don't have access to the system, they are able to complete a hard copy form, which must be subsequently authorised by their Director of Service prior to being submitted to Corporate Services for recording. Guidance on how to complete a declaration via ESR is available and should managers require this, they can contact Corporate Services for assistance.

At the current time, there is still a significant number of staff who have yet to complete the declaration. This is particularly the case in areas such as Health Courier Services and Laundry where a number of staff have limited access to ESR. We will bring the compliance position for all staff to the October Committee but for now the table below records the current position with regards to completion across the organisation, as at 07 July 2022, based on prior year requirements as follows:

- Audit & Assurance Services – **Band 7 & above**
- Finance & Corporate Services – **All**
    - *Accounts Payable division agreed **Band 6 & above***
- Employment Services – **Band 7 & above**

- Legal & Risk Services – **Band 7 & above**
- People & Organisational Development – **Band 7 & above**
- Primary Care Services – **Band 7 & above**
- Procurement Services – **Band 6 & above**
- Specialist Estates Services – **Band 7 & above**

Directorate	Headcount	Percentage Completion	Outstanding Declarations
Audit & Assurance Services	54	96%	2
Accounts Payable	5	100%	0
Employment Services	23	87%	3
Finance & Corporate Services	73	86%	10
Laundry Services	7	43%	4
Legal & Risk Services	109	90%	11
Medical Examiners	35	14%	30
People and OD	10	80%	2
Planning, Performance Informatics	19	89%	2
Primary Care Services	28	86%	4
Procurement Services	159	89%	18
Specialist Estates Services	32	100%	0
SMTL	9	100%	0
TMU	3	0%	2
Total	566	76%	88

A summary of the declarations received for each directorate will be emailed through to the Director, to develop a local Action Plan for the Management of Potential Conflicts. Directors will find a link to the guidance and templates below to use in developing best practice Action Plans.

- http://nww.sharedservicespartnership.wales.nhs.uk/conflicts-of-interest

3. RECOMMENDATION

The Audit Committee is asked to:

NOTE the Conflicts of Interest declared to date.

Appendix A – List of Declarations for SLG Members and Independent Members

No.	Name	Job Title	Disclosure
1.	Neil Frow	Managing Director of NWSSP	Observer Life Science Hub Board - Attend Board Meetings Non-Paid.
			Spouse is employed by Cwm Taf Morgannwg University Local Health Board.
2.	Andy Butler	Director of Finance and Corporate Services	Spouse is an Audit Manager in Audit Wales.
			Independent member of the Arts Council for Wales Audit & Risk Committee.
			Son – is a Graduate Trainee in Swansea Bay University Health Board
			Nephew - Bursary Assessor – Student Awards Service
3.	Ruth Alcolado	Medical Director	No interests to declare.
4.	Simon Cookson	Director of Audit & Assurance Services	Independent Member of the Audit Committee at Bristol City Council.
5.	Neil Davies	Director of SES	Son who is a professional sportsman. I am a shareholder in his image rights company.
			One of my sons works for NWSSP - Procurement Services as a Category Manager.
6.	Andrew Evans	Director of PCS	No interests to declare.
7.	Gareth Hardacre	Director of People & OD	Wife is Director of Midwifery at Cwm Taf UHB.
			Son is an Admin Employee in C&V UHB
			Chair of HPMA Cymru - and National Committee Member of HPMA (a Charity for NHS HR Professionals).
8.	Mark Harris	Director of Legal & Risk Services	Wife is a GP partner in a medical centre in the Aneurin Bevan area.
9.	Jonathan Irvine	Director of Procurement Services	No interests to declare.
10.	Colin Powell	Director of Pharmacy Technical Services	No interests to declare.
11.	Alison Ramsey	Director of Planning, Performance, and Informatics	Governor on the University of South Wales Board and Chair of the Audit Committee of the University of South Wales.
12.	Gareth Jones	Independent Member	Senior Counsel (Previously Partner) - Womble Bond Dickinson UK LLP. My firm and I personally advise the Department of Health and Social Care on various arrangements relating to COVID response. My firm has acted for John Sisk & Son Limited which is named in one of the Consortia – PQQ for the nVCC. I do not have any dealings with that client. In addition, we work regularly with other consultants, such as Ove Arup, on behalf of other clients - 13 Years - Salary and Profit Share
			Director - Dentrain Limited - 19 Years - Dormant Company.
			Spouse/Partner is a Director at Gill Jones Consulting Limited - 2 Years -Trading Company
			Interest in Dentrain Limited - 19 years as a 50% shareholder.
			Spouse/Partner has an interest in Gill Jones Consulting Limited - 2 years - 100% Shareholder

			Spouse Partner is a Trustee of National Examining Board for Dental Nurses - 2 years - honorary Trustee
13.	Vicky Morris	Independent Member	Local Authority School Governor- St Mary's RC Primary School, Newtown, Powys - February 2022 to date.
14.	Tracy Myhill	NWSSP Chair	Senior Independent Panel Member for Public Appointments in Wales – WG Public appointment.
			Non-Executive Director - Ministry of Defence People Committee Associate Harvey Nash - now Alumi Global - executive recruitment NHS.
			Director and owner of Tracy Myhill Associates Ltd; Management Consultancy providing Organisational Development Support and Mentoring to public, private and third sector including the NHS.
			Wife Denise Campbell is Director in Tracy Myhill Associates Ltd. Management Consultancy providing Organisational Development Support and Mentoring to public, private and third sector including the NHS.
15.	Martin Veale	NWSSP Audit Committee Chair	Sport Wales - Board Member and Chair of Audit and Risk Committee 2018 – Remunerated
			Hafod (Housing Association & Care Homes) - Member of Audit and Risk Committee 2020 – Remunerated
			Pen y Cymoedd Windfarm Community Fund (charity) - Director 2019– Daily Rate
			Welsh Government Member of Audit and Risk Assurance Committee, Health and Social Services Directorate 2019– Daily Rate
			Merthyr Tydfil County Borough Council - Lay Member of Standards Committee 2019– Daily Rate
			Pembrokeshire County Council - Lay Member of Audit Committee 2017– Daily Rate
			Blaenau Gwent County Borough Council - Lay Member of Audit Committee 2020– Daily Rate
			HM Court and Tribunal Service Justice of the Peace, Mid Wales Bench 2016– Voluntary
			Coleg Gwent - Governor and Chair of Audit Committee 2015– Voluntary
			Hawthorn High School, Pontypridd - Governor 2019– Voluntary
			South Wales Police – Member of Joint Audit Committee (joint committee reporting to Chief Constable and Police & Crime Commissioner) – 2021– Daily Rate
			Mid and West Wales Fire Authority – Chair of Standards Committee – 2021– Daily Rate
			Merthyr Tydfil County Borough Council Lay Member of Governance and Audit Committee – 2022– Daily rate
			Brecon Beacons National Park Authority – Lay member of Standards Committee – 2021- Daily rate
			Rhondda Cynon Taf CBC – Governor member of Children & Young People Committee – 2022- Daily rate
			Monmouthshire County Council – Lay member of Governance and Audit Committee – 2022- Daily rate
			New 3-16 school at Hawthorn, Pontypridd – Governor of temporary governing body – 2021- Voluntary

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	13 July 2022
AGENDA ITEM	6.5
PREPARED BY	Peter Stephenson, Head of Finance and Business Development
PRESENTED BY	Peter Stephenson, Head of Finance and Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	NWSSP Corporate Risk Register

PURPOSE

To provide the Audit Committee with an update as to the progress made against the organisation's Corporate Risk Register.

1. INTRODUCTION

The Corporate Register is presented at **Appendix 1** for information.

2. RISKS FOR ACTION

The ratings are summarised below in relation to the Risks for Action:

Current Risk Rating	July 2022
Red Risk	1
Amber Risk	9
Yellow Risk	2
Green Risk	0
Total	**12**

2.1 Red-rated Risks

There remains one red risk relating to the inflationary impact on goods and services, particularly relating to energy. This continues to be mitigated as far as possible through the actions of the Energy Price Risk Management Group.

2.2 Changes to Risk Profile

There are two new risks that have been added to the register since the last meeting of the Committee. These are:

- The replacement of the Student Awards system which is approaching end-of-life and where funding needs to be identified for a new system; and
- The reputational risks associated with the request for NWSSP to help establish the Citizens' Voice Body.

3. RISKS FOR MONITORING

There are now eight risks that have reached their target score, and which are rated as follows:

Current Risk Rating	July 2022
Red Risk	0
Amber Risk	0
Yellow Risk	2
Green Risk	6
Total	**8**

4. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the Corporate Risk Register.

Corporate Risk Register

Ref	Risk Summary	Inherent Risk			Existing Controls & Mitigations	Current Risk			Further Action Required	Progress	Trend since last review	Target & Date
		Likelihood	Impact	Total Score		Likelihood	impact	Total Score				
Risks for Action												
	Escalated Directorate Risk									**Risk Lead: Director of Primary Care Services**		
A1	Lack of storage space across NWSSP due to increased demands on space linked to COVID and specific requirements for IP5 (added April 2021)	4	4	16	IP5 Board Additional facilities secured at Picketston	2	4	8	PCS reviewing options for medical records storage - additional space is available from Johnseys on Mamhilad site. Business Case prepared and subject to consideration for approval at July SSPC.	Business Case approved at June SLG and to go to July SSPC for approval.	→	**31-Jul-22**
	Strategic Objective - Service Development									**Risk Lead: Programme Director**		
A2	Suppliers, Staff or the general public committing fraud against NWSSP. (added April 2019)	5	3	15	Dedicated NWSSP LCFS Counter Fraud Service Internal Audit WAO PPV National Fraud Initiative Counter Fraud Steering Group Policies & Procedures Fraud Awareness Training Fighting Fraud Strategy & Action Plan	3	3	9	Develop work plan for dedicated LCFS resource (PS 31/07/2022)	C&V have recruited an additional Band 6 LCFS and an 8A to replace Craig Greenstock. Mark Weston commenced in post as dedicated LCFS for NWSSP with effect from 6/6/22.	→	**31-Jul-22**
	Strategic Objective - Value For Money									**Risk Lead: Director of Finance & Corporate Services**		
A3	Specific fraud risk relating to amendment of banking details for suppliers due to hacking of supplier e-mail accounts leading to payments being made to fraudsters (added April 2021)	5	3	15	Documented process for bank mandate changes Role of Supplier Maintenance Team Authorisation by Senior Finance Staff Internal Audit Reviews Experian Bank Mandate Checker	2	3	6	Recent spate of attacks (Apr 22) reinforces need to maintain current controls.	Further spate of attempted frauds in April/May 2022 (4) but all stopped by team. This has reinforced the need to maintain and possibly even strengthen existing controls.	→	**30-Sep-22**
	Strategic Objective - Value For Money									**Risk Lead: Director of Finance & Corporate Services**		
A4	Risk of cyber attack exacerbated if NWSSP, or other NHS Wales organisations, run unsupported versions of software. (added Apr 2019)	5	5	25	Cyber Security Action Plan BCP Champions Meeting Information Governance training Mandatory cyber security e-learn Internal Audit review Band 6 IT Security Officer appointed Sept 21 BCP Action Cards (updated March 22) CAF completed and report received from CRU CAF remediation project established with support from PMO. 'Exercise in a box' launch event held with SLG (face to face) on 12 May. Phishing testing has been running since February 2022 alongside proactive communications on cyber awareness.	2	5	10	Initial phase of work to review and update the service catalogue and make assessment of risk on existing systems has commenced (w/c 20th June). IT security team attended BCP meeting on 16 June to explain the process and requirements of All Divisions. Given the heightened level of risk promotion of good practice to staff and phishing testing continues. Progress against the CAF will be reported to SLG on a quarterly basis. CRU is holding a workshop with SIRO and Director of Informatics on 29 June. The need for additional resources discussed at SLG on 26 May but has yet to be agreed.	Team was strengthened in Sept 21 with additional member of staff. Following war in Ukraine staff have been reminded of good housekeeping procedures and guidance reissued. All directorates have completed or updated their action cards relating to the potential loss of IT systems and networks. Focus on this topic at May SLG.	→	**31-Jul-22**
	Strategic Objective - Service Development									**Risk Lead: Director of Planning, Performance & Informatics**		
A5	The failure to engage with appropriate specialists (e.g. H&S/Fire Safety, Information Security/IG) sufficiently early enough when considering major developments may result in actions being taken that do not consider all relevant potential issues.	4	4	16	In-house H&S and Fire Safety Expertise Role of PMO Recent appointment of Programme Director Appointment of IP5 Facilities Manager (Jan 22)	1	4	4	PMO to ensure that Project Officers consult appropriately at outset of project. (IR-ongoing) Consider adequacy of resourcing within H&S. (AB/PS - complete)	All organisations contributing towards a Fire & Evacuation Strategy for IP5. Additional H&S staff member recruited (Jan 22)	→	**31-Jul-22**
	Strategic Objective - Service Development									**Risk Lead: Director of People and OD**		
A6	The introduction of new technology and the promotion of the digitisation agenda may impact NWSSP staff in terms of their current roles and responsibilities. (added January 2022)	3	3	9	Learning and Development Programmes	3	3	9	There is a need to ensure that staff are provided with the learning and development opportunities to equip them with the required skills.		→	**31-Mar-23**
	Strategic Objective - Staff									**Risk Lead: Director of People and OD**		

A7	The demand on services within Employment Services as a result of Health Boards taking on substantial numbers of staff to respond to and recover from the pandemic, is unsustainable, leading to poor levels of performance. (added November 2021) **Strategic Objective - Customers**	4	4	16	Established working practices governed by Service Level Agreements and measured by reporting of KPIs on monthly basis.	3	4	12	Additional staff being recruited Use of students from Cardiff Univeristy Temporary support from other Directorates Modernisation Programme being implemented Accessing KickStart scheme	Focus on training staff on pinch points rather than whole process Backlog in applications in Student Awards reduced from 1800 to <800. Significant reduction in complaints as at March 2022 Deep Dive Presentation to SSPC March 2022 **Risk Lead: Director of People and OD**	↓	**31-Jul-22**
A8	Given the level of stock holding there may be items that reach their end of life (expiry date) before being issued for use and need to be written off causing a loss to public funds and possible reputational damage to NWSSP. (added January 2022) **Strategic Objective - Value For Money**	5	5	25	Internal Audit Review of Stores Stock Rotation - based on FIFO Donations to India and Namibia	2	5	10	SMTL working on behalf of DHCS on an Accelerated Aging Programme (SMTL 31/05/22) Produce briefing for Audit Committee (AB complete)	Wales On-Line FoI request robustly responded to on 31/1. SMTL working with DHSC to investigate whether expiry dates can be extended on some PPE equipment Schedules produced and discussed with senior finance officials in WG and Velindre. There is a need to write off significant values of PPE stock **Risk Lead: Director of Finance & Corporate Services**	→	**31/07/2022**
A9	The increase in energy prices, exacerbated by the war in Ukraine, is likely to lead to significant price increases across the whole range of goods and services resulting in severe cost pressures for NWSSP and NHS Wales budgets. (added March 2022) **Strategic Objective - Value For Money**	5	5	25	Energy Price Risk Management Group Forward purchase of energy Briefings to Welsh Government	4	5	20	Review of energy costs to March SSPC (AB) Reviewof general price rises to May SSPC (JI)	Paper on energy costs to March SSPC. Daily monitoring of prices and buying ahead at fixed price where possible. **Risk Lead: Director of Finance & Corporate Services**	→	**30/09/2022**
A10	The Student Awards software is at end of life and needs replacement without which delays to student bursary payments could be significantly affected. (added May 2022) **Strategic Objective - Customers**	5	5	25	Formal project management in place	3	4	12	Complete Outline Business Case Confirm whether selected roure is via DHCW development or procurement from a third party supplier. Get funding approvals from Welsh Government.	SAS contract support agreement with Kainos in place to end of March 2023. This option has now been exhausted & further extensions would contravene Procurement OJEU rules & regulations. The OBC is currently being updated & an emergent option of utilising the services of the Centre of Excellence (DHCW) to develop new software for SAS & SSP is being explored & will be concluded at the end of April. The preferred option is to procure new software from the marketplace via Procurement & the deadline to submit the tender to market is 31st May, subject to funding being approved by Welsh Government. **Risk Lead: Director of People and OD**	*	**31/10/2022**
A11	There is a reputational risk associated with the establishment of the Citizens' Voice Body if this does not go to plan. (added July 2022) **Strategic Objective - Service Development**	4	4	16	Experienced Programme Director	3	4	12	Provide options for financial systems (PB) Provide support for governance processes (PS)	Role is to assist WG in deciding options on how CVB will operate. Paul Beckett and Peter Stephenson providing advice. **Risk Lead: Director of Finance & Corporate Services**	*	**31/03/2023**
A12	The transfer of the laundries to NWSSP expose a number of risks including concerns over health and safety and formality of customer relationships. (added April 2021) **Strategic Objective - Service Development**	4	4	16	All-Wales Programme Business Case Programme Board Regular updates to SLG and H&S Group on progress with Action Plan Draft SLAs approved by SSPC Appointment of Assistant Director for Laundry Services H&S Audits of Laundry Sites	3	3	9	Arrange internal audit review of Laundry service (AB/PS - complete) Prioritised report to be submitted to SLGs to monitor progress. (on-going)	Transfer has now taken place for all of the 5 laundries, although arrangements are different for Hywel Dda and Cwm Taf. Updates provided to SLG. IA review focused on Swansea Laundry provides reasonable assurance. Choice of new sites in North Wales and Swansea apparently well received. **Risk Lead: Director of Procurement Services**	→	**31-Jul-22**
	Risks for Monitoring											
M1	Disruption to services and threats to staff due to unauthorised access to NWSSP sites. (Added May 2018) **Strategic Objective - Staff**	5	4	20	Manned Security at Matrix CCTV Locked Gates installed at Matrix. Security Review Undertaken (reported Dec 18) Increased Security Patrols at Matrix. CTSA underake annual reviews of high risk buildings e.g. IP5, Picketston	1	4	4	Review results from security checklists (PS - 31/07/22)	Security Review undertaken and reported to SMT in Dec 2018. No major findings and all agreed actions implemented or superceded. **Risk Lead; Director Specialist Estates Services/Director of Finance and Corporate Services**	→	
M2	There is an increased fire risk with a consequence for protection of buildings at Alder House, Brecon House and Matrix House due to a lack of compartmentation in the roof space. (added Feb 2020) **Strategic Objective - Staff**	2	5	10	Fire Safety Officer Risk Assessment - assessed risk to life as low - Update Paper to Feb, May and November SMTs.	1	5	5	Discrete fire risk assessments to be undertaken for each site at the recommended intervals. Risk to remain on Corporate Risk Register to ensure sufficient monitoring. .	Landlords consider any work on compartmentation to be our responsibility. SES reported to Nov 2020 SLT where it was agreed that the risk to life is very low. Further discrete risk assessments to be undertaken and reported back to Feb 2021 SLT. **Risk Lead: Director of People and OD**	→	

M3	The total quantum for funding for addressing Covid-19 across Wales remains fluid and uncertain. There is a risk that the organisation's operational cost of addressing the pandemic cannot be contained within available funding resulting in a potential breach of the planned outturn for 2021-22.	3	3	9	Financial modelling and forecasting is co-ordinated on a regular basis; Financial reporting to Welsh Government on local costs incurred as a result of Covid-19 to inform central and local scrutiny, feedback and decision-making; Oversight arrangements in place at SMT level, and through the command structure. Financial Governance Committee considers VFM in all expenditure	1	3	3	Ensure that the costs directly associated with COVID-19 are identified and accurately captured. Provide regular updates to Welsh Government.	WG issued letter on 24/3/21 setting out funding allocations for 2021/22. The sum of £170m is available but this is being distributed only to HBs in the first instance. **Risk Lead: Director of Finance & Corporate Services**	➔	
M4	NWSSP are unable to procure sufficient orders of PPE, medical consumables and equipment resulting in clinical staff being able to treat patients safely and effectively.	5	5	25	PPE Winter Plan Finance Governance Committee Streamlined arrangements for Trust Board and WG approvals Increased limits approved for Scheme of Delegation. Regular meetings with UK and Welsh Government. Active involvement in UK Mutual Aid Schemes. Deloitte undertook consultancy work on behalf of WG to assist in this area. Internal Audit Review (Sept 2020)	1	3	3	Audit Wales published their findings on 14 April 2021 and report largely positive but action plan developed to respond to their findings.	The PPE plan has been developed in consultation with key stakeholders. Some pressure from Chief Medical Officers that may lead to Type IIR masks being totally replaced by FFP3 masks. £5m COVID expenditure authorisation limit reinstated. **Risk Lead: Director of Procurement Services**	➔	
M5	By requiring our staff to continue working we expose them to a greater risk of being infected with COVID-19 which may cause them significant health problems.	5	5	25	Vaccination Programme All staff encouraged to work from home where possible. Risk Assessments undertaken for all staff. Social Distancing measures in place in each office. Any staff displaying any symptoms told not to come into office or go home immediately. Testing for front-line staff Weekly Site Leads' meetings to assess position in each office.	1	3	3	Following the updated guidance issued by Welsh Government on 22 Dec additional communications have been issued to all staff. This provide information regarding access to lateral flow tests as well as signposting to the requirements for self-isolation. SLG agreed to reinforce the key message to work from home unless there is a requirement to attend site.	Current measures seem to be effective, but need to be closely monitored in view of Omnicrom variant. Large numbers of staff are working from home and social distancing measures are in place for those staff who need to continue to come into work. Daily reporting of absences shows that the numbers of staff reporting COVID-19 like symptoms continues to be low, but are increasing. **Risk Lead: Senior Leadership Group**	➔	
M6	NWSSP are unable to continue to provide business-critical services due to having insufficient numbers of staff available and able to undertake the work.	5	5	25	Identification of all business-critical services Redeployment of staff to business-critical services Increased provision of laptops and VPN Roll-out of Office 365 Use of Bomgar service for PCS Daily monitoring and reporting of absence figures. IT Update also given to weekly COVID-19 Planning & Response Group.	1	3	3	Updated BCP document covering response to COVID and possible impact of future waves presented to August SMT, and September SSPC. Throughout Oct and Nov the BCP group has asked Divisions to review and refresh BCP arrangements. Consideration of an oncall rota is something that will be taken forward in the new calendar year. Oncall arrangements in place for HCS and Supply Chain teams essential to the BAU and Vaccine	Contact details on the SLG WhatsApp group have been refreshed and updated. The daily report on staff absence shows that absence rates remain low, but OMICRON may increase rates through community transmission so will be monitored closely. The investment in hardware and software has allowed large numbers of staff to work remotely with minimal problems thus far. There are good rates of uptake for the vaccination programme. **Risk Lead: Senior Leadership Group**	➔	
M7	Staff wellbeing is adversely affected through concerns arising from COVID-19 either directly in terms of their health and that of their families, or financially from loss of income of a family member. This includes the risk of "burn-out" for	5	5	25	Regular communications to all staff Reminders of how to access Employee Assistance schemes Mental Health First Aiders Formal Peer Group with phone surgery times	1	3	3	Implement action plan to respond to findings from staff surveys - monitored and managed through Adapt and Future Change Group.	As previously stated, absence rates are very low. Communications are regularly issued and all Directors and Managers are tasked with regularly checking the health and well-being of their staff. **Risk Lead: Director of People and OD**	➔	
M8	GP Trainees, who are employed by NWSSP, are exposed to a level of risk of risk of catching COVID-19 but are outside the direct control and influence of NWSSP.	5	5	25	Risk Assessments by Education Supervisor - leads to decision on what PPE is to be provided. Tripartite Agreement	1	3	3	Confirming vaccination rates with staff individually as Health Board reports to total numbers vaccinated suggest under-reporting.	The tripartite agreement was agreed by the Project Board on 7/9/2020 and sets out the general duties of the host organisation for all trainees employed by NWSSP including the general duty to provide a safe working environment. Vaccination of front-line staff further mitigates this risk. **Risk Lead: Director of People and OD**	➔	

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	13 July 2022
PREPARED BY	Carly Wilce, Corporate Services
PRESENTED BY	Peter Stephenson, Head of Finance & Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Update on the Implementation of Audit Recommendations

PURPOSE

This report provides an update to the Audit Committee on the progress of audit recommendations within NWSSP. Please note that this report does not include figures and assurance ratings for the audit reports listed on the present Audit Committee agenda.

1. INTRODUCTION

NWSSP records audit recommendations raised by Internal Audit, Audit Wales and other external bodies, as appropriate. It is essential that stakeholder confidence is upheld and maintained; an important way in which to enhance assurance and confidence is to monitor and implement audit recommendations in an effective and efficient way.

2. CURRENT POSITION

The detailed recommendations raised in respect of our services have been captured in a database. A copy of the summary extract is attached at **Appendix A**, for information.

There are **64** reports covered in this review; **16** reports have achieved **Substantial** assurance; **28** reports have achieved **Reasonable** assurance, **1** report has achieved **Limited** assurance and no reports have been awarded **No Assurance;** and **19** reports were generated with **Assurance Not Applicable**. The reports include **242** recommendations for action.

Table 1 - Summary of Audit Recommendations

As at 07 July 2022					
Recommendations		**Implemented**	**Not Yet Due**	**Overdue**	**Not NWSSP Action**
Internal Audit	**198**	**184**	**12**	**1**	**1**
High	18	15	3	0	0
Medium	97	87	8	1	1
Low	72	71	1	0	0
Not Applicable	11	11	0	0	0
External Audit	**16**	**13**	**2**	**0**	**1**
High	2	1	0	0	1
Medium	9	7	2	0	0
Low	2	2	0	0	0
Not Applicable	3	3	0	0	0
Other Audit	**28**	**28**	**0**	0	0
High	4	4	0	0	0
Medium	5	5	0	0	0
Low	19	19	0	0	0
Not Applicable	0	0	0	0	0
TOTALS:	**242**	**225**	**14**	**1**	**2**

3. Overdue Recommendations

There is currently one overdue recommendation relating to Laundry Services. Full details of the recommendations are set out in Appendix A, for the attention of the Audit Committee.

4. Not within the gift of NWSSP

Any actions not within the gift of implementation by NWSSP are escalated to the relevant contact and marked as Not for NWSSP with the action taken clearly stated in the progress box. There are two recommendations for NWSSP in this category.

5. RECOMMENDATIONS

The Audit Committee is asked to:

- **NOTE** the report findings and progress made to date regarding implementation of audit recommendations.

APPENDIX A - PROGRESS OF AUDIT RECOMMENDATIONS

ID	Internal Audit Report Ref Rec No / Ref NWSSP Service Report Title Report Year	Status	Issue Identified	Risk Rating	Recommendation	Responsibility for Action	Management Response	Original Deadline	Updated Deadline	Update On Progress Made
PROGRESS WITH RECOMMENDATIONS										
FINANCE AND CORPORATE SERVICES										
Cyber Security										
CTES										
1.	Review of National Hosted NHS IT Systems. Oracle Financial Management System - IT Controls. AW/2020-21/2	NYD	CTES has completed and a gap analysis assessment of the Oracle FMS to the Information Security Management Standard (ISO 27001) to identify potential improvement areas. The outcome will be a set of recommendations for implementation during 2021-22. It is good security management practice to assess and baseline a comparison to the ISO 27001 standard.	Medium	Complete the accreditation to the Information Security Management Standard (ISO 27001) to identify potential improvement areas.	Stuart Fraser- Acting Head, CTeS	Work in Progress - It was agreed by the All Wales Oracle (STRAD) Board that this would be deferred due to high priority projects and in particular the requirement to complete the major Oracle system upgrade in October 2021. It has been agreed by STRAD that we will seek to obtain accreditation by 31 December 2022 and approval has been obtained to appoint a dedicated project manager.	31/12/2022		Still on track to complete by deadline. A Project Manager has recently been appointed to progress the action. Update received on 20/05/2022
2.	Review of National Hosted NHS IT Systems. Oracle Financial Management System - IT Controls. AW/2020-21/2	NYD	CTES provides FMS services to the consortium of Welsh NHS organisations. It is good practice IT service management to conform or be accredited to the Information Technology Service Management (ISO 20000) standard. CTES have completed the gap analysis and we were informed during our fieldwork that they aim to complete accreditation during 2021-22 cycle. TES consider there are benefits to complete accreditation to the Information Technology Service Management (ISO 20000) standard for service management.	Medium	Complete CTES accreditation to the Information Technology Service Management (ISO 20000) standard for service management.	Stuart Fraser- Acting Head, CTeS	Work in progress It was agreed by the All Wales Oracle (STRAD) Board that this would be deferred due to high priority projects and in particular the requirement to complete the major Oracle system upgrade in October 2021. It has been agreed by STRAD that we will seek to obtain accreditation by 31 December 2022 and approval has been obtained to appoint a dedicated project Manager.	31/12/2022		As above
3.	Review of National Hosted NHS IT Systems. Oracle Financial Management System - IT Controls. AW/2020-21/2	NOT WITHIN THE GIFT OF NWSSP	The last IT DR test was completed in November 2019 and the scheduled test in November 2020 was deferred due to disruptions caused the pandemic. We were informed during our fieldwork that the next scheduled IT DR test would not be until after both the Oracle version upgrade to 12.2.9 has been completed in October 2021 and the February 2022 Oracle patch release.	High	Complete the Oracle FMS IT Disaster Recovery (DR) test in 2021-22 as soon as is practically possible ensuring all NHS organisations attend the next scheduled test.	Stuart Fraser- Acting Head, CTeS	Work in progress CTeS are on track to implement the Oracle upgrade in October 2021 and complete a full Business Continuity (BC) & DR test in February2022 across all FMS Services. A change release including latest patch sets planned for January 2022 implementation.	28/02/2022	31/05/2022	May DR cancelled, testing has been rescheduled for November 2022. The cancellations and revised dates are set by C&VUHB. 24.06.2022
Accounts Payable										

APPENDIX A - PROGRESS OF AUDIT RECOMMENDATIONS

4.	NWSSP-2122-15 CORP/21-22/1 Procure to Pay (P2P)	NYD	Accounts Payable performance data report for January 2022 reports a 29.8% increase in the number of invoices on hold for more than 30 days, since 1 April 2021. In 2019/20 a temporary, centralised IOH Team was established to focus on aged invoices on hold. We understand that this was effective in clearing invoice holds with a similar exercise scheduled for September 2022 focusing on invoices on hold prior to 1 April 2021. However, this does not address the root cause(s) of invoices being placed on hold in the first place. Whilst Accounts Payable are responsible for releasing and in a minority of cases resolving some of the invoice holds, addressing the root cause of the hold predominantly rests with Procurement and health bodies.	High	3.1 A deep dive review is required to establish the root cause of key invoice holds and identify corrective action to prevent recurrence. This will require a collaborative approach between Central Sourcing, Local Procurement Teams, Accounts Payable and health bodies, as well as involvement of the supplier where appropriate, depending on the hold type.	Director of Procurement Services Director of Finance and Corporate Services Head of Accounts Payble & Enablement.	3.1 Agreed. A collaborative approach involving representatives from Health Organisations, Procurement Services and Accounts Payable is necessary for this to succeed. Monthly reporting will be undertaken. An NWSSP P2P Group has been established and a work plan has been agreed. The Groups initial focus will be to investigate those Invoices on Hold that are the responsibility of NWSSP for resolving and releasing eg Price Holds etc In addition, the Finance Academy All Wales P2P Group will reconvene on the 14 July. The input from this Group is key to investigating and resolving Invoices on Hold where responsibility resides with the Health Organisation eg Awaiting Authorisation holds etc	30/09/2022		**Invoices on hold** – The NWSSP P2P Group will be conducting a 'deep dive' over the next couple of weeks in respect of why invoices are going on hold for Price, with the remainder of invoice holds being discussed at the All-Wales P2P Forum on the 14th July. **A Task & Finish group comprising AP & Procurement staff has been set up and they are meeting on the 27 June to target the high number of Invoices on Hold. In addition, a 'summit' meeting took place on the 7 June chaired by Darren Griffiths, DoF for Swansea Bay and documents are in the process of being finalised for circulation to the All Wales P2P Forum members who are scheduled to meet on the 14th July.** **Update received on 24.06.2022**
5.	NWSSP-2122-15 CORP/21-22/1 Procure to Pay (P2P)	NYD	Management is aware of the need to agree an escalation process with sanctions for non-compliance with the No PO No Pay Policy, and update the all-Wales exceptions list which is fundamental to the operation of the policy. We recognise that these actions require collective input from all NHS Wales organisations and are reflected on the work plans for the newly formed NWSSP P2P and Finance Academy P2P Groups for 2022/23. The Finance Academy P2P Group has not met for over 13 months although we were advised that it is scheduled to reconvene later this year.	Low	4.1 The importance of the Finance Academy P2P Group, as a forum for an all-Wales collaborative approach to address issues and enhance the P2P process, should be escalated to the Finance Academy Board to make formal arrangements to reconvene the Group.	Director of Finance & Corporate Services	4.1 Agreed. The Head of AP and Director of Finance & Corporate Services have met with the Chair of the Finance Academy P2P Group and the Group will reconvene on the 14 July 2022. In addition, it is proposed to hold a 'Summit' meeting with the Finance Academy Lead Director of Finance, prior to the 14 July meeting.	14/07/2022		Awaiting outcome of meeting on 14 July.
EMPLOYMENT SERVICES										

APPENDIX A - PROGRESS OF AUDIT RECOMMENDATIONS

Payroll										
6.	NWSSP-2122-14 Payroll Services - 2021-22	NOT WITHIN THE GIFT OF NWSSP	The previous Payroll audit report (NWSSP-2021-08) highlighted an inconsistent approach across NHS Wales organisations and Payroll teams. An all-Wales Overpayments Policy has been drafted but has not yet been approved. Overpayment registers are maintained for each health body. Sample testing of 60 overpayments for the period February 2021 to January 2022 noted that all had evidence on file to demonstrate action taken to recover monies. However, we identified 27 instances where there were delays of more than five weeks between identification of the overpayment and initiating action to recover.		2.2 Management should progress in agreeing and approving the drafted all-Wales Overpayments Policy to ensure a consistent approach is implemented across all Payroll Teams.	Head of modernisation	2.2 We acknowledge the finding of the audit report, the All-Wales Overpayments Procedure has been completed, it has been out for consultation with the Finance Colleagues and Counter Fraud and the details of the responses will be discussed on how to progress this.	30/06/2022		**This issue is still being considered by Finance colleagues.**

APPENDIX A - PROGRESS OF AUDIT RECOMMENDATIONS

7.	NWSSP-2122-14 Payroll Services - 2021-22	NYD	A sample of 30 employees who were enrolled on the NHS Pensions Scheme were selected and tested to ensure their pension contribution listed on their payslip as of December 2021 accurately matched the contribution rate. Of the 30 employees tested, we noted that eight individual pension contribution rates were incorrect.	High	3.1 Management should ensure pension contribution rates are reviewed and promptly updated to reflect any changes following an in-year pay increase.	Head of modernisation	3.1 We acknowledge the finding of the audit report, a fix to this issue was deployed by IBM in RN469 Release 49.0.0.0 and 49.1.01.01 Automatic Pension Reassessment, however the fix deployed by IBM did not work, IBM are aware of this and due to the impending changes to the NHS Pensions Regulation, the system will be modified in October 2022 to accommodate this change. It should be noted that in October each year, there is an automatic reassessment of Pension Tiers undertaking in ESR. It is accepted by IBM and NHSBA Pensions Agency of this process. This process checks to see if staff have changed bands or have had additional enhancements, it then evaluates what pension tier they should be on and updates their record in ESR, it is not retrospective, the change is only updated from the date of assessment, where the tier has been changed there is no recovery of over or underpayments of Pension Contributions and this does not affect the employees' pension. Due to the changes in Pensions Legislation that is being implemented on 01.10.2022 This will include the fix to the Automatic Pension Reassessment process previously deployed. This process will review the Pension tier for each member of the NHS Pension scheme before every payroll run to check the correct status of the employee's tier banding to ensure they are correct, in the meantime the team has been reminded to check the Increment Report an action appropriately, once the fix is deployed it will eradicate the manual workaround mentioned. It should be noted that this finding does not affect any pensionable pay for members as stated in para two, when Staff retire their pension is based on their TPP not the % tier contribution.	01/10/2022		On Target to complete by deadline. IBM confirmed in late June
Planning, Performance &Informatics											

APPENDIX A - PROGRESS OF AUDIT RECOMMENDATIONS

8..	NWSSP-2122-16 NWSSP Operational ICT infrastructure	NYD	There is an inherent lack of resilience for the telecoms system, with the following issues noted: There is only one person with the knowledge of managing it within NWSSP, so when absent there is no capability for managing the system and updating numbers etc.	Medium	The knowledge of the system and how to manage it should be shared within the IT team in NWSSP and back up support factored in to allow cover for times of absence.	Director of Planning, Performance, and Informatics	Work has already commenced to share user guides and this will be progressed to provide additional support within the team.	31/07/2022		A set of resources is being compiled designed to ensure that standard tasks can be completed by any support officer within the BS&I team. This is on target to complete by 31 July 2022.
9.	NWSSP-2122-16 NWSSP Operational ICT infrastructure	NYD	There is no performance reporting on the Telecoms system, despite the contract stating that performance reports are to be provided. The lack of performance reporting means that there is very limited information on the system and its use, with no information on call volumes, latency, dropped calls, call quality etc. We note that there have been issues with quality and dropped calls, but this cannot be tracked without the information.	Medium	NWSSP should request that the supplier provide performance reports as per the contractual requirement.	Director of Planning, Performance, and Informatics	We are in the process of procuring a replacement telephony system, as the current contract is due to expire in the next 12 months. We will ensure that the new contract specification clearly captures regular performance reporting requirements.	31/01/2023		This requirement has been logged with the Contact Centre and Telephony Upgrade project.

APPENDIX A - PROGRESS OF AUDIT RECOMMENDATIONS

10	NWSSP-2122-16 NWSSP Operational ICT infrastructure	NYD	Performance against service standards is reported by DHCW, however there is no reporting on the detail of the performance of the functions within the SLA. e.g. there is no reporting on how servers are supported and managed that would show the success of this service. Without this NWSSP has no visibility of the status of this service. We note that DHCW have developed internal performance reporting on some aspects of these.	Medium	NWSSP should formally request that DHCW provide performance reports that show the successful delivery of the functional aspects of the service, covering items such as: - patch compliance; - nodes with alerts resolved / unresolved; - server alerts outstanding / dealt with; and - proactive monitoring reports.	Chief Digital Officer	The format and content of our performance and monitoring reports is constantly evolving and will be continue to be reviewed.	31/07/2022		DHCW are in the process of developing a dashboard to provide the required information. The desktop reporting module has been released to NWSSP with the server module expected within the estimated time frame.
11.	NWSSP-2122-16 NWSSP Operational ICT infrastructure	NYD	There are a number of old servers and switches still in use within NWSSP. These are out of support, contain security vulnerabilities and represent a security risk to the organisation. We note that some new switches have been purchased, however these have not yet been installed	High	The existing plan to replace all the Windows 2008 servers should be reviewed and where appropriate revised timescales should be agreed and enacted. A funded, rolling replacement programme for infrastructure equipment should be developed.	Chief Digital Officer/ Director of Planning, Performance, and Informatics	1)We will ensure that the replacement plan is reviewed to ensure that it is comprehensive and has identified all relevant servers. 2) A rolling programme for the replacement of infrastructure equipment will also be further developed and funding sought as appropriate.	1) 31/07/2022 2) 31/12/2022		The Infrastructure Upgrade / Replacement project has been launched to address these issues. The project is currently in start-up phase. Scope, governance and project brief have been defined and initial discovery routines have been run to assess cloud vs on-premises replacement opportunities.

APPENDIX A - PROGRESS OF AUDIT RECOMMENDATIONS

12.	NWSSP-2122-16 NWSSP Operational ICT infrastructure	NYD	An Asset management system is included as a charge within the SLA with DHCW. This as defined as Asset Studio, which we note has been replaced by Snow Asset Management. The service statement for Asset Studio / Snow states that it provides in depth information on the hardware assets to provide a fully rounded view of the IT environment. However servers and switches were never included in Asset Studio, and they are not currently within Snow. As NWSSP do not have access into the CMDB, SCCM or Dell OpenManage this means that there is no full record held by NWSSP IT of what hardware is owned by NWWSP and there is very little visibility on the state of the infrastructure for NWSSP IT and the service as per the SLA may not be being completely delivered.	Medium	NWSSP should have further discussions with DHCW regarding the possibility of adding the servers should added to Snow to enable visibility of the whole infrastructure. In the interim, access should be granted to Dell OpenManage for NWSSP IT staff.	Chief Digital Officer	1) This issue has been raised with DHCW whose policy is not to include servers on Snow. 2) We have previously raised this issue regarding Dell OpenManage with DHCW, and the current challenge is understood to be that NWSSP cannot be given access to solely the NWSSP information within the system. We would need to be given access to the whole system, as it is currently configured including the infrastructure information of others, and this would not be appropriate. However with the appointment of the new Chief Digital Officer we will continue to investigate with DHCW any alternative solutions to address this problem.	31/07/2022		DHCW has recently completed the migration of its own and the GP estate to new asset management solution. This solution has been assessed as suitable for NWSSP. A project support request has been raised with DHCW to commence the migration of NWSSP IT assets. Delivery is expected in a 4-6 month time frame.
13.	NWSSP-2122-16 NWSSP Operational ICT infrastructure	NYD	The overall use of memory and processing within the virtual environment is low, although some VMs run at their maximum allocation. There is no visibility into the environment for NWSSP IT staff and no ongoing discussion with users to see if more resource could be utilised. As users define the resource requirements at outset they may not be aware of the potential to increase the allocated resource and potentially improve performance.		Consideration should be given to providing (read only) access to the hypervisor monitoring to NWSSP IT staff. A process should be established for reviewing the potential to increase resource allocations to improve performance for specific VMs and maximise the value gained from investment in the virtual environment.	Chief Digital Officer	Agreed - Management considers that DHCW should be doing this for NWSSP as part of the SLA. Given we, like many other NHS organisations are still relatively early on in our transition to virtual environment and have future plans to do more in this area, the Chief Digital Officer will address this as part of our Digital Strategy and review of DHCW SLA arrangements.	31/01/2023		This requirement has been logged with the Infrastructure Upgrade / Replacement project and will be actioned through this project.

APPENDIX A - PROGRESS OF AUDIT RECOMMENDATIONS

14.	NWSSP-2122-16 NWSSP Operational ICT infrastructure	NYD	Although there have been desktop exercises to review the continuity procedures, there is no planned, regular schedule for testing of the continuity and disaster recovery plans. There is also no structure to ensure that each service has assurance that DR plans are in place as appropriate. In addition, although data is recovered from backup on an ad-hoc basis, there is no ongoing scheduled testing of backups to confirm their validity	Medium	Services should be requested to formally confirm that they have assessed the requirement for business continuity and disaster recovery plans and that they are in place accordingly. A formal schedule of testing should be established for: • business continuity plans; and • disaster recovery plans. AS the back up process is managed by DHCW, NWSSP should request that a schedule of regular testing of the back ups be implemented and the results fed back to NWSSP.	Director of Planning, Performance, and Informatics	A workshop is planned for Qtr 4 of 2021-22 to explore further our approach to this, and prioritise the testing plans to commence from April 2022. The Central Business Team (Oracle) has offered to demonstrate their approach to DR testing. This is also an area of risk that has been identified by most other NHS Wales organisations, and there will be opportunities to work with others and share learning from respective scenario testing.	31/07/2022		All Divisions have reviewed and updated their Business Continuity Action Cards and this was completed by end of April 2022. Given the heightened level of alert caused by the war in Ukraine specific scenarios were asked to be planned for including: • Loss of Critical Software • Loss of Service Infrastructure • Loss of Service hardware • Loss of specialist equipment As part of the Cyber Assessment Framework response, all system owners within NWSSP Divisions will be asked to review their systems (as per service catalogue) and confirm arrangements for disaster recovery with third party suppliers, and seek evidence of regular testing. We plan to complete this for all business-critical systems before 31 Dec 2022. In addition, SLG have completed the management oversight element of the 'exercise in a box' scenario on 12 May. This helps organisations consider how resilient they are to cyber-attacks and discuss their likely response in a safe environment. This highlighted that given the dependency of most of our services on IT systems to continue service delivery, that disaster recovery more, so than business continuity needs to be our area of focus. The planned offer by CTeS to talk about their experience is on pause as their disaster recovery test has been postponed twice due to Storm Eunice and also a power failure at C&V site. This will still happen once their test has been rearranged in the autumn 2022.

APPENDIX A - PROGRESS OF AUDIT RECOMMENDATIONS

15.	NWSSP-2122-16 NWSSP Operational ICT infrastructure	NYD	Although NWSSP is moving towards increasing use of modern / future technology, there is a lack of skills and knowledge in place to enable successful use of these: • the move towards cloud based services using Azure requires a role within the organisation to manage resource use to ensure costs are minimised, however there is no role established and there are no such skills within NWSSP which would enable this role. • NWSSP is upgrading servers to 2016, the direction of travel in this space is towards a hyperconverged infrastructure, however there are not enough skills within NWSSP to be able to successfully influence the move from 2016 towards this. There are no skills within NWSSP to enable a move towards software defined networking which would enable the modernisation of the network when the current switches become end of life.	Medium	Training should be provided on Azure management and a role for managing resource established. Training should be provided to NWSSP IT staff on modern architecture and network trends in order to influence the direction of travel when replacement servers and switches is required.	Chief Digital Officer	The Chief Digital Officer will take forward the future training needs plan for the internal team and will address this recommendation as part of that work.	31/01/2023		
Procurement										
All Wales Laundry										
16.	Review of Laundry Services NWSSP-2122-12 PROC/21-22/1	NYD	The Finance Programme Lead advised that current prices are based on 2019/20 prices plus 2% inflation. However, during the audit the Project Accountant identified that this global uplift was not applied to all customers due to a 'system error'. At the time of reporting, we were assured that this error has been corrected. Laundry item prices vary across Wales due to legacy arrangements, following the agreed 'lift and shift' transition into NWSSP. Furthermore, the cost of missing linen stock is currently absorbed by the Laundry in terms of replacement costs. We were advised that a standard pricing model will be implemented following completion of the All-Wales Laundry Transformational Programme which will incorporate all operating costs including replacement linen stock.	Medium	We concur with the plans to implement a standard pricing model following completion of the All-Wales Laundry Transformational Programme. This should incorporate all operating costs including linen stock purchases to ensure that the service is not operating at a loss.	Assistant Director of Laundry & Operations	Management accepts the recommendation. The all-Wales pricing policy is reliant on the transformational programme and the redevelopment of the service with the provision of two new sites and the development of Greenvale. The agreement by the Shared Services Partnership Committee was that the transfer was based on a 'lift and shift' model and there would be no changes until the completion of the transformational programme, expected in 2023/24.	30/04/2024		This recommendation cannot be actioned for some time as the pricing model is fixed until the completion of the transformational programme. No further update to report. **Update provided 14.02.2022**
17.	Review of Laundry Services NWSSP-2122-12 PROC/21-22/1	Overdue	There is no record of PADRs undertaken prior to the transfer of Llansamlet Laundry to NWSSP due to an ESR data transfer issue, and PADRs have not yet been undertaken following transfer. We understand that the Laundry Manager is liaising with Workforce colleagues to recover the pre-transfer PADR history. At the time of audit, objectives had not been set for Laundry staff. We understand that this will be done following completion of the All-Wales Transformational Programme, with the transfer of the two remaining laundries in October 2021.	Medium	Following completion of the All-Wales Laundry Transformational Programme, all laundry staff should be set objectives and subject to personal appraisal and development reviews in line with the NWSSP Appraisal Procedure.	Assistant Director of Laundry & Operations	Management accepts the recommendation.	31/03/2022	31/05/2022	Work to complete all PADR's for the service is progressing well. An extension to original deadline was requested and approved at April's Audit Committee. However, upon review the recommendation remains overdue current compliance recorded as at 6 July 2022 is approximately 70%. **Update provided on 01/07/2022**

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	13 July 2022
PREPARED BY	Carly Wilce, Corporate Services Manager
PRESENTED BY	Andy Butler, Director of Finance and Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Annual Review of Audit Committee Terms Of Reference

PURPOSE

The Audit Committee is required to review its Terms of Reference annually in accordance with the Shared Services Standing Orders. These are attached below, no changes have been made since it was last reviewed by the committee in 2021.

1. RECOMMENDATIONS

The Committee is asked to **NOTE** and APPROVE the Terms of Reference.

Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Terms of Reference & Operating Arrangements

April 2022

1. BACKGROUND

1.1 In May 2012, all Health Boards and Trusts approved the Standing Orders for Shared Services Partnership Committee. Section 4.0.3 of the Standing Orders (as amended 1 March 2019) states:

*"The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or **utilise Velindre's Committee arrangements** to assist in discharging its governance responsibilities."*

These Terms of Reference set out the arrangements for utilising the Velindre University NHS Trust Audit Committee to support the discharge of those relevant functions in relation to NHS Wales Shared Services Partnership (NWSSP).

ORGANISATIONAL STRUCTURE

Velindre University NHS Trust has an interest in NWSSP on two levels:

a) The internal governance of NWSSP in relation to the host relationship; and
b) As a member of NWSSP Committee in relation to the running of national systems and services.

The governance and issues relating to the hosting of NWSSP dealt with in **(a)** will be incorporated into the standard business of the existing Velindre University NHS Trust Audit Committee, with a specific focus on alternating Trust Audit Committee business. The assurance for the business dealt with in **(a)** will be to the Velindre University NHS Trust Board. The Chair of NWSSP Audit Committee should receive copies of the meeting papers and will be invited to attend, should there be anything on the agenda which has implications for the Shared Services Partnership Committee (SSPC).

Issues relating to NWSSP nationally run systems and services **(b)** will be fed into a separate Velindre University NHS Trust Audit Committee for NWSSP operating within its own work cycle. The assurance for the business dealt with in **(b)** will be to NWSSP Chair and the NWSSP Audit Committee, via the communication routes, detailed below.

The arrangements for **(a)** above, will not be considered further within these Terms of Reference, as it is for Velindre University NHS Trust Audit Committee to determine the relevant assurance required in relation to the host relationship.

2. INTRODUCTION

2.1 Velindre University NHS Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust 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".

2.2 In line with Standing Orders and NWSSP's scheme of delegation, the SSPC shall nominate, annually, a Committee to be known as the Velindre University NHS Trust Audit Committee for NWSSP. The detailed Terms of Reference and Operating Arrangements in respect of this Committee are set out below.

2.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference, as detailed in the NHS Wales Audit Committee Handbook, June 2012.

3 PURPOSE

3.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the SSPC and the Accountable Officer on whether effective arrangements are in place - through the design and operation of NWSSP's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the organisation's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Velindre University NHS Trust Board and SSPC as to where and how its system of assurance may be strengthened and developed further.

4 DELEGATED POWERS AND AUTHORITY

4.1 With regard to its role in providing advice to both Velindre University NHS Trust Board and the SSPC, the Audit Committee will comment specifically upon:

- The adequacy of NWSSP's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, designed to support the public disclosure statements that flow from the assurance processes (including the Annual Governance Statement) and providing reasonable assurance on:

  - NWSSP's ability to achieve its objectives;
  - Compliance with relevant regulatory requirements, standards, quality and service delivery requirements, other directions and requirements set by the Welsh Government and others;

- The reliability, integrity, safety and security of the information collected and used by the organisation;
- The efficiency, effectiveness and economic use of resources; and
- The extent to which NWSSP safeguards and protects all of its assets, including its people.

- NWSSP's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- The planned activity and results of Internal Audit, External Audit and the Local Counter Fraud Specialist (including Strategies, Annual Work Plans and Annual Reports);
- The adequacy of executive and management's response to issues identified by audit, inspection and other assurance activity, via monitoring of NWSSP's Audit Action Plan;
- Proposals for accessing Internal Audit service (where appropriate);
- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and
- Any particular matter or issue upon which the SSPC or the Accountable Officer may seek advice.

4.2 The Audit Committee will support the SSPC with regard to its responsibilities for governance (including risk and control) by reviewing:

- 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 assurances), prior to endorsement by the SSPC;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by NHS Protect.

4.3 In carrying out this work, the Audit Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

4.4 This will be evidenced through the Audit Committee's use of effective

governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Audit Committee to review and form an opinion on:

- The ***comprehensiveness*** of assurances in meeting the SSPC and the Accountable Officer's assurance needs across the whole of the organisation's activities; and
- The ***reliability and integrity*** of these assurances.

4.5 To achieve this, the Audit Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There is an effective Counter Fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the SSPC and the Accountable Officer or through the effective completion of Audit Recommendations and the Audit Committee's review of the development and drafting of the Annual Governance Statement;
- The work carried out by key sources of external assurance, in particular, but not limited to the SSPC's 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 work carried out by the whole range of external review bodies is brought to the attention of the SSPC and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, together with the risks of failing to comply;
- The systems for financial reporting to the SSPC, including those of budgetary control, are effective; and
- The results of audit and assurance work specific to the organisation and the implications of the findings of wider audit and assurance activity relevant to the SSPC's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Audit Committee will follow and implement the Audit Committee for Shared Services Annual Work Plan and will be evidenced through meeting papers, formal minutes, and highlight reports to the SSPC, Velindre Trust Board and annually, via the Annual Governance Statement, to the Velindre University NHS Trust's Chief Executive.

Authority

4.6 The Audit Committee is authorised by the SSPC to investigate or to have investigated any activity within its Terms of Reference. In doing so, the Audit Committee shall have the right to inspect any books, records or documents of NWSSP, relevant to the Audit Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to co-operate with any reasonable request made by the Audit Committee); and
- Any other Committee, Sub Committee or Group set up by the SSPC to assist it in the delivery of its functions.

4.7 The Audit Committee is authorised by the SSPC to obtain external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the SSPC's procurement, budgetary and other requirements.

Access

4.8 The Head of Internal Audit and the Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee at any time and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

4.9 The Audit Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist, without the presence of officials, on at least one occasion each year.

4.10 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

4.11 The Audit Committee may, subject to the approval of the SSPC, establish Sub Committees or Task and Finish Groups to carry out on its behalf specific aspects of Committee business. Currently, there is an established Welsh Risk Pool Committee which is a Sub Committee of the SSPC, however, there are no Sub Committees of the Audit Committee.

5 MEMBERSHIP

Members

5.1 A minimum of 3 members, comprising:

Chair	Independent member of the Board
Members	Two other independent members of the Velindre Trust Board. The Audit Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

5.2 In attendance:

NWSSP Managing Director, as Accountable Officer
NWSSP Chair
NWSSP Director of Finance & Corporate Services
NWSSP Director of Audit & Assurance
NWSSP Head of Internal Audit
NWSSP Audit Manager
NWSSP Head of Finance and Business Development
NWSSP Corporate Services Manager
Representative of Velindre University NHS Trust
Local Counter Fraud Specialist
Representative of the Auditor General for Wales
Other Executive Directors will attend as required by the Committee Chair

By invitation The Committee Chair may invite:

- any other Partnership officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

The Velindre Chief Executive Officer should be invited to attend, where appropriate, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Secretariat

Secretary	As determined by the Accountable Officer

Member Appointments

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

5.4 Members shall be appointed to hold office for a period of four years. Members may be re-appointed, up to a maximum of their term of office. During this time a member may resign or be removed by the Velindre Trust Board.

5.5 Audit Committee members' Terms and Conditions of Appointment, (including any remuneration and reimbursement) are determined on appointment by the Minister for Health and Social Services.

Support to Audit Committee Members

5.6 The NWSSP Head of Finance and Business Development and NWSSP Corporate Services Manager, on behalf of the Audit Committee Chair, shall:

- Arrange the provision of advice and support to Audit Committee members on any aspect related to the conduct of their role;
- Ensure that Committee agenda and supporting papers are issued 5 working days in advance of the meeting taking place; and
- Ensure the provision of a programme of organisational development for Audit Committee members as part of the Trust's overall Organisational Development programme developed by the Velindre Executive Director of Workforce & Organisational Development.

6 AUDIT COMMITTEE MEETINGS

Quorum

6.1 At least two members must be present to ensure the quorum of the Audit Committee, one of whom should be the Audit Committee Chair or Vice Chair.

Frequency of Meetings

6.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Audit Committee deems necessary, consistent with NWSSP's Annual Plan of Business. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Withdrawal of Individuals in Attendance

6.3 The Audit 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.

7 RELATIONSHIP & ACCOUNTABILITIES WITH THE TRUST BOARD & SSPC DELEGATED TO THE AUDIT COMMITTEE

7.1 Although the Velindre Trust Board, with the SSPC and its Sub Committees, including the Welsh Risk Pool Sub Committee, has delegated authority to the Audit Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The Audit Committee is directly accountable to the Velindre Trust Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Audit Committee, through its Chair and members, shall work closely with NWSSP and its other Sub Committees to provide advice and assurance to the SSPC by taking into account:

- Joint planning and co-ordination of the SSPC business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into NWSSP's overall risk and assurance arrangements. This will primarily be achieved through the discussions held at the SSPC, annually, at the end of the financial year.

7.4 The Audit Committee will consider the assurance provided through the work of the SSPC's other Committees and Sub Committees to meet its responsibilities for advising the SSPC on the adequacy of the organisation's overall system of assurance by receipt of their annual work plans.

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

8 REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Audit Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board, SSPC and the Accountable Officer on the Audit Committee's activities. This includes verbal updates on activity and the submission of committee minutes, and written highlight reports throughout the year;
- Bring to the Velindre University NHS Trust Board, SSPC and the Accountable Officer's specific attention any significant matters under consideration by the Audit Committee; and
- Ensure appropriate escalation arrangements are in place to alert the SSPC Chair, Managing Director (and Accountable Officer) or Chairs of other relevant Committees, of any urgent/critical matters that may affect the operation and/or reputation of the organisation.

8.2 The Audit Committee shall provide a written Annual Report to the SSPC and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, 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 Audit Committee's self-assessment and evaluation.

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

8.4 The NWSSP Head of Finance and Business Development and Corporate Services Manager, on behalf of the Partnership, shall oversee a process of regular and rigorous self-assessment and evaluation of the Audit Committee's performance and operation, including that of any Sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

9 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *(as per section on Committee meetings)*
- Notice of meetings
- Notifying the public of meetings
- Admission of the public, the press and other observers

10 REVIEW

10.1 These Terms of Reference and operating arrangements shall be reviewed annually by the Audit Committee with reference to the SSPC and Velindre Trust Board.