VELINDRE NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP

TUESDAY 24 APRIL 2018 / 2.00 pm – 4.00 pm

NWSSP HEADQUARTERS – CHARNWOOD COURT, NANTGARW

AGENDA

ITEM NO.	ITEM	DOCUMENT	PRESENTED BY
PART A			
PRESENTATIONS / BRIEFINGS			
0.1	Cyber Security Update	Presentation 0.1 Cyber Security Presentation for Audit	Nicholas Lewis
0.2	GDPR Readiness Update	Presentation 0.2 GDPR presentation for Audit	Tim Knifton
STANDARD BUSINESS			
1.1	Welcome and Opening Remarks	(Verbal)	Martin Veale
1.2	Apologies	(Verbal)	Martin Veale
1.3	Declarations of Interest	(Verbal)	Martin Veale
1.4	Minutes from meeting held on 7th November 2017	1.4 DRAFT Minutes of Audit Cttee Meeting o	Martin Veale
1.5	Matters Arising	1.5 Matters Arising.pdf	Martin Veale

ASSURANCE, RISK & GOVERNANCE			
2.1	DRAFT Annual Governance Statement	2.1 DRAFT Annual Governance Statemen 2.1 Appendix 1 - DRAFT Annual Govern	Peter Stephenson
2.2	Governance Matters	2.2 Governance Matters.pdf	Andy Butler
2.3	Tracking of Audit Recommendations	2.3 Tracking of Audit Recommendations.pd 2.3 Appendix A - Summary.pdf 2.3 Appendix B - Audit Recommendatic	Peter Stephenson
2.4	Audit Committee Effectiveness Survey	2.5 Audit Committee Effectiveness Survey.p 2.5 Appendix 1 Audit Committee Effectivene	Roxann Davies
INTERNAL AUDIT			
3.1	Internal Audit Progress Report	3.1 Internal Audit Progress Report.pdf	James Quance
3.2	Internal Audit Report of Accounts Payable	3.2 NWSSP-1718-11 Accounts Payable Inte	Sophie Corbett
3.3	Internal Audit Report of Primary Care Services	3.3 NWSSP-1718-12-Cont	James Quance
3.4	Internal Audit Report of Non-Medical Education Training Budget	3.4 NWSSP-1718-03 Non-Medical Educatic	Sophie Corbett
3.5	Internal Audit External Quality Assessment	3.5 External Quality Assessment.pdf 3.5 Appendix 1 External Quality Asses	Simon Cookson

EXTERNAL AUDIT			
4.1	Wales Audit Office Position Statement	4.1 WAO Progress Report.pdf 4.1 Appendix 1 WAO Progress Report.pdf	Gillian Gillett
COUNTER FRAUD			
5.1	Counter Fraud Progress Update	5.1 Counter Fraud Progress Report.pdf 5 1 Appendix 1 Counter Fraud Progre	Craig Greenstock
ITEMS FOR INFORMATION			
6.1	Integrated Medium Term Plan 2018-2021 Summary	6.1 IMTP 2018-21 Summary.pdf 6.1 Appendix 1 IMTP Summary 2018-21.pdf	Andy Butler
6.2	Caldicott Principles Into Practice (C-PIP) Annual Report & Improvement Plan	6.2 Caldicott Principles Into Practice 6.2 Appendix 1 NWSSP Caldicott Rep	Andy Butler
6.3	Forward Plan	6.3 Audit Committee Forward Plan.pdf	Roxann Davies
ANY OTHER BUSINESS (Prior Approval Only)			
DATE OF NEXT MEETING: Tuesday, 5 June 2018 from 14:00-16:00 NWSSP Boardroom HQ, Charnwood Court, Nantgarw			

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Cyber Security

NWSSP Overview

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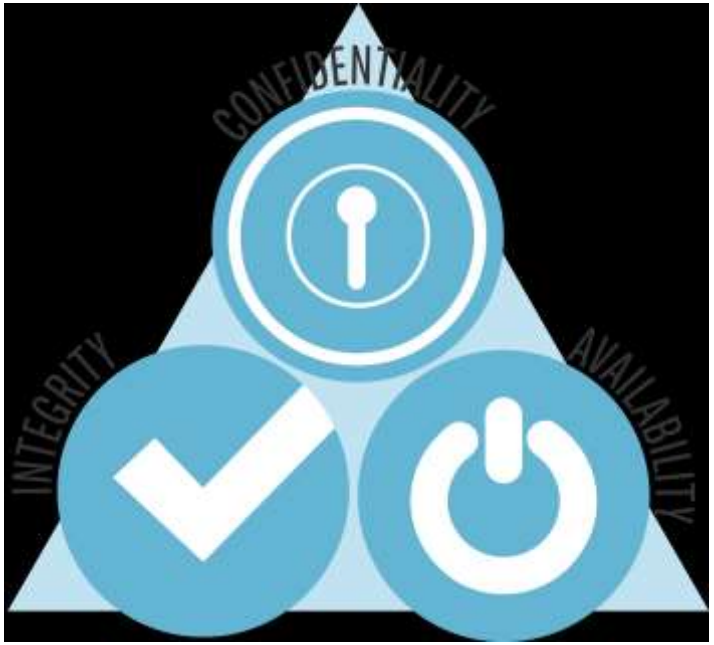
Partneriaeth Cydwasanaethau
Shared Services Partnership

What is cyber security

Cyber security comprises technologies, processes and controls that are designed to protect systems, networks and data from cyber attacks.

Effective cyber security reduces the risk of cyber attacks, and protects organisations and individuals from the unauthorised exploitation of systems, networks and technologies.



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What are the consequences of a cyber attack?

Cyber attacks can disrupt and cause considerable financial and reputational damage to even the most resilient organisation.

If we suffered a cyber attack, we could stand to lose assets, reputation and business, and potentially face regulatory fines and litigation – as well as the costs of remediation.

The UK government's Cyber Security Breaches Survey 2017 found that the average cost of a cyber security breach for a large business is £19,600 and for a small to medium-sized business is £1,570.

Our Approach – NIST Cyber Security Framework

The NIST Cyber Security Framework is guidance, based on existing standards, guidelines, and practices, for critical infrastructure organisations to better manage and reduce cybersecurity risk.

In addition to helping organisations manage and reduce risks, it was designed to foster risk and cybersecurity management communications amongst both internal and external stakeholders.

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Actions to date

NWSSP Cyber Action Plan developed

Vulnerability assessments and mitigations of all new software and infrastructure in NWSSP virtual environment

Vulnerability assessments of new Oracle infrastructure

Procurement of Incident Response capability from Dell Secureworks

Procurement and pilot, in partnership with NWIS, of Security Incident and Event Monitoring solution from Logrhythm

Identification of devices not centrally managed across NWSSP

3rd Party providers security posture identified

Secure remote connectivity for 3rd Parties

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Next Steps

Use of new asset management to identify and secure managed devices

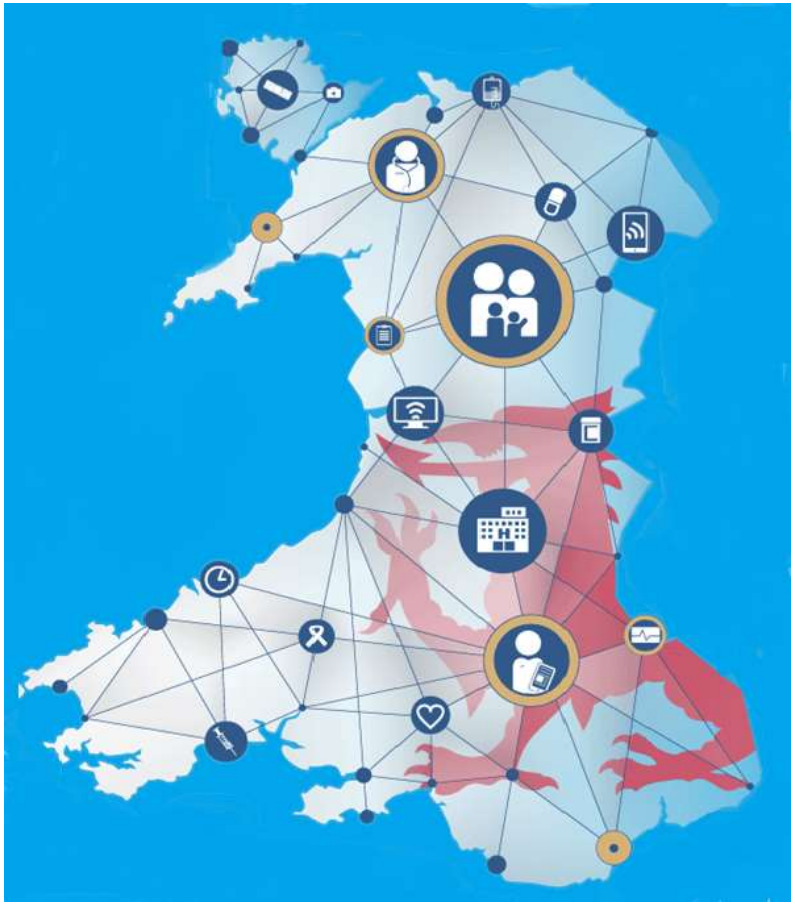
Implementation and Testing of local Cyber Security Incident Response Plan

Development of secure baseline OS images for deployment to servers and workstations

Rollout of SIEM across NWSSP estate

Embedding of Welsh Health Circular 025 into procurement process

Cyber Security training for NWSSP staff



General Data Protection Regulation (GDPR)

Audit Committee update

Tim Knifton, Information Governance Manager
NHS Wales Shared Services Partnership

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Partneriaeth Cydwasanaethau
Shared Services Partnership

GDPR: What is it?

- The GDPR is the new Data Protection regulation.
- First change in 20 years (original 1984/1998).
- GDPR is designed to enable individuals to better control their personal data.
- The Regulation will come into force on **25th May 2018** and will replace the existing Data Protection Act 1998.

"The biggest change to Data Protection law for a generation". (Elizabeth Denham, Information Commissioner)


Breach Notifications
Children
Accountability
International Transfers
Principles
Conditions for Processing
Monetary Penalties
Subject Access Requests
Profiling

NWSSP arrangements

- Information Governance Steering Group
- GDPR Workplan
- National Policy T&F Development Group
- Velindre local T&F Group
- Guidance from ICO/s29 Working Party
- Individual's Rights T&F Group
- Privacy Notices/Privacy by Design
- Information Asset Ownership process/Register

GDPR 12 Steps

Preparing for the General Data Protection Regulation (GDPR) 12 steps to take now

1. **Awareness**
   You should make sure that decision makers and key people in your organisation are aware that the law is changing to the GDPR. They need to appreciate the impact this is likely to have.

2. **Information you hold**
   You should document what personal data you hold, where it came from and who you share it with. You may need to organise an information audit.

3. **Communicating privacy information**
   You should review your current privacy notices and put a plan in place for making any necessary changes in time for GDPR implementation.

4. **Individuals' rights**
   You should check your procedures to ensure they cover all the rights individuals have, including how you would delete personal data or provide data electronically and in a commonly used format.

5. **Subject access requests**
   You should update your procedures and plan how you will handle requests within the new timescales and provide any additional information.

6. **Legal basis for processing personal data**
   You should look at the various types of data processing you carry out, identify your legal basis for carrying it out and document it.

7. **Consent**
   You should review how you are seeking, obtaining and recording consent and whether you need to make any changes.

8. **Children**
   You should start thinking now about putting systems in place to verify individuals' ages and to gather parental or guardian consent for the data processing activity.

9. **Data breaches**
   You should make sure you have the right procedures in place to detect, report and investigate a personal data breach.

10. **Data Protection by Design and Data Protection Impact Assessments**
    You should familiarise yourself now with the guidance the ICO has produced on Privacy Impact Assessments and work out how and when to implement them in your organisation.

11. **Data Protection Officers**
    You should designate a Data Protection Officer, if required, or someone to take responsibility for data protection compliance and assess where this role will sit within your organisation's structure and governance arrangements.

12. **International**
    If your organisation operates internationally, you should determine which data protection supervisory authority you come under.

ico.
Information Commissioner's Office

ico.org.uk

To ensure compliance……

We **MUST:**

1. Keep a record of data operations and activities and consider if we have the required data processing agreements in place – Greater Data Processor liabilities under GDPR.

2. Implement "privacy by design" & carry out privacy impact assessments (PIAs) on products and systems.

3. 'Appoint' a Data Protection Officer (DPO).

4. Review processes for the collection of personal data.

5. Be aware of our duty to notify the relevant supervisory authority [ICO] of a data breach.

6. Ensure appropriate and adequate resources are in place.

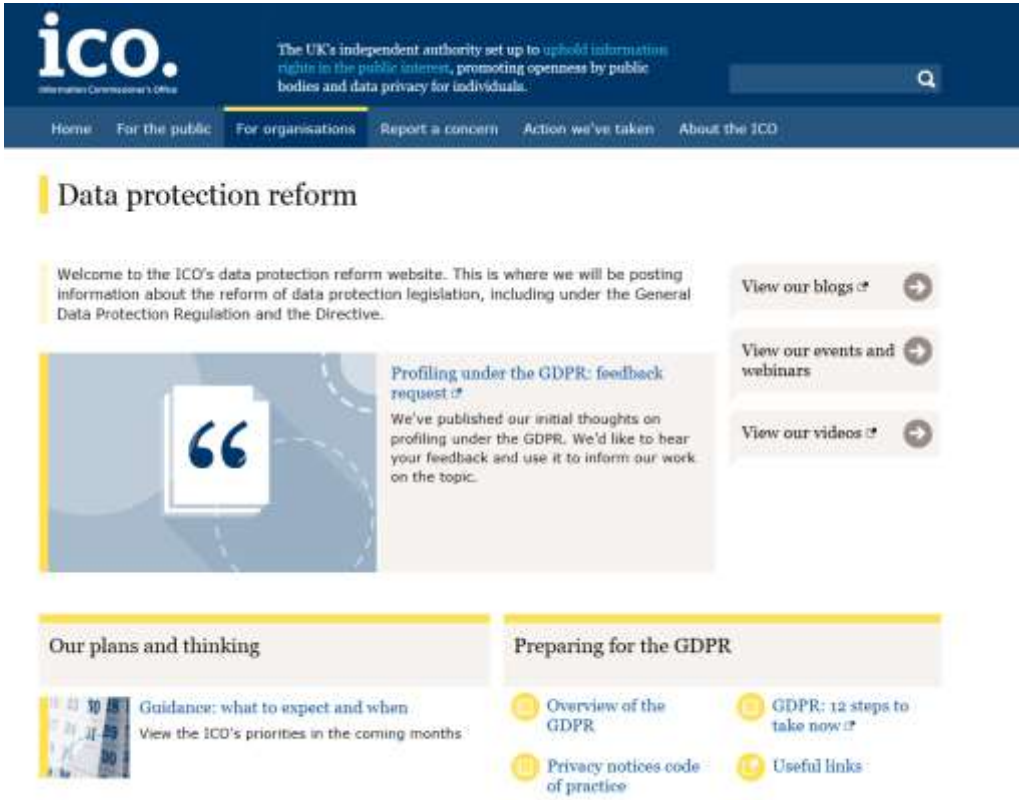
Privacy Notices

- Workforce
- Employment Services
- Recruitment Services
- Payroll and Expenses
- Student Awards Services
- Primary Care Services

Other changes

- Information Governance protocols and documentation reviews.
- Areas involving consent for consideration.
- References to the Data Protection Act.
- Review of website and contents.
- Internal audit for readiness.
- Extra slides added to training sessions.

Resources



www.ico.org.uk/dpreform

Questions??

VELINDRE NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP

MINUTES OF MEETING HELD TUESDAY 6TH FEBRUARY 2018
14:00 – 16:00
BOARDROOM, NWSSP HQ, NANTGARW

ATTENDANCE	**DESIGNATION**	
INDEPENDENT MEMBERS:		
Martin Veale (MV)	Chair & Independent Member	
Jane Hopkinson (JH)	Independent Member	
ATTENDANCE	**DESIGNATION**	**ORGANISATION**
ATTENDEES:		
Margaret Foster (MF)	Chair	NWSSP
Neil Frow (NF)	Managing Director	NWSSP
Andy Butler (AB)	Director of Finance & Corporate Services	NWSSP
Jacqui Maunder (JM)	Head of Corporate Services	NWSSP
Peter Stephenson (PS)	Head of Finance & Business Development	NWSSP
Simon Cookson (SC)	Director of Audit & Assurance	NWSSP
Sophie Corbett (SC1)	Audit Manager	NWSSP
James Quance (JQ)	Head of Internal Audit	NWSSP
Roxann Davies (RD)	Compliance Officer	NWSSP
Craig Greenstock (CG)	Counter Fraud Manager	Cardiff & Vale UHB
Gillian Gillett (GG)	Audit Representative	Wales Audit Office
Mark Osland (MO)	Executive Director of Finance	Velindre NHS Trust
ATTENDANCE	**DESIGNATION**	**ORGANISATION**
IN ATTENDANCE:		
Mark Roscrow ***(Item 2.1 only)***	Head of Procurement Services	NWSSP
Claire Salisbury ***(Item 2.1 only)***	Head of Purchasing E-Business & Capital Development	NWSSP

Item		**Action**
STANDARD BUSINESS		
1.1	**Welcome and Opening Remarks** The Chair welcomed attendees to the first meeting of the Audit Committee for 2018.	

<table>
<tr><th>Item</th><th></th><th>Action</th></tr>
<tr><td></td><td>The Chair welcomed Peter Stephenson, Head of Finance and Business Development (PS) to the meeting and noted that PS will be now supporting the Committee as Jacqueline Maunder, Head of Corporate Services (JM) is working with Cwm Taf Health Board.

The Chair queried whether Committee papers are published on the NWSSP internet site. It was noted that they were not currently, however it was confirmed by Andy Butler, Director of Finance and Corporate Services (AB) that this was being reviewed as part of our transparency agenda.</td><td>PS/RD</td></tr>
<tr><td>1.2</td><td>Apologies

Apologies of absence were received from:

<table>
<tr><th>ATTENDANCE</th><th>DESIGNATION</th><th>ORGANISATION</th></tr>
<tr><td>Steve Ham</td><td>Chief Executive</td><td>Velindre NHS Trust</td></tr>
<tr><td>Georgina Galletly</td><td>Director of Corporate Governance</td><td>Velindre NHS Trust</td></tr>
<tr><td>Julia Manfield</td><td>Audit Representative</td><td>Wales Audit Office</td></tr>
<tr><td>Ann-Marie Harkin</td><td>Audit Representative</td><td>Wales Audit Office</td></tr>
</table>
</td><td></td></tr>
<tr><td>1.3</td><td>Declarations of Interest

None identified.</td><td></td></tr>
<tr><td>1.4</td><td>Unconfirmed Minutes from meeting held on 4th July 2017

The minutes of the meeting held on the 7th November 2017 were AGREED as a true and accurate record of the meeting.</td><td></td></tr>
<tr><td>1.5</td><td>Matters Arising from meeting held on 7th November 2017

The Chair highlighted the matters arising from the meeting held on 7th November 2017 and noted that all items were either complete or included within the agenda.

AB noted that in relation to Agenda Item 7.2, we propose to invite Nick Lewis, information security expert at NWSSP to a future meeting and RD agreed to action this.</td><td>RD</td></tr>
</table>

INTERNAL AUDIT		
2.1	**Procurement Services Update on RKC Associates Report (for noting)** The Chair welcomed Mark Roscrow, Director of Procurement Services (MR) and Claire Salisbury, Head of Purchasing E-Business & Capital Development (CS) to present a verbal update as to the internal review on the lessons learned from the RKC Associates WAO report in the Public Interest. MR provided background as to the report for the Committee and CS highlighted the key changes implemented in order to address the points raised. CS tabled a paper at the meeting and the main highlights were: • Mistakes were undoubtedly made and since then action has been taken to improve documentation of agreed actions; • Procedures have been strengthened and training provided to all relevant staff; • Monthly meetings are taking place with the team and the message reinforced to staff that they must not be afraid to challenge senior staff and to refer the matter to their line manager if they are unsure; and • A further review was undertaken of all other similar consultancy contracts Members of the Committee discussed at length the need for all staff (i.e. not just Procurement Services) to be confident in challenging senior staff within Health Boards and Trusts, should they be asked to act outside defined procedures. The Committee **RESOLVED** to: • **NOTE** the update	
2.2	**Internal Audit Progress Report (for noting)** James Quance, Head of Internal Audit (JQ) presented the report and noted that Internal Audit had made significant progress since the last meeting of the Committee. JQ noted that amendments to the remainder of the Internal Audit Plan have been made to reflect changes in NWSSP's risk profile and that these were being presented to the Committee for approval in order to commence the delivery of the remainder of the audit programme.	

	JQ noted that profiling for 2018/19 would ensure a fair split of Internal Audit reports between the Committee meetings, and that the Head of Internal Audit Opinion for 2017/18 would be presented in June. The Committee **RESOLVED** to: • **APPROVE** the changes to the Internal Audit Plan; and • **NOTE** the update provided	
2.3	**Information Governance GDPR Internal Audit Report (for noting)** Sophie Corbett, Audit Manager (SC1) presented the report which had achieved substantial assurance. SC1 highlighted the key findings for which two recommendations were raised (one low/one medium). SC1 had reviewed arrangements in place for ensuring compliance with the General Data Protection Regulations, which are due to come into force on 25th May 2018 and that good progress had been made in readiness for this. Professor Jane Hopkinson, Independent Member (JH) queried the changes required in order to achieve full compliance. SC1 confirmed that the findings were in relation to consent; the way in which it is recorded and/or held within the organisation and also in relation to the training component of the Regulations, and more specifically the need for a training needs analysis. SC1 confirmed that work is ongoing in relation to both recommendations and that the Information Governance agenda had been communicated effectively to staff. The Chair requested that Tim Knifton, Information Governance Manager (TK) attend the April Committee meeting, to provide an update ahead of the GPDR Regulations coming into force. RD agreed to invite TK to present. The Chair acknowledged that it was a positive internal audit report and that a lot of work had been undertaken in order to achieve substantial assurance. The Committee **RESOLVED** to: • **NOTE** the report	**RD**

2.4	**WfIS ESR Occupational Health Bi-Directional Interface (Immunisations) Internal Audit Report (for noting)** SC1 presented the report which had achieved substantial assurance. SC1 highlighted the key findings and the one low priority recommendation raised. SC1 noted that this is a follow-up report, specific to an ongoing piece of work in relation to an ESR project. SC1 confirmed that in relation to the subject matter there is very little residual risk. The Chair queried the difference in approach across NHS Wales and JQ clarified that Hywel Dda had conducted a pilot and therefore there is no inconsistency or comparison to be made. Neil Frow, Managing Director (NF) noted that the approach to this area was on a Once for Wales basis, and that receiving substantial assurance in this area allows us to move forward to realise savings, make improvements and deliver innovation. The Committee **RESOLVED** to: • **NOTE** the report	
2.5	**Carbon Reduction Commitment (CRC) Payment Review Internal Audit Report (for noting)** SC1 presented the report and noted that this was an additional piece of work, which had been requested due to an issue arising in the method of payment for CRC allowances for ABMUHB. For this reason, the report was not allocated an assurance rating, however, improvement actions had been identified SC1 noted that Accounts Payable had complied with all aspects of the Health Board's Financial Control Procedure and the main reason for the error arising was due to the Health Board submitting the incorrect form for processing. The Chair noted that we must take care when tracking the recommendations due to them being split between the Health Board and NWSSP. SC1 confirmed that the report was also shared with ABMUHB. SC1 confirmed that no fine was issued due to the error, however additional VAT was charged. The Committee **RESOLVED** to: • **NOTE** the report	

EXTERNAL AUDIT		
3.1	**Wales Audit Office (WAO) Position Statement (for noting – Verbal update)** Gillian Gillett, Audit Representative of Wales Audit Office (GG) informed the Committee that the WAO are on track to deliver their work plan, which is to be formally reported at the June meeting. AB noted that he is pleased that the WAO are regularly meeting with Finance staff regarding developments around the change in discount rate and the methodology adopted in respect of the Welsh Risk Pool. NF noted that it continues to be a challenge to forecast this accurately. The Committee **RESOLVED** to: • **NOTE** the update	
3.2	**WAO Assurance Arrangements 2018 (for noting)** GG presented the report and noted that it sets out the work plan for the coming year. GG confirmed that Exhibit 1 covers the extent of the work to be undertaken, in further detail. The Chair queried the unwinding of discount rates and GG confirmed that this is complex and features in the Velindre NHS Trust plan. GG noted that in terms of findings, these would be expected towards the end of the audit cycle in June. The Committee **RESOLVED** to: • **NOTE** the report	
COUNTER FRAUD		
4.1	**Counter Fraud Progress Report (for noting)** Craig Greenstock (CG), Counter Fraud Manager, presented the Counter Fraud Progress Report and highlighted the work undertaken, for the period ending 31st December 2017. CG noted that five cases were currently under investigation and these were detailed in Appendix 2.	

	CG noted that he would develop an Annual Counter Fraud Report solely for NWSSP, in addition to that prepared for Velindre NHS Trust, to be brought to the April meeting. NF praised staff who were required to attend Court and give evidence in relation to counter fraud cases and CG confirmed that his team are able to provide guidance and support in relation to preparedness. The Committee **RESOLVED** to: • **NOTE** the update	**CG**
ASSURANCE AND RISK MANAGEMENT DEVELOPMENT AND MONITORING		
5.1	**Governance Matters (for noting)** AB introduced the report and highlighted the contracting activity undertaken during the period October 2017 to January 2018 as detailed in Appendices A and B. AB summarised the update provided as to stores write-offs and summarised the six declarations received in relation to gifts, hospitality and sponsorship. The Chair noted that going forward, it would be useful if contracting activity was summarised in the comments column and sorted into categories for briefing, ratification and extension. The Committee **RESOLVED** to: • **NOTE** the update	**RD**
5.2	**Tracking of Audit Recommendations (for noting and approval)** PS updated the Committee as to the progress made towards the tracking of audit recommendations and noted that 100% of reports had achieved either substantial or reasonable levels of assurance, with all high priority recommendations raised implemented. PS confirmed that Internal Audit were due to conduct a review of the audit tracking process which would provide assurance to the Committee that recommendations have been implemented which mitigated the risk associated with the finding. PS noted that three recommendations were presented with revised deadlines for approval by the Committee. These were approved,	

	but PS confirmed that the revision of deadlines for implementation should be on an exception basis only and highlighted that actions agreed with Internal Audit should be realistic in terms of the set deadlines. The Committee **RESOLVED** to: • **APPROVE** the revised deadlines; and • **NOTE** progress made to date	
5.3	**Corporate Risk Register (for noting)** PS introduced the report and highlighted the two current red risks, as set out in Appendix 1, which related to the Exeter software system, and recruitment and retention within the Procurement Services division. PS confirmed that a number of risks where the target date was scheduled for January 2018 had achieved their target score as intended and suggested that, going forward, these be relocated to a "Risks for Monitoring" section of the Risk Register, to which the Committee agreed. The Chair noted that Velindre NHS Trust have issued an open and transparent statement regarding risk management and PS stated that we were in the process of reviewing our Risk Management Protocol. The Chair requested that a paper would be brought to a future meeting in relation to Risk Development and the revised Risk Protocol. The Committee **RESOLVED** to: • **NOTE** the update	**RD** **PS**
NEW REPORTS		
6.1	**Stores Losses Protocol Guidelines and Procedure (for information)** AB presented the report and highlighted that this was developed in consultation with the services, following a successful testing phase, to reflect the different systems in operation across the three main Procurement Stores. AB confirmed that currently, Bridgend and Denbigh Stores are utilising a warehouse management system and Cwmbran Stores are operating a different system, also used by Abertawe Bro	

	Morgannwg University Health Board and Aneurin Bevan Health Board. SC1 confirmed that she has reviewed relevant procedures and provided comments which were be incorporated into the documentation. The Committee **RESOLVED** to: • **APPROVE** the updated Stores Losses Protocol Guidelines and Procedure	
ITEMS FOR INFORMATION		
7.1	**Draft Integrated Medium Term Plan (IMTP) Summary (for information)** AB presented the Summary Report and confirmed that the finalised document was submitted to the Welsh Government on 31st January 2018. NWSSP were the first organisation to submit their IMTP in Wales. AB noted that the document sets out the process we follow and emphasises our strategic objectives, key priorities and efficiency techniques in order to deliver the considerable project portfolio for the coming years. Business Partners are in place to monitor savings plans and a report was taken to the Shared Services Partnership Committee (SSPC) in relation to generated savings and reinvesting in our services. The Chair concluded that this was a very helpful summary and puts us in a position of strength, going forward. The Committee **RESOLVED** to: • **NOTE** the report	
7.2	**National Audit Office (NAO) Cyber Security and Risk Guidance for Audit Committees (for information)** The Committee **RESOLVED** to: • **NOTE** the report	

7.3	**Information Commissioner's Office (ICO) Training Audit 2017 Summary (for information)** AB presented the report, and noted that this was a positive outcome for NWSSP. AB confirmed that the ICO had conducted a follow-up audit in October 2017 and the findings noted that there was a significant improvement in this area since the previous audit of 2015. AB and NF confirmed that they were very pleased with the result and that an Action Plan was being developed to address the recommendations. Professor Jane Hopkinson (JH), Independent Member, observed that the impact of non-compliance has been set out clearly and that, going forward, we could showcase the impact of compliance through associated case studies. AB agreed to feed this back to the Information Governance Manager. The Committee **RESOLVED** to: • **NOTE** the report	**PS** **AB**
7.4	**Annual Review of the Shared Services Partnership Committee Standing Orders (for assurance and endorsement).** JM confirmed that the Standing Orders are reviewed annually and the Partnership Committee had approved the revisions during November 2017, as outlined in Appendix B. The Committee **RESOLVED** to: • **ENDORSE** the revised Standing Orders	
7.5	**Audit Committee – Forward Plan (for information)** Roxann Davies, Compliance Officer (RD) presented the Forward Plan. The Committee **RESOLVED** to: • **NOTE** the update	

ANY OTHER BUSINESS		
8.1	**Meeting Review** The Chair noted that the Committee would appreciate written reports be submitted in advance, where possible, rather than verbal updates provided at meetings. The Chair confirmed that consideration should be given as to Committee dates required for the 2019-2020 cycle, as traditionally the July meeting would be reserved specifically for approving accounts.	
DATES OF FUTURE MEETINGS		
9.1	Tuesday, 24th April 2018 Tuesday, 5th June 2018 Tuesday, 24th July 2018 Tuesday, 23rd October 2018 All meetings are to be held between **14.00 - 16.00** and will take place at **NWSSP HQ, Unit 4-5 Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff, CF15 7QZ**.	
PART B – CONFIDENTIAL ITEMS		
10.1	**Cyber Security and Information Risk Action Plan (for information)** AB presented the Action Plan and noted that it was developed following on from the initial response prepared to the National Audit Office Cyber Security and Information Risk Guidance, brought to the November 2017 meeting of the Committee. AB noted that Chair had requested the response be presented as a formal Action Plan and therefore both documents were listed as agenda items. Chair confirmed that he was content with Action Plan. AB stated that he had recently received a separate report from an external consultant, which had painted a slightly less positive view of NWSSP's cyber security arrangements. However, AB noted that most of the actions arising from the additional report were the responsibility of NWIS rather than NWSSP. Committee members took part in a lengthy debate concerning arrangements currently in place with NWIS and it was agreed that an appropriate action was for NWSSP to write to NWIS and seek assurance that the actions identified in the report had been	

	followed up and implemented. JH endorsed this point and noted that it was most appropriate for NF and AB to write to NWIS to seek further assurances. AB noted that he would invite Nick Lewis, our information security expert, to a future Committee meeting to provide an update. The Committee **RESOLVED** to: • **NOTE** the update	**AB/RD**

Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Matters Arising

Actions arising from the meeting held on 6 February 2018			
1.1	PS/RD	**Welcome and Opening Remarks** Review of transparency agenda to include publishing of Committee papers on the NWSSP website, going forward.	Ongoing Minutes and Agenda to be published online, once agreed at Committee.
1.5	RD	**Matters Arising from meeting held on 7th November 2017** Nick Lewis, Information Security Expert, to be invited to present an update as to Cyber Security at a future meeting.	Completed / April 2018 Agenda Item for Committee.
2.3	RD	**Information Governance GDPR Internal Audit Report (for noting)** Tim Knifton, Information Governance Manager, to be invited to present an update as to GDPR readiness at a future meeting.	Completed / April 2018 Agenda Item for Committee.
4.1	CG	**Counter Fraud Progress Report (for noting)** CG would develop an Annual Counter Fraud Report solely for NWSSP, in addition to that prepared for Velindre NHS Trust.	Ongoing Added to the Forward Plan for July 2018.
5.1	RD	**Governance Matters (for noting)** Chair requested that contracting activity be sorted by categories (briefing, ratification and extension).	Completed / April 2018 Agenda Item 5.1 for Committee.
5.3	RD	**Corporate Risk Register (for noting)** RD to relocate risks that have reached their target score as intended to a "Risks For Monitoring" section of the Corporate Risk Register.	Completed / April 2018 Agenda Item 5.3 for Committee.

5.3	PS	**Corporate Risk Register (for noting)** PS agreed to review the NWSSP Risk Management Protocol, to be brought to a future Committee meeting.	Ongoing Draft revised Protocol being presented at SMT on 26 April 2018. Added to Forward Plan for June 2018.
7.3	PS	**Information Commissioner's Office (ICO) Training Audit 2017 Summary (for information)** AB and NF confirmed that an Action Plan is to be developed to address the recommendations, to be brought to a future Committee meeting.	Ongoing Action Plan developed and awaiting progress update from Workforce. Added to Forward Plan for June 2018.
7.3	AB	**Information Commissioner's Office (ICO) Training Audit 2017 Summary (for information)** AB to feed back the observation that going forward we could showcase the impact of compliance through associated case studies to the Information Governance Manager.	Completed / February 2018 RD has notified TK of this opportunity.

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	24 April 2018
AGENDA ITEM	2.1
REPORT AUTHOR	Peter Stephenson – Head of Finance and Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler – Director of Finance and Corporate Services
PRESENTED BY	Peter Stephenson – Head of Finance and Business Development

TITLE OF REPORT

Annual Governance Statement 2017-2018

PURPOSE OF REPORT

The purpose of this report is to receive for assurance purposes the draft Annual Governance Statement (AGS) for the NHS Wales Shared Services Partnership (NWSSP). The Audit Committee are requested to endorse the Annual Governance Statement 2017-2018, following submission to the Senior Management Team on 29 March 2018.

1. BACKGROUND

The Shared Services Partnership Committee ("the Committee") was established in accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 No. 1261(W.156) and the functions of managing and providing shared services (professional, technical and administrative services) to the health service in Wales is included within the Velindre National Health Service Trust (Establishment) (Amendment) Order 2012.

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 details 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 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 NHS Trust Audit Committee for NWSSP on the adequacy and effectiveness of the risk management, control and governance processes to support the Statement.

The Annual Governance Statement for 2017-2018 is presented at **Appendix 1.**

2. TIMELINE FOR APPROVAL

The timeline for approving the statement is as follows:

Date	**Action**
29 March 2018	Senior Management Team (SMT) The SMT review the draft statement
24 April 2018	Audit Committee The Velindre NHS Trust Audit Committee for Shared Services considered the draft and agree that if it is consistent with the Committee's view on the NWSSP's assurance framework
26 April 2018	Formal SMT SMT to formally adopt the statement
17 May 2018	SSPC SSPC to note the AGS prior to submission to Audit committee on 5 June 2018
5 June 2018	Audit Committee Velindre NHS Trust Audit Committee for NWSSP review of the Statement along with the final Head of Internal Audit Opinion and final version agreed.
30 June 2018	Arrange Welsh language translation
21 July 2018	Publicise on NWSSP website

3. GOVERNANCE & RISK

The Managing Director of Shared Services, 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 ....."*

The Annual Governance Statement is substantially completed. However, there are a small number of areas where information is awaited e.g. results of Committee effectiveness survey. These areas are shaded for reference. The Annual Governance Statement will be updated to reflect the information once available.

4. RECOMMENDATION

The Audit Committee is asked to: -

- **ENDORSE** the report

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Annual Governance Statement (Draft) 2017/2018

Version	Approved
1	SSPC 27 March 2018 draft for endorsement
2	SMT 29 March 2018 draft for information
3	Velindre Integrated Governance Group 10 April 2018
4	Audit Committee 24 April 2018
5	SSPC 17 May 2018
6	Audit Committee 5 June 2018

CONTENTS

1. SCOPE OF RESPONSIBILITY

As Accounting Officer, the Managing Director has responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Wales Shared Services Partnership's (NWSSP), and the host's (Velindre NHS Trust) policies, aims and objectives. The Managing Director also safeguards the public funds and departmental assets for which he is personally responsible, in accordance with the responsibilities assigned to him. The Managing Director is responsible for ensuring that NWSSP is administered prudently and economically and that resources are applied efficiently and effectively.

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

The Chief Executive of Velindre NHS 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 Velindre Board) has a legitimate interest in the activities of the Shared Services Partnership and has certain statutory responsibilities as the legal entity hosting Shared Services.

The Managing Director of Shared Services (as the Accountable Officer for Shared Services) and the Chief Executive of Velindre NHS 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 the Shared Services and Velindre NHS 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

Underpinned through the overarching Velindre NHS Trust legal and assurance framework

2. GOVERNANCE FRAMEWORK

NWSSP has two main Committees that have key roles in relation to the Governance and Assurance Framework. Both Committees are chaired by Independent Members and 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

The Shared Services Partnership Committee (Partnership Committee) was established in accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 No. 1261(W.156) and the functions of managing and providing shared services (professional, technical and administrative services) to the health service in Wales is included within the Velindre National Health Service Trust (Establishment) (Amendment) Order 2012.

The composition of the Partnership Committee 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 representative who acts on behalf of the respective Health Board or Trust.

At a local level, Health Boards and NHS Trusts in Wales 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 Velindre NHS Trust policies and NWSSP's corporate protocols, approved by the SMT, provide NWSSP's Governance Framework.

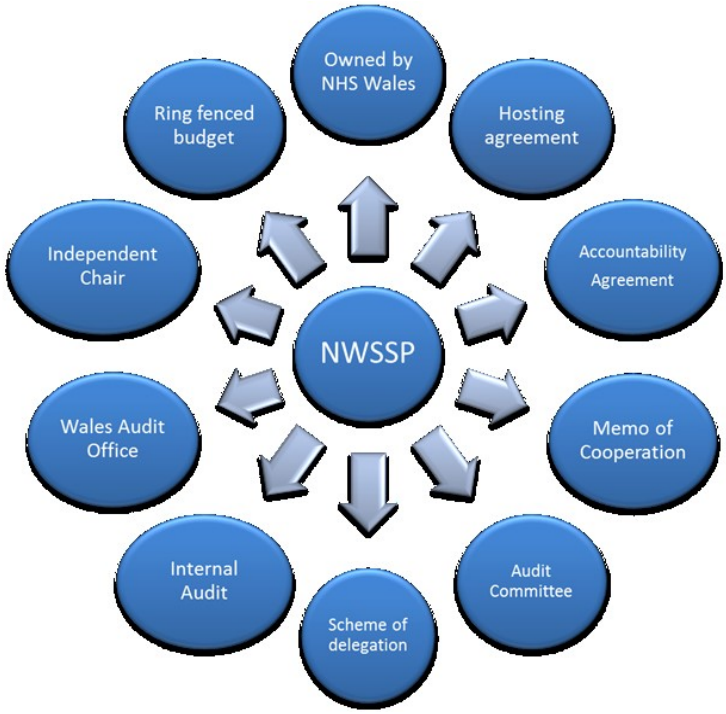
Health Boards and NHS Trusts in Wales have collaborated over the operational arrangements for the provision of shared services and have an agreed Memorandum of Co-operation to ensure that the arrangements operate effectively through collective decision making in accordance with the policy and strategy set out above, determined by the Partnership Committee.

Whilst the Partnership Committee acts on behalf of the Health Boards and NHS Trusts in undertaking its functions, the responsibility for the exercise of Shared Services functions is a shared responsibility of all NHS bodies in Wales.

The Partnership Committee is supported by the Director of Corporate Governance/Board Secretary of Cwm Taf University Health Board, who acts as the guardian of good governance within the Committee.

NWSSP's governance arrangements are summarised below.

Figure 2: Summary of Governance Arrangements



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

- Standing Orders;
- Hosting Agreement;
- Interface Agreement between the Chief Executive Velindre NHS Trust and Managing Director of NHS Wales Shared Services Partnership; and
- Accountability Agreement between the Partnership Committee and the Managing Director of NHS Wales Shared Services Partnership.

These documents, together with the Memorandum of Co-operation form the basis upon which the Partnership Committee's Governance and Accountability Framework is developed. Together with the Velindre 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 Committee during the year ended 31 March 2018 is outlined in Figure 3 below. All meetings were quorate and attended by the Chair, and the attendance of the Committee is outlined in Figure 4.

Figure 3: Table of Members of the NHS Wales Shared Services Partnership Committee during 2017/2018

Name	Position	Organisation	From – To
Margaret Foster (Chair)	*Independent Member*	*NHS Wales Shared Services Partnership*	*Full Year*
Neil Frow	*Managing Director of NWSSP*	*NHS Wales Shared Services Partnership*	*Full Year*
Paul Gilchrist	*Deputy Director of Finance*	*Abertawe Bro Morgannwg UHB*	*Full Year*
Geraint Evans	*Director of Workforce and OD*	*Aneurin Bevan UHB*	*Full Year*
Huw Thomas (Vice Chair)	*Director of Operational Finance*	*Betsi Cadwaladr UHB*	*Full Year*
Christopher Lewis	*Deputy Director of Finance*	*Cardiff and Vale UHB*	*Full Year*
Joanna Davies	*Director of Workforce & OD*	*Cwm Taf UHB*	*Full Year*
Nia Williams	*Executive Project Manager*	*Hywel Dda UHB*	*Full Year*
Eifion Williams	*Director of Finance*	*Powys THB*	*Full Year*
Melanie Westlake	*Head of Corporate Governance/Board Secretary*	*Public Health Wales NHS Trust*	*Full Year*
Steve Ham	*Chief Executive*	*Velindre NHS Trust*	*Full Year*
Chris Turley	*Acting Director of Finance*	*Welsh Ambulance Services NHS Trust*	*Full Year*

The composition of the Committee also requires the attendance of the following: Director of Finance, Welsh Government, Director of Finance & Corporate Services, NWSSP, Director of Workforce & Organisational Development, Boards Secretary/Director of Governance, Cwm Taf UHB as governance support.

Figure 4 – Attendance at the Meetings of the NHS Wales Shared Services Partnership Committee during 2017/2018

Organisation	18/05/ 2017	07/06/ 2017	19/09/ 2017	16/11/ 2017	18/01/ 2018	27/03/ 2018
Abertawe Bro Morgannwg UHB	✗	✗	✗	✓*	✗	
Aneurin Bevan UHB	✗	✓	✓	✓	✓	
Betsi Cadwaladr UHB	✓	✓	✗	✓	✓	✓

Cardiff and Vale UHB	✓	✓*	✓*	✓	✓	✓
Cwm Taf UHB	✓✓	×	✓✓	✓✓	✓	
Hywel Dda LHB	✓	✓	✓*	✓	✓	
Powys Teaching Health Board	×	×	✓	×	×	
Public Health Wales Trust	×	✓	✓	✓	×	
Welsh Ambulance Service Trust	✓	×	✓	✓	✓	
Welsh Government	×	✓	×	✓	✓	
Velindre NHS Trust	×	✓	×	✓✓	✓	

✓ Denotes the nominated member was present

✓**Denotes the nominated member was not present and that a suitable officer attended on their behalf*

× Denotes Health Body not represented

*** Denotes the Director of Corporate Governance/Board Secretary, Governance Support role deputised for the Cwm Taf UHB representative*

The purpose of the Partnership Committee is set out below:

- To set the policy and strategy for shared services;
- To monitor the delivery of Shared Services through the Managing Director of Shared Services;
- 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 Shared Services; and
- To ensure a strong focus on delivering savings that can be re-invested in direct patient care.

The Partnership Committee 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 Partnership Committee 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 Partnership Committee 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 Partnership Committee assesses strategic and corporate risks through the Corporate Risk Register.

2.2 Partnership Committee Performance and Self Assessment

During 2017/2018, the Partnership Committee approved an annual forward plan of business, including:

A "Horizon Scanning" Workshop – following on from the SMT Horizon Scanning workshop held on 13 September 2017. A specific workshop was held with the Partnership Committee which provided an opportunity for members to:

- Review performance;
- Review NWSSP achievements over the preceding 12 months;
- Review how NWSSP is performing against its Integrated Medium Term Plan (IMTP);
- Consider the future macro challenges to service delivery; and
- Consider what additional support NWSSP could provide to NHS Wales.

- A workshop to discuss the potential expansion of NWSSP services to further support NHS Wales; and
- *Deep Dive* sessions to explore in detail individual service areas and to collectively discuss areas of success and potential weakness with a view to collectively agreeing a potential solution.

The Partnership Committee undertook a self-assessment of its effectiveness in accordance with section 8 of its standing orders, which states that the Partnership Committee must:

".....introduce a process of regular and rigorous self assessment and evaluation of its own operations and performance.."

This covers:

- the Partnership Committee members and Chair;
- the quality of reports presented; and
- the effectiveness of the Partnership Committee secretariat which is crucial to the ongoing development and maintenance of a strong governance framework within the Partnership Committee, and is a key source of advice and support for the Chair and members.

The survey was anonymous and 10 responses were received in 2017 equating to a 66% response rate, in comparison with 15 in 2016, equating to a 100% response rate in 2016.

2.3 Velindre Audit Committee for NWSSP

The primary role of the Velindre 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 2017/2018 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 Partnership Committee 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 Committee attendees during 2017/2018 comprised of three Independent Members of Velindre NHS Trust supported by representatives of both Internal and External Audit and Senior Officers of NWSSP and Velindre NHS Trust.

Figure 5 - Composition of the Velindre NHS Trust Audit Committee for NWSSP during 2017/18

In Attendance	April 2017	June 2017	July 2017	Nov 2017	Feb 2018	Total Out of 5
Committee Members						
Martin Veale, Chair & Independent Member	✓	✓	✓	✓	✓	**5**
Ray Singh, Independent Member	✓		✓	✓		**3**
Professor Jane Hopkinson, Independent Member	✓	✓	✓	✓	✓	**5**
Wales Audit Office						
Audit Team Representative	✓✓	✓	✓		✓	**4**
NWSSP Audit Service						
Director of Audit & Assurance	✓	✓	✓	✓	✓	**5**
Head of Internal Audit	✓	✓	✓	✓	✓	**5**
Audit Manager	✓	✓	✓	✓	✓	**5**
Counter Fraud Services						
Local Counter Fraud Specialist	✓	✓	✓	✓	✓	**5**
NWSSP						
Margaret Foster, Chair NWSSP	✓		✓	✓	✓	**4**
Neil Frow, Managing Director	✓	✓	✓		✓	**4**
Andy Butler, Director of Finance & Corporate Services	✓	✓	✓	✓	✓	**5**
Jacqui Maunder, Head of Corporate Services	✓	✓	✓	✓	✓	**5**

In Attendance	April 2017	June 2017	July 2017	Nov 2017	Feb 2018	Total Out of 5
Roxann Davies, Compliance Officer	✓	✓	✓	✓	✓	**5**
NWSSP Secretariat	✓	✓		✓		**3**
Other Staff		✓✓	✓✓	✓	✓✓	**4**
Velindre NHS Trust						
Steve Ham, Chief Executive		✓				**1**
Mark Osland, Director of Finance	✓	✓	✓		✓	**4**

The Audit Committee met formally on five occasions during the year with the majority of members attending regularly and all meetings were quorate. An Audit Committee "Highlight Report" and Minutes of the meeting have been reported back to the Partnership Committee.

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 Committee in assessing their effectiveness with a view to identifying potential areas for development going forward.

In 2017-2018 the overall responses were very positive indeed and the response rate was 100% (10 out of 10 core attendees responded). The Audit Committee members were asked to strongly agree/agree or disagree/strongly disagree with 44 positive statements made about the operation of the Audit Committee. The overwhelming number of responses to each statement was positive with respondents either agreeing or strongly agreeing to the statements made. It should be noted that a number of respondents were relatively new attendees to the Committee and were therefore unable to respond to all of the questions. The survey was issued to the Audit Committee in April 2017 to coincide with the appointment of the new Chair of Audit Committee, Martin Veale who attended his first meeting on the 11th April 2017.

2.5 Sub Groups and Advisory Groups

The Partnership Committee is supported by four advisory groups:

- **Workforce Education and Development Services Advisory Group (WEDSAG)**
  - Advisory group to the Shared Services Partnership Committee; and

- Reviews progress with Workforce Development and Education activity on behalf of NHS Wales.

- **Welsh Risk Pool Committee**
  - Reimburse losses over £25,000 incurred by Welsh NHS bodies arising out of negligence;
  - Funded through the NHS Wales Healthcare budget;
  - Oversees the work and expenditure of the Welsh Risk Pool; and
  - Helps promote best clinical practice and lessons learnt from clinical incidents.

- **Evidence-Based Procurement Board**
  - Advisory group to promote wider liaison across NHS Wales;
  - Includes representatives of various disciplines across NHS Wales and relevant research bodies;
  - Helps inform and develop a value and evidence based procurement process for medical consumables and devices for NHS Wales.

- **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 Management Team (SMT)

The Managing Director leads the SMT and reports to the Chair of the Partnership Committee on the overall performance of NWSSP. The Managing Director is the designated Accountable Officer for Shared Services and is accountable, through the leadership of the Senior Management Team, 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 Committee and the preparation of Service Improvement plans;
- Leading the SMT to deliver the IMTP and Service Improvement Plans;
- Establishing an appropriate Scheme of Delegation for the SMT; and
- Ensuring that adequate internal controls and procedures are in place to ensure that delegated functions are exercised properly and prudently.

The SMT are 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 SMT is responsible for ensuring that NWSSP is responsive to the needs of Health Boards and Trusts.

The SMT comprises:

Figure 7 – Composition of the SMT at NWSSP during 2017/2018

Name	Designation
Mr Neil Frow	Managing Director
Mr Andy Butler	Director of Finance and Corporate Services
Mrs Hazel Robinson	Director of Workforce and Organisational Development
Mr Mark Roscrow	Director of Procurement Services
Mr Paul Thomas	Director of Employment Services
Mr Simon Cookson	Director of Audit and Assurance
Mrs Anne-Louise Ferguson	Director of Legal and Risk
Mr Dave Hopkins	Director of Primary Care Services
Mr Neil Davies	Director of Specialist Estates
Mr Stephen Griffiths	Director of Workforce Education and Development Services (WEDS)

3. 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 2018.

3.1 External Audit

During 2017/2018, NWSSP's external auditors were the Wales Audit Office (WAO). The Audit Committee has worked constructively with the WAO and the areas examined included:

- NWSSP Nationally Hosted NHS IT Systems Assurance Report 2016-17;
- WAO Proposed Work 2016-2017;
- Capital Expenditure Scheme Update;
- Internal Audit Visit Update;
- WAO Report of NWSSP 2016-17; and
- WAO Assurance Arrangements 2018.

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 have attended each meeting 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 2017/18 no internal audit reports were rated as limited or no assurance.

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.

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

3.3 Counter Fraud Specialists

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 Committee to monitor progress against the agreed Counter Fraud Plan; including the following reports:

- Progress Update at each meeting
- Quality Assessment Final Report
- Velindre NHS Trust Annual Report 2016-17
- Counter Fraud Work Plan 2017-18
- Counter Fraud Self Review Tool Submission 2016-17
- Counter Fraud Press Release
- Counter Fraud Quarterly Newsletter

During 2017/18, four (4) new investigations into possible fraudulent or corrupt activity were instigated together with the five (5) cases that were

brought forward from 2016/17. Out of the four (4) new cases, three (3) involved alleged false claims submitted to the NHS Student Awards Service and which are still under investigation.

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

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

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

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 2015-16 year end 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 2017/2018, the Audit Committee reported any areas of concern to the Partnership Committee and played a proactive role in communicating suggested amendments to governance procedures and the corporate risk register.

3.5 Quality

During 2017/2018, the Partnership Committee 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 Partnership Committee meetings.

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.

NWSSP is also committed to continuously reviewing its services and has made a commitment for all of its services to undergo the rigorous Wales Quality Award (WQA) Assessment, based on the European Foundation for Quality Management (EFQM) system, through the Wales Quality Centre. Following on from the initial follow up assessment in February 2016, the feedback indicated that NWSSP had matured as an organisation over the preceding 12 months and that significant progress has been made in developing IT strategies and Programme Management.

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 2018-2019 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 Partnership Committee 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 Partnership Committee.

4. CAPACITY TO HANDLE RISK

The Shared Services Partnership Committee 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.

Velindre NHS Trust has an approved strategy for risk management and NWSSP has a risk management protocol in line with our host's strategy

providing a clear systematic approach to the management of risk within NWSSP.

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 SMT who ensure that key risks are aligned to delivery and are considered and scrutinised by the SMT as a whole. 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 SMT, and if deemed appropriate the risk is added to the NWSSP Corporate Risk Register.

During 2017/18 the risk management framework and approach was subject to a detailed review building on the recommendations of an internal audit report issued in March 2017. The report contained findings that highlighted the need to make risk management more effective and dynamic within NWSSP and two workshops were held in the spring of 2017 to share the findings with directors and senior management.

Changes have since been made to the format of the corporate and directorate risk registers to ensure that they are both consistent and that they provide a more concise picture of the current position with each risk. The recently appointed Head of Finance and Business Development, supported by the Compliance Officer, is working with Directors and their Senior Management Teams to ensure that the risks recorded within each register remains current and that there is focus on achievement of planned actions to mitigate the risk. This is reinforced through the quarterly review process of each directorate where review of the directorate risk register is a standing agenda item.

In 2017/18 assurance maps were produced for each of the directorates to provide a view on how the key operational, or business-as-usual risks were being mitigated. These were presented to the Audit Committee in November 2017 and they will be updated and reviewed by the Audit Committee annually.

The NWSSP Risk Protocol has been updated accordingly and now includes a greater focus on the risk appetite of the organisation. The operationalisation of the risk appetite is through the target score applied to

each risk, and this has led to a re-structuring of the Corporate Risk Register 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).

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; and
- The effectiveness of key controls is regularly assured.

5. THE RISK AND CONTROL FRAMEWORK

NWSSP's commitment to the principle that risk is managed effectively means that we will continue to work 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 Partnership Committee and the Audit Committee;
- Damage and injuries are minimised, and people 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. As at 31 March 2018, there is one corporate risk categorised as having a "red" risk rating. This relates to issues surrounding the outsourcing of a number of primary care services in England which have an impact on NHS Wales. There are a number of options for NWSSP in managing this particular risk and these are being evaluated at present.

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 Partnership Committee 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 Committee self-effectiveness surveys;
- The front cover pro-forma for reports for Committees 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 the Health Boards and NHS Trusts set out the operational arrangements for NWSSP's services to them and are reviewed on an annual basis;
- NWSSP are proactive in completing the Welsh Government's Health and Care Standards framework and ensure that Theme 2 Safe Care provided 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 Velindre NHS 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. Velindre NHS Trust ensures that NWSSP have access to all of the Trust's policies and procedures and that any amendments to the policies are made known to the Managing Director and the Corporate Governance Manager and other designated staff 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 Partnership Committee 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 Velindre NHS Trust Scheme of Delegation.

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. These cover the data that the organisation collects and the processing of this to ensure that NWSSP only uses it for compatible purposes and it remains secure and confidential whilst in our custody.

The Director of Finance and Corporate Services is the designated Senior Information Risk Owner (SIRO) in relation to Information Governance for NWSSP and, due to NWSSP's hosted status, the Caldicott Guardian for decisions of a clinical nature is Mr Rhydian Hurle, Medical Director, who is employed by the NHS Wales Informatics Service (NWIS).

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 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 (via ActionPoint) 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. This is to ensure that all information assets are accounted for as they are realised. This is an area that forms part of the recommendations of the General Data Protection Regulation (GDPR) that is due to be implemented by 25 May 2018 and which will be an increasing area of focus.

The IGSG discusses quarterly issues such as 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 including the implementation of GDPR.

All members of the IGSG have the opportunity during a defined consultation period to review any work that requires comment before being approved by the NWSSP Senior Management Team. The Information Governance Manager provides information in relation to any areas that require input

and determines the agenda for each meeting based on their own requirements and also from those members who have items for discussion. There is also an IT or "Informatics" section on the agenda for discussion of technological issues such as Cyber Security.

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 workstreams proposing to use identifiable information in some form. This poses questions on the Who, What, Why, Where, When and How of the project to get official Information Governance sign off and ensure that the work will not breach any confidentiality of patients, service users, clients or staff and that the integrity of the data is secure.

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 Velindre NHS 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 Boards. This allows discussion of issues on an All Wales basis. The Information Governance Manager is also Chair of the Freedom of Information Community of Practice, and Chair and Author for the review of the "Your Information, Your Rights" public document in readiness for the new legislation on an All Wales basis. This document will inform patients of their rights and promotes openness and transparency within the NHS.

5.4 Counter Fraud

Counter Fraud support is incorporated within the hosting agreement with Velindre NHS 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, 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.

5.5 Internal Audit

The NWSSP hosting agreement provides in Section 14 that the Partnership Committee 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 Shared Services and in turn the Partnership Committee and Velindre NHS 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 Partnership Committee and partner organisations.

In March 2018, the internal audit team was subject to a formal external quality assessment undertaken by the Chartered Institute of Internal Auditors. The draft opinion from this review has recently been received and states that:

The Institute of Internal Audit's (IIA's) International Professional Practice Framework (IPPF) includes the Definition of Internal Auditing, Code of Ethics, Core Principles and International Standards. The Public Sector Internal Audit Standards are wholly aligned with these standards. There are 64 fundamental principles to achieve with 118 points of recommended practice. It is our view that NWSSP Audit and Assurance Services conforms to all of these 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"****.*

5.6 Integrated Medium Term Plan (IMTP)

The basis for NWSSP planning has been the Business Case approved by the Minister for Health and Social Services in October 2010.

Further to the National Health Service Finance (Wales) Act 2014 becoming law in Wales from January 2014, new duties with regard to operational planning were placed upon Health Boards and Trusts. The legislative changes were effected to section 175 of the NHS Wales Act 2006 and placed a duty to produce three year Integrated Medium Term Plans.

NWSSP has continued with the medium term approach to planning and has undertaken a significant amount of work which continues to ensure it maintains progress to develop its three year IMTP. The IMTP is approved by the Partnership Committee and performance against the plan is monitored throughout the year.

The IMTP is formally reviewed and amended annually and approved by the Partnership Committee in March each year prior to submission to Welsh Government. The 2018-2020 IMTP was submitted to Welsh Government on 31 March 2018.

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. A summary of the themes is outlined below:

The process for undertaking the annual self-assessments is:

- The Head of Corporate Services and Corporate Governance Manager undertake an initial evaluation;
- A draft self-assessment is then presented to the SMT 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 SMT for final approval
- Once approved, it is presented to the Partnership Committee, Audit Committee and the Velindre NHS 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.

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

Figure 9 – Self- Assessments Rating Against the Health and Care Standards 2017/2018

Theme	Executive Lead	2017/2018 Self-Assessment Rating	2016/2017 Self-Assessment Rating
Governance, Leadership and Accountability	Senior Management Team	4	4
Staying Healthy	Director of Workforce and Organisational Development	3	3
Safe Care	Director of Finance and Corporate Services Director of Specialist Estates	4	4
Effective Care	Senior Management Team	3	3
Dignified Care	Not applicable	Not applicable	
Timely Care	Not applicable	Not applicable	
Individual Care	Senior Management Team	3	3
Staff and Resources	Director of Workforce and Organisational Development	4	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 3 as outlined below:

Figure 10 – NWSSP's Overall Self-Assessment Score Health and Care Standards 2017/2018

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

We are committed to eliminating discrimination, valuing diversity and promoting inclusion and equality of opportunity in everything we do. Our priority is to develop a culture that values each person for the contribution they can make to our services for NHS Wales.

As a non-statutory hosted organisation under Velindre NHS Trust, we are required to adhere to Velindre NHS Trust's Equality and Diversity Policy, Strategic Equality Plan 2016-2020 and Equality Objectives, which set out the Trust's commitment and legislative requirements to promoting inclusion: http://www.nwssp.wales.nhs.uk/governance-and-assurance-arrangements

We work together with colleagues across NHS Wales 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.

We also benefit from the proactive work undertaken by our host organisation to strengthen compliance with equality and diversity legislation; the Trust has received the Positive About Disabled People "Double Tick" symbol which demonstrates the encouragement of applications from people who identify as having a disability. In addition, the

Trust has attained "The Rainbow Mark" which is an equality mark sponsored by the Welsh Assembly Government and supported by the Welsh Local Government Association and Tai Pawb. The Mark is a signifier of good practice, commitment, and knowledge of the specific needs, issues and barriers facing those who identify as lesbian, gay, bisexual, and transgender (LGBT+) in Wales.

We have worked with the NHS Wales Centre for Equality & Human Rights (CEHR) to introduce our own process for undertaking Equality Integrated Impact Assessments (EQIIA), which we are integrating into our Project Management System software. The EQIIA will consider the needs of the protected characteristics identified under the Equality Act 2010 (including the Welsh specific duties), the Human Rights Act 1998, 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), and Welsh Language, Information Governance and Health and Safety aspects.

We have provided key managers with training on the EQIIA process and introduced an "Equality Integrated Impact Assessment Panel" to review completed assessments to ensure that our policies, projects and events do not discriminate against vulnerable or disadvantaged people. Further training sessions to strengthen awareness are planned for 2018/19. We also ensure compliance with the engagement provisions of the "Gunning Principles" and the duty to have "due regard" laid out in the "Brown Principles" when reviewing existing policies, or assessing new policies for impact on protected characteristics.

Our Assistant Director of Workforce and Organisational Development is a member of the Equality Group within Velindre NHS Trust and any NWSSP specific issues are integrated into this process. Our Head of Corporate Services is a member of the NHS Wales Centre for Equality and Human Rights (CEHR) Business Planning Group and the NHS Wales Equality Leadership Group, together with our Compliance Officer, who also sits on the All Wales Senior Offices Group for Equality. We adhere to the CEHR "Governance and Scrutiny: A Guide for Boards" in respect of EQIIAs.

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: Ethnic Origin; Nationality; Country of Birth; Religious Belief, Sexual Orientation and Welsh language competencies.

NWSSP has a statutory and mandatory induction training programme for all new recruits which includes the NHS Wales "Treat Me Fairly" e-learning module focusing on equality and diversity. The module is a national training package and the statistical information pertinent to NWSSP completion contributes to the overall figure for NHS Wales. NWSSP provides a "Core Skills for Managers" Training Programme and the "Managing Conflict" module includes an awareness session on the Dignity at Work Policy and Procedure. A corporate induction package on equality, diversity and

inclusion has been included within the 2018 programme for new starters in the organisation.

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.

6.2 Welsh Language

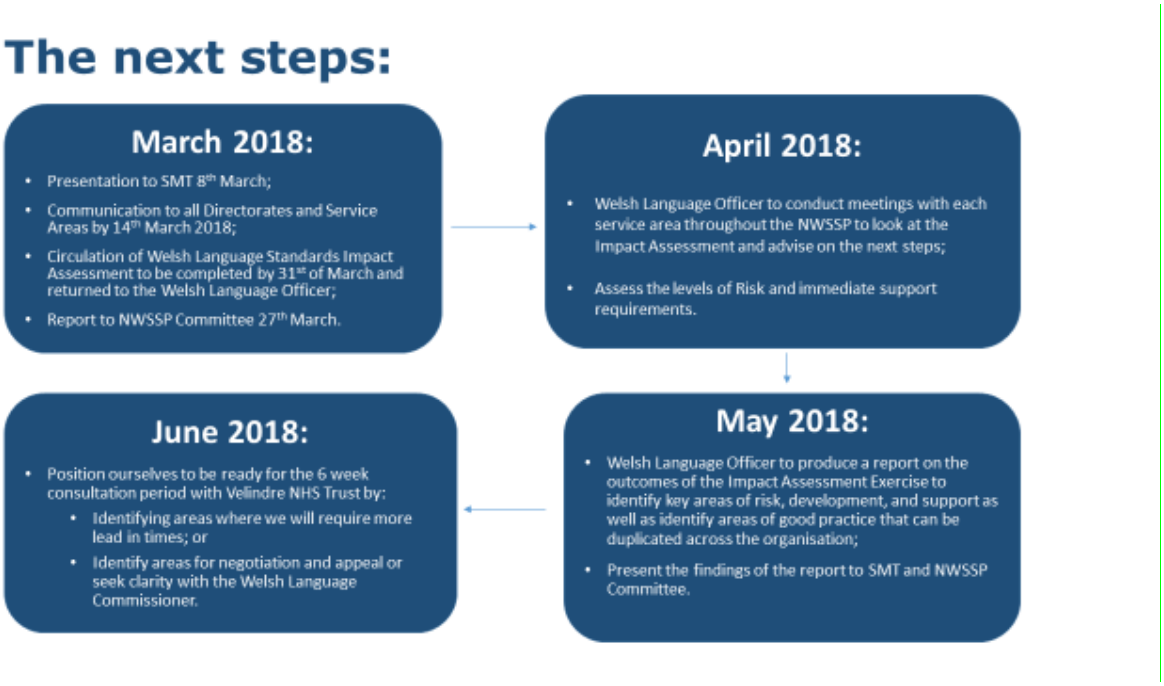
NWSSP is committed to ensuring that the Welsh and English languages are treated equally in the services we provide to the public and NHS partner organisations in Wales. This is in accordance with the current Velindre NHS Trust Welsh Language Scheme, Welsh Language Act 1993 and the Welsh Language Measure (Wales) 2011. In addition the Welsh Language Standards [No7.] Regulations 2018 will come into force in June 2018.

The work of NWSSP in relation to Welsh language delivery and performance is reported to the Welsh Government, National Assembly and the Welsh Language Commissioner within the Annual Performance Report. This work is largely undertaken by the Welsh Language Officer and a Welsh Language Translator. In March 2018 we advertised another full time Welsh Language Translator post for a fixed-term period of 12 months in the first instance.

These posts enable us to comply with our current obligations under the current Welsh Language Scheme and in the planning and preparations to meet the requirements of the Welsh Language Standards. This will increase the demand for translation services in the following areas:

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

The plans already in place to meet the requirements of the Welsh Language Standards are as follows:



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 we have invested in the development of a candidate interface on the TRAC recruitment system.

The Impact Assessment Exercise referred to above will enable NWSSP to further develop our services. The findings from the impact assessment will be compiled into a report informing the Welsh Language Strategy and Welsh Language Implementation Plan. Our achievements from the implementation plan will enable us to report on our performance against the Welsh Language Standards within our Annual Performance Report, which is bilingually to the Welsh Language Commissioner in June each year.

6.3 Handling Complaints and Concerns

NWSSP is committed to the delivery of high quality services to its customers; the NWSSP mission is 'to enable the delivery of world class Public Services in Wales through customer focus, collaboration and innovation'. In addition, one of NWSSP's corporate objectives is to 'develop customer insight and a customer focused culture'.

NWSSP's Issues and Complaints Protocol is reviewed annually. The Protocol aligns with the Velindre NHS Trust Handling Concerns Policy, the Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 and Putting Things Right Guidance. In addition the protocol was recently amended to include specific guidance on identifying if a complaint is vexatious and how to manage such complaints within NWSSP.

During 2017-18, 14 complaints were received. 12 were responded to within the 30 working day target, with two being substantively responded to at 34 and 32 working days respectively. However, in both instances correspondence was issued to the complainants detailing that we were

investigating the matter and that a formal response would be provided at the earliest opportunity.

6.4 Freedom of Information Requests

The Freedom of Information Act (FOIA) 2000 gives the wider 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.

In the financial year 2017/2018, NWSSP responded to 60 requests for information by the end of March 2018:

Figure 12 – Freedom of Information Requests Apr 2017- March 2018

FOI Breakdown
60 answered within the 20 day target
0 transferred out to another NHS body
0 responded to outside of the deadline
0 withdrawn

6.5 Data Security

In 2017/2018 (to end of February 2018), 33 information governance breaches were reported within NWSSP, these included issues with misdirection of email and records management.

All breaches are recorded in the Datix risk management software, and investigated in accordance with the Information Governance and Confidentiality Breach Reporting protocols. The protocols encourage staff to report those breaches that originate outside the organisation for recording purposes. Incidents reported for information purposes that originated outside the NWSSP were 97 (to end February 2018).

From this, the Information Governance Manager writes a report including relevant recommendations and any areas for improvement to minimise the possibility of further breaches.

Any gaps identified during incident investigation provide an opportunity for changes to practice and development of new protocols. Staff are also requested to provide feedback to any recommendations made by the Information Governance Manager where action is required to further improve the service and demonstrate prevention of any further breaches.

Members of the IGSG are required to report to the Steering Group meetings 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 reported in 2017/18 that was assessed as being of a category serious enough to report to the

Information Commissioner's Office (ICO) for further investigation. However, this was done as a matter of course as the mitigations in place and the circumstances of the breach were handled in such a way that the data in question was not released into the public domain and was controlled and secured to a point where there were no risks to the data subject's information. The ICO were satisfied with the processes involved and the recommendations made and did not consider it to be an issue that required enforcement action.

It is important to note that following implementation of the new Data Protection Legislation, all breaches, regardless of perceived severity, will have to be reported to the ICO within 72 hours.

6.6 ISO14001 – Sustainability and Carbon Reduction Delivery Plan

NWSSP is committed to managing its environmental impact, lowering the organisation's carbon footprint and adhering to the sustainable development principle. As part of this organisational commitment, NWSSP was successful in attaining the ISO14001:2004 Environmental Management System certification in December 2014, in accordance with the Welsh Government mandate for all NHS Wales organisations to attain the Standard. NWSSP successfully achieved re-certification to the Standard in August 2017. One minor non-conformity (which will be closed off at the next audit) and four opportunities for improvement were identified, which have since been investigated. These are detailed below:

- **Minor Non Conformity -** The Control of Contractors Policy states that a "*record of inductions is to be kept for future auditing signed and dated by the contractors upon completion.*" However, the procedure, Contractor Management (ENV008), does not state the above. No records of signed contractor inductions were able to be retrieved at Cwmbran Stores, as the procedure was being used rather than the policy.

- **Opportunities for Improvement**
  - Consideration to be given as to separating waste providers on the electronic system to aid retrieval (Cwmbran House);
  - Consideration to investigate as to why version control on the Contract Planning Form was removed (Companies House);
  - Expand on the environmental training available through e-learning; and
  - Consideration to be given as to adding an environmental incident coding type onto DATIX, which is currently under the heading of "Health and Safety" (Cwmbran Stores).

- **Observations (highlighting good practice)**
  - Positive comments on initiatives (Cwmbran House); and
  - Excellent record keeping and retrieval of documentation (Companies House).

Carbon Footprint

As part of our commitment to reduce our contribution to climate change, a target of 3% carbon reduction year on year from a baseline of our carbon footprint, taken from 2014-2015, has been agreed and this is reflected within our Environmental Objectives.

During 2017/18, we committed to reducing our carbon reduction by implementing various environmental initiatives at our sites within the scope. It is anticipated that we achieve our target for the reporting period, having achieved a reduction of [xx]%. NWSSP's Sustainability Report for 2017/18 explores this area in further detail: http://www.nwssp.wales.nhs.uk/governance-and-assurance-arrangements

6.7 Business Continuity Planning/Emergency Preparedness

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. We recognise our 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 Velindre NHS Trust we are 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. At present there are local directorate plans in place for ensuring business continuity arrangements are effective for key services and buildings, and work is progressing in developing an overarching Business Continuity Plan which outlines our response to incidents and outbreaks, including the mobilisation of additional resource.

In addition, we complete the Caldicott Principles Into Practice (CPIP) annual self-assessment which assesses if organisations have current and tested

business continuity plans in place for all of their critical infrastructure components and core information systems.

NWSSP are working 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 Shared Services. 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.

6.8 UK Corporate Governance Code

NWSSP operates within the scope of the Velindre NHS Trust governance arrangements. Velindre NHS Trust has undertaken 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 under Velindre NHS Trust and as the Payroll function for NHS Wales, within NWSSP's remit 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 NHS Wales Shared Services Partnership Committee regarding the effectiveness of risk management across NWSSP. My advice to the Partnership Committee 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 audit 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 Velindre NHS Trust and the local Health Boards.

Internal Audit Opinion

Internal audit provide me and the Partnership Committee 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 Head of Internal Audit opinion for 2017/2018 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.

The rating of each assurance domain is based upon the audit work performed in that area and takes account of the relative significance of the issues identified. It should be recognised that many of the reviews were directed at high risk areas, and the overarching opinion needs to be read in that context. Of the reviews undertaken, around 45% were given a substantial assurance rating, and around 53% a reasonable assurance rating (as at 13th June 2017).

Internal Audit review of Corporate Governance

Internal Audit undertook a review of Corporate Governance in 2016/2017 to assess the control environment including management of the new Health and Care Standards Framework self-assessment process and the assurance framework including the Annual Governance Statement. This audit provides assurance to the Audit Committee of Velindre NHS Trust that risks material to the achievement of system objectives are managed appropriately.

Internal Audit concluded that the level of assurance given as to the effectiveness of the system of internal control in place to manage the risk associated with Corporate Governance was **Substantial Assurance**. This report was taken into account when completing the theme on the Governance, Leadership and Accountability Health and Care Standards self-assessment for 2016/2017.

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

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 Partnership Committee.

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 Velindre NHS Trust. These procedures include the Standing Orders for the regulation of their 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), they provide the regulatory framework for the business conduct of the Trust. These arrangements are supported by detailed financial operating procedures covering the whole of Velindre and also local procedures specific to NWSSP.

- **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. The SLAs are reviewed annually to ensure 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

This Governance Statement indicates that NWSSP has continued to make progress and mature as an organisation during 2017/2018 and that we are further developing and embedding good governance and appropriate controls throughout the organisation. No significant control weaknesses have been identified during the year. 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 2018-19:

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 2018-2019.

Signed by:

Managing Director – NHS Wales Shared Services Partnership

Date: 2018

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	24th April 2018
AGENDA ITEM	2.2
PREPARED BY	Roxann Davies, Compliance Officer
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

NWSSP Governance Matters

PURPOSE OF REPORT

The purpose of this paper is to provide the Audit Committee with a brief update on governance developments within NWSSP.

1. DEPARTURES FROM STANDING ORDERS

There have been no departures from the Standing Orders and financial regulations during the period.

2. CONTRACTS FOR NWSSP

The table overleaf summarises contracting activity undertaken during the period **11th January to 6th April 2018**.

A summary of activity for the period **5 January 2018 – 27 March 2018** is set out in **Appendix A**.

Description	No.
Single Quotation Actions	4
Invitation to competitive tender of value between £25,000 and the prevailing OJEU threshold (exclusive of VAT)	3
Direct Call Off against National Framework Agreement	3
Invitation to competitive quote of value between £5,000 and £25,000 (exclusive of VAT)	1
Invitation to competitive tender of value exceeding prevailing OJEU threshold (exclusive of VAT)	1
Single Tender Actions	1
Contract Extensions	0

3. NWSSP PROCUREMENT SERVICES ALL WALES CONTRACTING ACTIVITY

All Wales Contracting Activity in progress

During the period **5 January 2018 – 27 March 2018**, activity against **53** contracts has been completed. This includes **14** contracts at the briefing stage and **29** contracts at the ratification stage. In addition to this activity, extensions have been actioned against **10** contracts.

A summary of activity for the period **5 January 2018 – 27 March 2018** is set out in **Appendix B**.

4. STORES WRITE OFFS

Out of Date Stock

The value of stores, at 31 March 2018, amounted to **£2,893,369**. For the period January to March 2018, a stock write off of **£1,988** has been actioned for out of date stock. This equates to 0.07% of the total stock holding value in March.

Stock Type	Bridgend Stores £	Denbigh Stores £	Cwmbran Stores £
Stock Value	1,543,197	688,398	661,774
Out of Date Stock	854	960	175
Total	**0.06%**	**0.14%**	**0.03%**

These items were reviewed through the stock losses protocol and stock write on/write off forms have been completed and authorised in line with the agreed protocol.

A summary of activity for the period **January 2018 – March 2018** is set out in **Appendix C**.

5. GIFTS, HOSPITALITY & SPONSORSHIP

Gifts, hospitality and sponsorship guidance has been re-issued to service heads and their respective Senior Management Teams. All staff are required to disclose any offers of gifts, hospitality or sponsorship to the Managing Director, or Director of Finance and Corporate Services, in his absence.

Gifts and/or Hospitality Declarations

There has been **2** declarations received relating to gifts and/or hospitality since the last Audit Committee meeting.

NWSSP Employee	Position	Type	Source	Description	Value	Authorised by	Accepted or Declined & Date
Mark Roscrow	Director of Procurement Services	Hospitality	Wales Quality Centre	St David's Day Business Breakfast 01.03.2018	£25.00	N Frow	24.01.2018 Accepted
Dave Hopkins	Director of Primary Care Services	Hospitality	National Pharmacy Association	Annual Awards Dinner 24.05.2018	£25.00	A Butler	04.04.2018 Accepted

Sponsorship Declarations

There has been **1** declaration received relating to sponsorship since the last Audit Committee meeting.

NWSSP Employee	Position	Type	Source	Description	Value	Authorised by	Accepted or Declined & Date
Rebecca Richards	Director of Finance Academy	Sponsorship	Siemens Healthcare	Travel and accommodation costs covered for presenting on behalf of NHS Wales at the Healthcare Challenge Congress, Katowice, Poland 08-10.03.2018	Estimated up to £5,000.00	A Butler	26.02.2018 Accepted

6. WELSH GOVERNMENT QUARTERLY UPDATE

On a quarterly basis, the NWSSP issues a letter to Dr Andrew Goodall at Welsh Government to confirm any Audit Reports which have achieved limited or no assurance.

For Quarter 4 of 2017/2018, we have submitted a nil return.

7. RECOMMENDATIONS

The Committee is asked to **NOTE** the report.

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	24th April 2018
AGENDA ITEM	2.3
REPORT PREPARED BY	Roxann Davies, Compliance Officer
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

Update on the Implementation of Audit Recommendations

PURPOSE OF REPORT

This report provides an update to the Audit Committee on the progress of tracking 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 has been in operation since 1st April 2011. Following its set up as a Virtual Organisation, NWSSP has recorded the recommendations from Internal Audit Reports, those received from Wales Audit Office and those issued directly prior to establishment. It is essential that user confidence in NWSSP is developed and maintained; an important way in which to develop user confidence is to monitor and implement audit recommendations, in an effective and efficient way.

2. CURRENT POSITION

The detailed recommendations relating to audit reports in respect of NWSSP services have been captured in a detailed tracking database. A copy of the summary extract is attached at **Appendix A**, for your information.

In this report, the base position has been taken from the previous report presented to the Audit Committee.

There are **47** reports covered in this review, including **3** Wales Audit Office reports and **1** SGS UK Ltd report relating to ISO14001, categorised as 'other' (where assurance is not applicable). **16** reports have achieved **Substantial** assurance, **26** reports have achieved **Reasonable** assurance, **0** reports have been awarded **Limited** assurance or **No Assurance** and **5** reports were generated with **Assurance Not Applicable**. The reports include **222** recommendations for action.

The figures relating to the level of assurance achieved for each directorate's audit reports is outlined in **Table 1** below. The progress towards implementation of recommendations is outlined **Table 2**.

The Wales Audit Office reports are not awarded assurance ratings. On this basis, they are categorised as assurance not applicable.

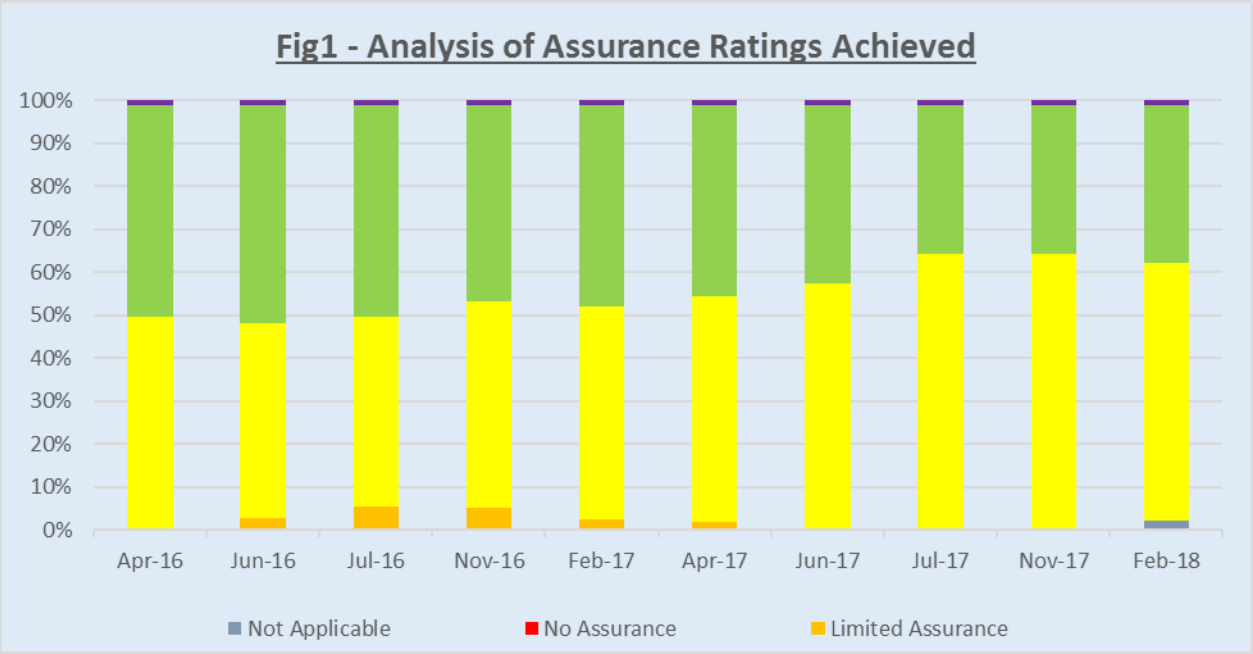
Table 1 - Summary of Audit Report Ratings

Position as at April 2018 (excluding reports on the current agenda)

NWSSP Service	Assurance Not Applicable	No Assurance	Limited	Reasonable	Substantial	Total
Corporate Services	0	0	0	2	4	**6**
Employment Services	0	0	0	6	4	**10**
Specialist Estates Services	0	0	0	2	2	**4**
Primary Care Services	0	0	0	2	4	**6**
Procurement Services	1	0	0	12	0	**13**
Workforce	0	0	0	1	2	**3**
Legal & Risk	0	0	0	1	0	**1**
Audit & Assurance	0	0	0	0	0	**0**
Total	**1**	**0**	**0**	**26**	**16**	**43**
Percentage	**2.25%**	**0%**	**0%**	**60.5%**	**37.25%**	**100%**
Wales Audit Office	N/A	N/A	N/A	N/A	N/A	**3**
Other	N/A	N/A	N/A	N/A	N/A	**1**
Total	**-**	**-**	**-**	**-**	**-**	**4**

At a previous meeting of the Audit Committee, it was agreed that NWSSP would provide a summary of the audit report assurance ratings achieved, to highlight the direction of travel.

The summary position can be analysed as in **Fig1**, below.



The above graph highlights an improvement over time and demonstrates that **100%** of NWSSP's audit reports are rated **Substantial** or **Reasonable** assurance, compared to **82%** in October 2012. In addition, **35%** of the reports are rated as 'substantial' compared with **30.7%** in October 2012.

Table 2 - Summary of Audit Recommendations

Recommendations		Implemented	Not Yet Due	Revised Deadline	Revised Deadline Not NWSSP	Overdue
Internal Audit	**177**	**170**	**2**	**2**	**3**	**0**
High	14	14	0	0	0	0
Medium	88	83	2	1	2	0
Low	70	69	0	1	0	0
Not Applicable	5	4	0	0	1	0
External Audit	**44**	**39**	**5**	**0**	**0**	**0**
High	8	8	0	0	0	0
Medium	35	30	5	0	0	0
Low	1	1	0	0		0
Not Applicable	0	0	0	0	0	0
Other Audit	**1**	**0**	**1**	**0**	**0**	**0**
High	0	0	0	0	0	0
Medium	0	0	0	0	0	0
Low	1	0	1	0	0	0
Not Applicable	0	0	0	0	0	0
TOTALS:	**222**	**209**	**8**	**2**	**3**	**0**

3. REVIEW OF RECOMMENDATIONS

A detailed breakdown of all audit recommendations is reviewed at each Senior Management Team meeting. At the last meeting, there were a number of recommendations identified where it was not possible to complete the recommendations within the original deadline, as set out in the management response.

The review has reflected that:

- Management need to be more realistic in terms of the timescale provided for management responses; and
- Management responses need to clearly distinguish between those actions that relate to NWSSP and those that relate to Health Boards and Trusts.

Appendix B sets out a breakdown of the audit recommendations with **Revised Deadlines** for **APPROVAL** and those which are **Overdue**, by date due.

4. REVISED DEADLINE PROPOSALS FOR APPROVAL

Five recommendations have now reached their target completion dates and it is requested that the deadlines be extended, by way of a Revised Deadline. These are also set out in **Appendix B**, for the **APPROVAL** by the Audit Committee.

1. Procurement Services Central Sourcing 2015-16
   Ref: PROC/15-16/5 Rec.1
   Requested extension from 31/03/2018 to **01/05/2018**.
2. Procurement Services Central Sourcing 2015-16
   Ref: PROC/15-16/5 Rec.6
   Requested extension from 31/03/2018 to **01/05/2018**.
3. Procurement Services ABMU Carbon Reduction Commitment 2017-18
   Ref: PROC/17-18/1 Rec.5
   Requested extension from 28/02/2018 to **31/05/2018**.
4. Employment Services Payroll Services 2015-16
   Ref: EMP/15-16/7 Rec.4
   Requested extension from 01/04/2018 to **01/08/2018**.
5. Employment Services Payroll Services 2015-16
   Ref: EMP/15-16/7 Rec.5
   Requested extension from 01/04/2018 to **31/08/2018**.

5. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the progress made to date; and
- **APPROVE** the proposed Revised Deadlines put forward.

SUMMARY OF LATEST AUDIT REVIEWS BY SERVICE AREA

Internal Audit Reference	Reference	Directorate	Health Board/Trust	Report Title	Year	Assurance Rating	Recommendations	Implemented	Not Yet Due	Revised Deadline	Outstanding	Not NWSSP Action
INTERNAL AUDIT REPORTS												
	CORP/13-14/1	Corporate Services	All Wales	Student Awards Services	2013-14	Substantial	2	2	0	0	0	0
	CORP/14-15/1	Corporate Services	NWSSP	Budgetary Control, Financial Reporitng & General Ledger	2014-15	Substantial	1	1	0	0	0	0
	CORP/15-16	Corporate Services	NWSSP	Information Goverance	2015-16	Reasonable	5	4	1	0	0	0
	CORP/16-17/1	Corporate Services	NWSSP	Risk Management	2016-17	Reasonable	4	4	0	0	0	0
	CORP/16-17/2	Corporate Services	NWSSP	Corporate Governance	2016-17	Substantial	7	7	0	0	0	0
NWSSP-1718-02	CORP/17-18/1	Corporate Services	NWSSP	Information Governance GDPR	2017-18	Substantial	2	1	1	0	0	0
						TOTAL	**21**	**19**	**2**	**0**	**0**	**0**
	EMP/14-15/1	Employment Services	All Wales	Recruitment: Qualifications & DBS Checks	2014-15	Substantial	2	2	0	0	0	0
	EMP/15-16/1	Employment Services	WAST	ESR CAATS	2015-16	Substantial	0	0	0	0	0	0
	EMP/15-16/2	Employment Services	BCU	ESR CAATS	2015-16	Substantial	1	1	0	0	0	0
	EMP/15-16/3	Employment Services	Hywel Dda	Payroll Services	2015-16	Reasonable	3	3	0	0	0	0
	EMP/15-16/4	Employment Services	BCU/WAST	Payroll Services	2015-16	Reasonable	3	3	0	0	0	0
	EMP/15-16/5	Employment Services	ABMU	Payroll Services	2015-16	Substantial	2	2	0	0	0	0
	EMP/15-16/6	Employment Services	Aneurin Bevan/Powys	Payroll Services	2015-16	Reasonable	8	8	0	0	0	0
	EMP/15-16/7	Employment Services	Cardiff & Vale/Cwm Taf/PHW/Velindre	Payroll Services	2015-16	Reasonable	9	7	0	0	0	2
	EMP/16-17/1	Employment Services	All Wales	Payroll Services	2016-17	Reasonable	8	8	0	0	0	0
	EMP/16-17/2	Employment Services	All Wales	TRAC System	2016-17	Reasonable	3	3	0	0	0	0
						TOTAL	**39**	**37**	**0**	**0**	**0**	**2**
	L&R/15-16/1	Legal & Risk	All Wales	Welsh Risk Pool Services	2015-16	Reasonable	2	2	0	0	0	0
						TOTAL	**2**	**2**	**0**	**0**	**0**	**0**
	PCS/14-15/1	Primary Care Services	All Wales	Contractor Payment Assurance: Prescribing Services	2014/15	Substantial	0	0	0	0	0	0
	PCS/14-15/2	Primary Care Services	All Wales	Post Payment Verification	2014-15	Substantial	3	3	0	0	0	0
	PCS/16-17/1	Primary Care Services	All Wales	Contractor Payment Assurance: General Dental Services Contract	2016-17	Reasonable	2	2	0	0	0	0
	PCS/16-17/2	Primary Care Services	All Wales	Contractor Payment Assurance: General Medical Services	2016-17	Substantial	2	2	0	0	0	0
	PCS/16-17/3	Primary Care Services	All Wales	Contractor Payment Assurance: Pharmacy Payments	2016-17	Substantial	3	3	0	0	0	0
	PCS/16-17/4	Primary Care Services	All Wales	Contractor Payment Assurance: General Ophthalmic Services Contract	2016-17	Reasonable	2	2	0	0	0	0
						TOTAL	**12**	**12**	**0**	**0**	**0**	**0**
	PROC/14-15/1	Procurement Services	ABMU	Local Procurement Team	2014-15	Reasonable	4	4	0	0	0	0
	PROC/14-15/2	Procurement Services	Cardiff & Vale	Local Procurement Team	2014-15	Reasonable	4	4	0	0	0	0
	PROC/15-16/1	Procurement Services	All Wales	Bridgend Stores	2015-16	Reasonable	11	11	0	0	0	0
	PROC/15-16/2	Procurement Services	All Wales	Cwmbran Stores **Follow Up**	2015-16	Reasonable	4	4	0	0	0	0
	PROC/15-16/3	Procurement Services	Cwm Taf	Local Procurement Team	2015-16	Reasonable	4	4	0	0	0	0
	PROC/15-16/4	Procurement Services	BCU & WAST	Local Procurement Team	2015-16	Reasonable	2	2	0	0	0	0
	PROC/15-16/5	Procurement Services	All Wales	Central Sourcing	2015-16	Reasonable	7	5	0	2	0	0
	PROC/16-17/1	Procurement Services	All Wales	Accounts Payable	2016-17	Reasonable	6	6	0	0	0	0
	PROC/16-17/2	Procurement Services	All Wales	Health Courier Services **Follow Up**	2016-17	Reasonable	10	10	0	0	0	0
	PROC/16-17/3	Procurement Services	All Wales	Supplier Master File **Follow Up**	2016-17	Reasonable	2	2	0	0	0	0
	PROC/16-17/4	Procurement Services	Velindre/PHW	Local Procurement Team	2016-17	Reasonable	5	5	0	0	0	0
	PROC/16-17/5	Procurement Services	All Wales	Denbigh Stores	2016-17	Reasonable	7	7	0	0	0	0
NWSSP-1718-19	PROC/17-18/1	Procurement Services	ABMU	Carbon Reduction Commitment (CRC) Payment Review	2017-18	Advisory Report	5	4	0	0	0	1
						TOTAL	**71**	**68**	**0**	**2**	**0**	**1**
	SES/15-16/1	Specialist Estates Services	All Wales	Design4Life - BAM	2015-16	Reasonable	5	5	0	0	0	0
	SES/15-16/2	Specialist Estates Services	All Wales	Design4Life - Interserve	2015-16	Substantial	3	3	0	0	0	0
	SES/15-16/3	Specialist Estates Services	All Wales	Mechanical & Electrical Sub Contractors	2015-16	Substantial	11	11	0	0	0	0
	SES/15-16/4	Specialist Estates Services	All Wales	Design4Life - Open Book Audit: Laing O'Rourke	2015-16	Reasonable	4	4	0	0	0	0
						TOTAL	**23**	**23**	**0**	**0**	**0**	**0**
	WORK/15-16/1	Workforce	All Wales	WfIS Core Skills & Training Framework **Follow Up**	2015-16	Substantial	4	4	0	0	0	0
	WORK/16-17/1	Workforce	All Wales	WfIS ESR OH Bi-Directional Interface	2016-17	Reasonable	4	4	0	0	0	0
NWSSP-1718-17	WORK/17-18/1	Workforce	All Wales	WfIS ESR / Occupational Health Bi-Directional Interface (Immunisations)	2017-18	Substantial	1	1	0	0	0	0
						TOTAL	**9**	**9**	**0**	**0**	**0**	**0**
WALES AUDIT OFFICE EXTERNAL AUDIT REPORTS												
	WAO/15-16	All Services	All Wales	WAO Review of NWSSP	2015-16	Not Applicable	12	12	0	0	0	0
	WAO/16-17/1	All Services	All Wales	WAO Nationally Hosted NHS IT Systems Assurance Report	2016-17	Not Applicable	25	20	5	0	0	0
	WAO/16-17/2	All Services	All Wales	WAO Management Letter	2016-17	Not Applicable	7	7	0	0	0	0
						TOTAL	**44**	**39**	**5**	**0**	**0**	**0**
OTHER AUDIT REPORTS												
	ISO14001/17/18	Corporate Services	NWSSP	SGS UK Ltd Audit of ISO14001 Environmental Management System	2017-18	Not Applicable	1	0	1	0	0	0
						TOTAL	**1**	**0**	**1**	**0**	**0**	**0**
						TOTAL RECS	**222**	**209**	**8**	**2**	**0**	**3**

APPENDIX B –AUDIT RECOMMENDATIONS WITH REVISED DEADLINES

ID	Rec No Reference NWSSP Service Customer of Service Report Title Report Year	Status	Issue Identified	Risk Rating	Recommendation	Responsibility for Action	Management Response	Original Deadline	Revised Deadline	Update On Progress Made	Last Updated
									REVISED DEADLINE – FOR APPROVAL REQUESTED		
1	Rec 1 PROC/15-16/5 Procurement Services All Wales Central Sourcing 2015-16 2015-16	**Revised Deadline**	There is no procedural guidance in relation to the process for single tender actions.	**Low**	Procedural guidance in relation to STAs should be developed	Keir Warner - Head of Sourcing (Non-Medical)	Whilst we do not consider this to be a significant risk factor this has been included in the scope of a wider procedure review project where a specific procedure for STA's will be developed. The scope of the procedure review project has been included as part of the management response for reference.	01/03/2017	**31/03/2018 Requested Extension to 01/05/2018**	The STA procedure has been developed and reviewed and it has been agreed that as there were similar forms for STA and SQA one form has now been agreed which has also had sign off by capital audit. The STA procedure now reflects what is a workable process for everybody i.e. Bravo is to be used for all STA/SQT's with the exception of those STA/SQT's that are completed retrospectively.	16/04/2018
2	Rec 6 PROC/15-16/5 Procurement Services All Wales Central Sourcing 2015-16	**Revised Deadline**	There is a Managing Supplier Performance procedure in place which includes general guidance in respect of complaints, bench marking and contract usage. There is currently no contract portfolio-wide protocol/risk matrix in place for determining the minimum steps which should be taken to monitor a contract, based on the level of risk associated with the contract.	**Medium**	Minimum requirements for contract management based on the level of risk associated with each contract should be agreed and documented. Management should risk assess existing contracts to ensure contract management arrangements are adequate.	Keir Warner - Head of Sourcing (Non-Medical)	This has been identified as an area of improvement by both the procedure review project team and the Business excellence group. Contract management is within the scope of the procedure review and will incorporate a more risk based approach to contract and category management. Further to this, work has already commenced through the Business Excellence Group by reviewing current supplier management tools and the development of a complaints management system for use by all divisions of Procurement services. The development of a risk matrix through the procedure review project will allow teams to assess the level of contract management required. This will be supplemented with staff awareness training to ensure that the appropriate approach is taken to each contract.	01/03/2017	**31/03/2018 Requested Extension to 01/05/2018**	The Supplier Performance management (SPM) tool was launched on the 13 October 2017 which ensures that a minimum standard of supplier/contract management is adhered to. This system also allows visibility across all Sourcing and Frontline teams to ensure a common understanding and approach to managing supplier/contract issues. A risk Matrix has been developed which will be used by Sourcing and Frontline teams in establishing the level of risk associated with the supplier/contract area as part of the contract planning and award processes. The matrix will be applied to existing suppliers/contracts in order to ensure that legacy issues are addressed	16/04/2018

APPENDIX B –AUDIT RECOMMENDATIONS WITH REVISED DEADLINES

ID	Rec No Reference NWSSP Service Customer of Service Report Title Report Year	Status	Issue Identified	Risk Rating	Recommendation	Responsibility for Action	Management Response	Original Deadline	Revised Deadline	Update On Progress Made	Last Updated
										FOR INFORMATION – NOT NWSSP ACTION	
3	NWSSP-1718-19 Rec 5 PROC/17-18/1 Procurement Services ABMU Carbon Reduction Commitment (CRC) Payment Review	**Revised Deadline - Not NWSSP**	There is an inconsistent approach to processing CRC allowance payments across NHS Wales. Risk - Payments not processed in accordance with supplier requirements, potentially leading to financial penalty.	**N/A**	Whilst it is recognised that the CRC scheme will be coming to an end in the next two years, an all-Wales procedure for the processing of CRC payments should be agreed to ensure payments are made on time and via the correct payment method. This should include clarity as to whether a purchase order is required, and if a memorandum of account can be processed as an invoice or additional documentation required (i.e. Miscellaneous Payment Request Form).	**Assistant Director of Finance ABMU**	This will need to be taken through the All Wales P2P Group – ABMU will raise at the next meeting on 6th February 2018	**28/02/2018**	**Requesting extension to 31/05/2018**	**ABMU ACTION - NOT FOR NWSSP** This has been added to the next All-Wales P2P Group meeting agenda which is being held on 4 May. The reason for this not yet being completed was a long term sickness absence.	
4	Rec 4 EMP/15-16/7 Employment Services Cardiff & Vale/Cwm Taf/PHW/Velindre Payroll Services 2015-16	**Revised Deadline - Not NWSSP**	Employment Services is in the process of implementing a new excel-based enrolment form following a pilot exercise within NWSSP. Whilst it is yet to be implemented within other organisations, the new process for the enrolment of new starters will provide additional controls to improve data quality and reduce the risk of ghost employees.	**Medium**	Implementation of the new enrolment form should be progressed.	Christine Richards/Lisa Williams	This is currently being rolled out throughout Health Boards and Trusts. Additional staff recruited to assist.	01/09/2015	**01/04/2018 Requested Extension to 01/08/2018**	Roll-out currently in C&VUHB (Bank Service); CTUHB M&D Pilot; Velindre NHST; PHW; WAST; ABUHB (Bank Service); Powys. Lack of progress and length of time achieving this recommendation is solely due to lack of organisations uptake. There has however been a change in the strategic direction during this period with the All-Wales Hire to Retire Project Board seeking to rollout ESR Hire functionality. A pilot project has been taking place in HDda since November 2017. The intended evaluation was planned for end of March, however not all process changes and risk mitigation have yet been concluded. A request will therefore be made to the Hire to Retire Project Board at the end of April to extend the project, which would then be evaluated and reviewed at the end of July. If preferred approach is ESR Hire this recommendation will be closed.	21/03/2018

APPENDIX B –AUDIT RECOMMENDATIONS WITH REVISED DEADLINES

5	Rec 5 EMP/15-16/7 Employment Services Cardiff & Vale/Cwm Taf/PHW/Velindre Payroll Services 2015-16	**Revised Deadline - Not NWSSP**	New appointments made via NHS Jobs should receive a pre-employment check by the NWSSP Recruitment Services Team prior to commencing employment with the Health Board/Trusts. There is a control within ESR system whereby Recruitment is required to select "offer-accept" following completion of an individuals' recruitment checks in order to allow Payroll to download the individual's record. However, the Payroll Manager advised that this control is not operational for C&VUHB/CTUHB/PHW/VNHST - a decision taken by the Health Boards/Trusts.	**Medium**	The "offer-accept" functionality should be operational for all Health Boards.	Lisa Williams, Service Improvement Development Manager, Kelly Skene, Regional Recruitment Services Manager	The functionality where Recruitment download appointees into ESR as offer conditional and change the status to offer accept following completion of all pre-employment checks is currently functional in two Health Boards. There are plans to roll this out across NHS Wales alongside the new enrolment form.	01/09/2015	**01/04/2018 Requested Extension to 31/08/2018**	Implementation of this recommendation will be considered during the ESR Hire pilot to determine the correct status change meets the needs of the new hire process, i.e. via ESR or e-appointments form. This will be consistently applied across all HBs/Trusts. Recommendations of this pilot will be presented to the All-Wales Hire to Retire Project Board at the end of July to determine preferred approach as set out above. If the decision is to utilise this function an implementation plan will be developed by end of August	21/03/2018

MEETING	Velindre NHS Trust Audit Committee for NHS Shared Services Partnership
DATE	24th April 2018
AGENDA ITEM	2.4
PREPARED BY	Roxann Davies, Compliance Officer
PRESENTED BY	Roxann Davies, Compliance Officer
TITLE OF REPORT	Audit Committee Effectiveness Survey

1. INTRODUCTION

The mandate of the Audit Committee is to **advise** and **assure** the Shared Services Partnership Committee (SSPC) and the Accountable Officer on whether effective arrangements are in place, regarding the design and operation of NWSSP's system of governance and assurance. This supports the SSPC in its decision making and in discharging its accountabilities for securing the achievement of the NWSSP's objectives in accordance with the standards of good governance determined for the NHS in Wales.

In order to gauge the Committee's effectiveness, an electronic survey has been devised to obtain the views of Committee members across a number of themes:

- Compliance With Law And Regulations Governing NHS Wales
- Internal Control and Risk Management
- Internal Audit
- External Audit
- Counter Fraud
- Committee Leadership

2. EFFECTIVENESS SURVEY

The survey is based on the guidance contained within the NHS Audit Committee Handbook and to ensure both Velindre and NWSSP

Committees have issued aligned survey questions, we have worked together to produce a template bringing together the best of both Committee self assessments, to be used going forward. The agreed questions are set out in **Appendix 1**.

The results of the survey will provide a rich source of information and provide assurance in terms of existing arrangements and potential areas for development, going forward. A report of the findings will be presented to the Committee in June.

The survey will be **issued** during the week commencing **30 April 2018** and Committee members are requested to **complete** the survey anonymously online by **Monday, 14 May 2018**.

Committee members requested to complete the survey are as follows:

- Chair – **Martin Veale**
- Independent Member – **Ray Singh**
- Independent Member – **Professor Jane Hopkinson**
- NWSSP Chair – **Margaret Foster**
- NWSSP Managing Director – **Neil Frow**
- Director of Finance & Corporate Services – **Andy Butler**
- Head of Finance & Business Development – **Peter Stephenson**
- Head of Internal Audit – **James Quance**
- Counter Fraud Representative – **Craig Greenstock**
- WAO Representative – **Gillian Gillett**

3. RECOMMENDATIONS

Audit Committee Members are asked to:

- Complete the online survey by **Monday, 14 May 2018**.

Velindre NHS Trust Audit Committee for NHS Wales Shared Services Audit Committee Self Assessment Survey

Composition, Establishment and Duties

1. Does the Audit Committee have written Terms of Reference, which adequately define its role in accordance with Welsh Government guidance?
2. Are the Terms of Reference reviewed annually to take into account governance developments (including good governance principles) and the remit of other Committees within the organisation?
3. Has the Audit Committee been provided with sufficient authority and resources to perform its role effectively?
4. Does the Audit Committee report regularly to the NWSSP Partnership Committee and Velindre Trust Board?
5. Does the Audit Committee prepare an Annual Report on its work and performance in preceding year, for consideration by the NWSSP Partnership Committee and Velindre Trust Board?
6. Has the Audit Committee established a cycle of business to be dealt with across the year?
7. Does the Audit Committee meet sufficiently frequently to deal with planned matters and is enough time allowed for questions and discussions?
8. Is the atmosphere at Audit Committee meetings conductive to open and productive debate?
9. Is the behaviour of all members/attendees courteous and professional?
10. Are Audit Committee meetings scheduled prior to important decisions being made?
11. Do you consider that where private meetings of the Audit Committee are held (Part B), that these have been used appropriately for items that should not be discussed in the public domain (i.e. commercially sensitive, identifiable information)?
12. Each agenda item is 'closed off' appropriately so it is clear what the conclusion is.
13. Would you welcome greater user of the Welsh Language at meetings?
14. Would you welcome greater use of Committee paper software, such as iBabs?

Compliance With Law And Regulations Governing NHS Wales

15. Does the Audit Committee review assurance and regulatory compliance reporting processes?
16. Does the Audit Committee have a mechanism to ensure awareness of topical, legal and regulatory issues?

Internal Control and Risk Management

17. Has the Audit Committee formally considered how it integrates with other Committees that are reviewing risk (e.g. Risk Management)?
18. Has the Audit Committee reviewed the robustness and effectiveness of the content of the organisation's system of assurance?
19. Do you consider that the reports received by the Audit Committee are timely and have the right format/content, to enhance it to discharge its internal control and risk management responsibilities?
20. Is there clarity over the timing and content of the assurance statements received by the Audit Committee from the Head of Internal Audit?

Internal Audit

21. Are the Charter or Terms of Reference approved by the Audit Committee and regularly reviewed?
22. Does the Audit Committee review and approve the Internal Audit Plan at the beginning of the financial year?
23. Does the Audit Committee approve any material changes to the Plan?
24. Are Audit Plans derived from clear processes based on risk assessment with clear links to the system of assurance?
25. Does the Audit Committee receive periodic progress reports from the Head of Internal Audit?
26. Does the Audit Committee investigate the reason for management refusal to accept audit recommendations?
27. Does the Audit Committee effectively monitor the implementation of management actions from Audit Reports?

28. Does the Head of Internal Audit have a direct line of reporting to the Audit Committee and its Chair?
29. Does the Audit Committee review the effectiveness of Internal Audit and the adequacy of staffing and resources within Internal Audit?
30. Has the Audit Committee evaluated whether Internal Audit complies with the Public Sector Internal Audit Standards (PSIAS)?
31. Has the Audit Committee agreed a range of Internal Audit performance measures to be reported on a routine basis?
32. Does the Audit Committee receive and review the Head of Internal Audit's Annual Report and Opinion?

External Audit

33. Do the Auditor General's representatives present their Audit Plans and Strategy to the Audit Committee, for consideration?
34. Does the Audit Committee receive and monitor actions taken in respect of prior years' reviews?
35. Does the Audit Committee consider the Auditor General's Annual Audit Letter?
36. Does the Audit Committee assess the quality and effectiveness of External Audit work (both financial and non-financial audit)?
37. Does the Audit Committee review the nature and value of non-statutory work commissioned by organisation from the Auditor General?

Counter Fraud

38. Does the Audit Committee review and approve the Counter Fraud Work Plan at the beginning of the financial year?
39. Does the Audit Committee satisfy itself that the Work Plan adequately covers each of the seven generic areas defined in the NHS Counter Fraud Policy?
40. Does the Audit Committee approve any material changes to the Plan?
41. Are Counter Fraud Plans derived from clear processes based on Risk Assessment?
42. Does the Audit Committee receive periodic reports from the Local Counter Fraud Specialist?
43. Does the Audit Committee effectively monitor the implementation of management actions arising from Counter Fraud reports?
44. Does the Local Counter Fraud Specialist have a right of direct access to the Audit Committee and its Chair?
45. Does the Audit Committee review the effectiveness of the Local Counter Fraud Service and the adequacy of its staffing resources?
46. Does the Audit Committee receive and review the Local Counter Fraud Specialist's Annual Report of Counter Fraud Activity and Qualitative Assessment?
47. Does the Audit Committee receive and discuss reports arising from quality inspections by NHS Counter Fraud Authority?

Committee Leadership

48. Do you consider that Audit Committee meetings are chaired effectively and with clarity of purpose and outcome?
49. Do you consider that the Audit Committee Chair provides clear and concise information to the governing body on the activities of the Audit Committee and the implication of all identified gaps in assurance and/or control?

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Shared Services Partnership

NHS Wales Shared Services Partnership

Audit Committee

24 April 2018

Internal Audit Progress Report

CONTENTS Page

1. INTRODUCTION

The purpose of this report is to highlight progress of the 2017/18 Internal Audit Plan at 17 April 2018 to the Audit Committee, together with an overview of other activity undertaken since the previous meeting.

2. PROGRESS AGAINST THE 2017/18 INTERNAL AUDIT PLAN

Number of audits in plan	19*
Of which:	
Number of audits finalised	12
Number of audits in progress	5
Number of audits in planning stage	2

* Total includes three additional reviews requested by management and excludes business continuity deferred to Q1 of 2018/19.

The following reports from the 2017/18 Internal Audit Plan have been issued since the previous meeting of the Audit Committee:

Audit Assignment	**Assurance Rating**
P2P – Accounts Payable	Reasonable
Primary Care Contractor Payments (covering GMS, GDS, GOS and Pharmacy)	Substantial
Non-Medical Education Training Budget	Substantial

Progress in respect of each of the reviews in the 2017/18 Internal Audit Plan is summarised at Appendix A.

4. ENGAGEMENT

We have commenced the 2018/19 planning process and will be meeting with Directors in due course.

The following meetings have been held/attended during the reporting period:

- Information Governance Steering Group
- All Wales P2P Group
- Wales Audit Office
- Audit scoping and debrief meetings
- Liaison meetings with senior management

Other activity:

- Advising on the implementation of ActionPoint within the South East Payroll Team
- Review and comment on the Stores Losses Protocol
- Advising on the development of an escalation procedure for Employment Services

5. RECOMMENDATION

The Audit Committee is invited to note the above.

2017/18 Internal Audit Plan

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
AUDITS FOR BOTH NWSSP AND INDIVIDUAL HEALTH BOARDS / TRUSTS								
PRIMARY CARE SERVICES								
General Medical Services (GMS)		Final	Substantial	0	0	0	0	April Audit Committee
General Dental Services (GDS)		Final	Reasonable	0	1	0	0	April Audit Committee
General Ophthalmic Services (GOS)		Final	Substantial	0	0	0	0	April Audit Committee
General Pharmaceutical Services (including Prescribing)		Final	Substantial	0	0	0	0	April Audit Committee
EMPLOYMENT SERVICES								
Payroll Services		Work in Progress						Fieldwork nearing completion
PROCUREMENT SERVICES								
Accounts Payable	8	Final	Reasonable	0	3	3	0	April Audit Committee
AUDITS FOR NWSSP								

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
FINANCE & CORPORATE SERVICES								
Audit Recommendation Tracker		Work in Progress						
Information Governance: GDPR	5	Final	Substantial	0	1	1	0	February Audit Committee
Non-Medical Education Training Budget	1	Final	Substantial	0	1	2	0	April Audit Committee
Corporate Governance inc. Risk Mgt Follow-Up		Work in Progress						
Business Continuity Plans								Deferred to 2018/19 Q1
Performance Management & Reporting		Planning						
PROCUREMENT SERVICES								
WAO Review – RKC Associates: Lessons Learned by NWSSP	0	Final	N/A	0	0	0	2	Additional review requested by management November Audit Committee
ABMUHB CRC Payment Review	33	Final	N/A	0	0	0	5	Additional review requested by management

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
								February Audit Committee
Surgical Materials Testing Laboratory (SMTL)		Work in Progress						Fieldwork nearing completion
PRIMARY CARE SERVICES								
Primary Medical Care Advisory Team (PMCAT)		Planning						
Exeter System – Advisory Review	N/A	Final	N/A	N/A	N/A	N/A	N/A	No further work required in 2017/18
WORKFORCE & ORGANISATION DEVELOPMENT								
GP Trainee Project		Work in Progress						
IT								
ESR OH Interface (Immunisations)	38	Final	Substantial	0	0	1	0	February Audit Committee
CAPITAL & ESTATES								
Renewal of the NHS Building for Wales Frameworks	N/A	Final	N/A	N/A	N/A	N/A	N/A	This is proactive ongoing support. Feedback has been provided on the pre-qualification stage of the procurement cycle at each

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
								framework – the current focus is on the invitation to tender stage.
PROJECT MANAGEMENT GROUPS								
WfIS Programme Board: H2R	Ongoing	To sit on Project Board to provide advice on internal controls						
IT Steering Group	Ongoing	To sit on Project Board to provide advice on internal controls						
Information Governance Steering Group	Ongoing	To sit on Project Board to provide advice on internal controls						
Finance Academy P2P Group	Ongoing	To sit on Project Board to provide advice on internal controls						
Audit Tracker Register	Ongoing	Consider the development of audit recommendation tracker functionality within Teammate						
AUDIT MANAGEMENT & REPORTING								
Audit Management & Reporting	Ongoing							

<u>For Reference</u>: The assurance ratings are defined as follows:

Assurance rating	Assessment rationale	Guide to Rating
	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.	Few matters arising and are compliance or advisory in nature. No issues about design of policies or procedures or controls. Any identified compliance (O) issues are restricted to a single control objective or risk area rather than more widespread. No high priority audit findings. Few Low or Medium priority findings. Even when taken together any issues have low impact on residual risk exposure even if remaining unresolved.
	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.	Some matters require management attention in either control design or operational compliance. Any control design (D) limitations are isolated to a single control objective or risk area rather than more widespread. However compliance issues (O) may present in more than one area. Typically High priority findings are rare; but/or some Low or Medium priority findings. Even when taken together these will have low to moderate impact on residual risk exposure until resolved.
	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.	More significant audit matters require management attention either in materiality or number. Control design limitations (D) may impact more than one control objective or risk area. Compliance issues (O) may be more widespread indicating non-compliance irrespective of control design. Typically some high priority audit findings have been identified and these are not isolated; and/or several Medium or Low audit findings. Either individually or when taken together these are significant audit matters with moderate impact on residual risk exposure until resolved.
	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to	Significant audit matters require management attention both in terms of materiality and number.

Assurance rating	Assessment rationale	Guide to Rating
	address the whole control framework in this area with **high impact on residual risk** exposure until resolved.	Control design limitations (D) impact the majority of control objectives or risk areas. Alternatively compliance issues (O) are widespread indicating wholesale non-compliance irrespective of control design. Several high priority audit findings have been identified in a number of areas; and/or several Medium audit findings. Either individually or when taken together these are significant audit matters with moderate impact on residual risk exposure until resolved.

For Reference: The priority of the findings and recommendations are as follows:

High	Medium	Low
Poor key control design OR widespread non-compliance with key control PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or mis-statement Timescale for action- Immediate	Minor weakness in control design OR limited non-compliance with control PLUS Some risk to achievement of a system objective Timescale for action- Within one month	Potential to enhance design of adequate systems further OR Isolated instances of non-compliance with control with negligible consequences Timescale for action- Within three months

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Shared Services Partnership
Audit and Assurance Services

Procurement Services - Accounts Payable

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Reasonable Assurance

Previous review rating: Reasonable Assurance

CONTENTS

Review Reference:	NWSSP-1718-11
Report Status:	Final
Fieldwork completion:	22nd March 2018
Debrief meeting:	26th March 2018
Audit management sign-off:	28th March 2018
Draft report issued:	28th March 2018
Management response received:	6th April 2018
Draft report v2 issued:	9th April 2018
Management response received:	9th April 2018
Final report issued:	10th April 2018
Executive sign off:	Mark Roscrow, Director of Procurement Services
Distribution:	Neil Frow, Managing Director Andy Butler, Director of Finance & Corporate Services Mark Roscrow, Director of Procurement Services Russell Ward, Head of Accounts Payable
Auditors:	Sophie Corbett, Audit Manager
Committee:	Velindre NHS Trust Audit Committee for NWSSP

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

1. EXECUTIVE SUMMARY

1.1 Introduction and Background

A review of the Accounts Payable function provided to Welsh Health Boards and Trusts by NHS Wales Shared Services Partnership (NWSSP) Procurement Services was completed in line with the 2017/18 Internal Audit Plan.

The Accounts Payable function is located across two sites:

- Alder House in St. Asaph, North Wales serving Betsi Cadwaladr University Health Board (BCUHB), Powys Teaching Health Board (PtHB) and Welsh Ambulance Service NHS Trust (WAST); and
- Companies House in Cardiff, South Wales serving Abertawe Bro Morgannwg University Health Board (ABMUHB), Aneurin Bevan University Health Board (ABUHB), Cardiff & Vale University Health Board (CVUHB), Cwm Taf University Health Board (CTUHB), Hywel Dda University Health Board (HDUHB), Public Health Wales (PHW) and Velindre NHS Trust (VNHST).

1.2 Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Accounts Payable in order to provide assurance to Velindre NHS Trust Audit Committee for NWSSP that risks material to the achievement of system objectives are managed appropriately.

The objectives reviewed were:

- there is adequate control over the creation and amendment of creditor master-file data;
- non-purchase order/manual invoices are authorised for payment prior to processing;
- invoices are processed and paid in a timely manner;
- systems ensure that invoice values paid are in accordance with agreed prices;
- invoices on hold are monitored and cleared on a regular basis to ensure compliance with PSPP;
- mechanisms are in place to ensure that duplicate payments are avoided or detected; and

- customer organisations are provided with appropriate management information to enable the identification and resolution of compliance issues within originating within their organisations.

1.3 Associated Risks

The potential risks considered at the outset of the review were as follows:

i. no segregation of duties between officers responsible for supplier creation/amendment, invoice entry and payment processing;
ii. payments are made without due authority;
iii. duplicate payments are not prevented or detected;
iv. late payments resulting in non-compliance with Public Sector Payment Policy; and
v. fraud.

2 CONCLUSION

2.1 Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Accounts Payable is **Reasonable** Assurance.

RATING	INDICATOR	DEFINITION
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.

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

2.2 Assurance Summary Table

Assurance Summary					
1	Supplier Master-file Data			✓	
2	Authorisation of Non-Purchase Order Invoices			✓	
3	Timeliness of Invoice Processing			✓	
4	Payments in Accordance with Agreed Prices				✓
5	Invoices on Hold / Compliance with PSPP			✓	
6	Duplicate Payments			✓	
7	Management Information				✓

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

2.3 Design of System / Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the system/control design for Accounts Payable. These are identified in Appendix A as (D).

2.4 Operation of System / Controls

The findings from the review have highlighted five issues that are classified as weaknesses in the operation of the designed system/control for Procurement Services. These are identified in Appendix A as (O).

2.5 Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**3**	**3**	**6**

Four further findings were identified which are outside of the direct control of NWSSP Accounts Payable and cannot be achieved without the agreement and cooperation of customer organisations. These are identified on page 10 of the report and have been reported to management to take forward with customer organisations.

3 SUMMARY OF AUDIT FINDINGS

The following examples of good practice were identified:

- Requests for additions/amendments to the supplier masterfile received via ActionPoint are independently checked to ensure accuracy of processing.
- There was evidence of supplier set-up/amendment requests being checked for authenticity, including contacting the supplier where appropriate.
- The Local Procurement Team for Aneurin Bevan produces an invoices on hold summary report identifying total number and value of invoices for each hold type, movement in the number and value of holds month on month, and the number of holds cleared each month. This is a useful source of information for identifying the biggest problem areas and the effectiveness of the invoice on hold review process.
- Participation in a priority payment programme (Oxygen Finance) where small rebates are received from suppliers in return for payment ahead of agreed terms. The process of on-boarding suppliers is ongoing with only a small number currently participating, but the value of rebates taken during January 2018 was £5,374.72.
- FiscalTec forensic software is used to identify potential duplicate payments on a daily basis prior to the processing of payment runs.
- Monthly KPI reports are produced for customer organisations identifying performance data in respect of:
    - Invoice turnaround
    - FiscalTec software (duplicate invoices)
    - Supplier Maintenance
    - Call handling
    - Customer survey
    - Invoices on hold
    - Oxygen Finance early repayment programme

We identified three **Medium Priority** findings:

1. Supplier Masterfile Access

   Two Accounts Payable (AP) Managers have access to the supplier masterfile via a generic login so segregation of duties is potentially compromised.

The Supplier Maintenance Team (SMT) Team Leader had requested view only access in June 2017 for the purpose of checking bank account amendment alerts. However, full access was granted in error by eEnablement. The AP Managers and SMT Team Leader were seemingly unaware of this.

Four individuals within Accounts Payable/Procurement were given access to the 'VEL AP NWSSP Supplier Maintenance' responsibility profile in error by eEnablement:

i. The responsibility profile was reactivated in error for three individuals who previously had access to the profile prior to the establishment of the Supplier Maintenance Team in 2015. The errors were identified and corrected prior to this audit. Oracle does not record reactivation dates (only original start and end dates) so we were unable to determine the period of access.

ii. A Payments Officer was given access in error in January 2018. This was immediately end-dated following identification by Audit.

An Oracle supplier masterfile audit report identifying the last update to supplier records did not identify any bank amendments processed by the generic login or the four individuals above.

The Supplier Masterfile Follow-Up review undertaken in 2016/17 recommended that arrangements for monitoring access to the supplier maintenance responsibility should be agreed, and user access lists should be reviewed for appropriateness by the Head of Accounts Payable on a periodic basis.

The first user access review was undertaken in December 2017. Oracle user access reports were produced by eEnablement and sent to responsibility owners for review. The Head of eEnablement advised that it will be a quarterly exercise.

See Finding 1 at Appendix A

2. Bank Account Amendment Alert Emails

Previous audits have highlighted a weakness with the Oracle supplier audit report as it only records the last update to a supplier record. In 2015/16 a compensatory control was introduced where Oracle automatically sends an email alert to a generic email address when supplier bank details are amended. The generic email address is monitored by the AP Managers in North Wales who verify a random sample of three amendments per day to supporting documentation.

Sample testing of supplier bank amendments identified two instances where an alert should have been generated but could not be located in the designated email inbox. The AP Manager advised us that a call was logged with Version 1 in January 2018 after no alert emails were received for a day, although no further issues occurred.

See Finding 2 at Appendix A

3. Duplicate Invoice

We identified one duplicate payment for £147 in February 2018 as a result of a reminder letter and final notice letter both being processed for payment. It relates to TV Licensing where the invoice number is the TV licence reference number which remains the same each year.

The second transaction was identified as a potential duplicate by the FiscalTec forensic software however the AP Officer recorded the status as "investigated" and the reason code as "no error", so no action was taken to cancel the duplicate prior to payment.

Accounts Payable have taken action to recover the overpayment.

See Finding 3 at Appendix A

We identified two **Low Priority** findings**:**

1. Supplier Maintenance Process

The Supplier Maintenance process document does not clearly set out the step-by-step process for requesting, processing and checking additions/amendments to the supplier masterfile, and is also contradictory in some areas.

The SMT Team Leader advised that the Supplier Maintenance Team have been asked by some organisations to accept data loads on the basis that checking is undertaken by the Health Board prior to sending to AP. This arrangement is not reflected in the process document and poses an increased risk of fraud as there is no purchase order, no invoice received by AP and no independent evidence to verify the authenticity of payee bank details.

Sample testing of 55 additions/amendments to the supplier masterfile confirmed that all could be verified to supporting documentation. However, in five instances, the New Supplier & Amendments Form had not been completed for a new supplier set-up, and four of the five

One-Off Payment Request Forms reviewed contained bank details but had not been authorised by an AP Manager, as required by the procedure. Non-compliant requests should be rejected.

See Finding 4 at Appendix A

Requests for additions/amendments to the supplier masterfile received via ActionPoint are independently checked to ensure accuracy of processing.

These checks are currently evidenced by means of an email sent by the checker to the actioning officer, which is then saved on the shared drive. Recording the checks in ActionPoint would be more efficient and also confirm that the ActionPoint call has been viewed by the checker.

2. Non-Purchase Order Invoices

For three of the 86 non-PO invoices sampled evidence of authorisation to pay had not been retained with the invoice.

Authorised signatory lists are the responsibility of customer organisations and were available for only 16 of the invoices reviewed. In nine cases, the authorised signatory was verified to the signatory list and the remaining seven signatures were illegible.

See Finding 5 at Appendix A & paragraph 1 on page 11 "Invoice Approval Workflow"

3. FiscalTec Forensic Software – Duplicate Invoices

Within the AP South Team, matches which are confirmed duplicates or require further investigation are passed by the Payments Officer to the Query Team where they will be cancelled or placed on hold. There is a small risk that these invoices could be paid if this is not actioned immediately by the Query Team.

There is a 'FiscalTec' hold category within Oracle. However, it is not used by all Payments Officers, with some instead using other manual hold categories (such as 'awaiting authorisation'). Use of the FiscalTec hold enables all confirmed duplicates or matches 'to be investigated' requiring action by the Query Team to be easily identified within Oracle. It would also improve data quality as using the correct hold type will enable appropriate investigation.

See Finding 6 at Appendix A

We identified the following findings which we have reported to management and are outside of the direct control of NWSSP Accounts Payable and cannot be addressed without the agreement and cooperation of customer organisations:

1. Invoice Approval Workflow

The table below summarises the volume of PO and non-PO invoices processed by Accounts Payable in January 2018:

Jan-18	ABMU	AB	C&V	CT	HD	PHW	VEL	BCU	POWYS	WAST	Total
Invoices processed	29,902	22,579	25,941	14,152	16,211	2,339	6,543	27,936	3,791	3,880	**153,274**
Number of PO Invoices	10,854	12,424	14,149	6,428	6,828	1,477	1,670	12,403	1,631	1,523	**69,387**
% of PO Invoices	**36%**	**55%**	**55%**	**45%**	**42%**	**63%**	**26%**	**44%**	**43%**	**39%**	**45%**
Number of NonPO Invoices	19,048	10,155	11,792	7,724	9,383	862	4,873	15,533	2,160	2,357	**83,887**
% of NonPO Invoices	**64%**	**45%**	**45%**	**55%**	**58%**	**37%**	**74%**	**56%**	**57%**	**61%**	**55%**

55% of the total invoices processed by Accounts Payable in January 2018 were non-PO invoices. 31% of invoices that had been on hold for more than 30 days related to non-PO invoices awaiting authorisation or a retrospective purchase order to be raised.

For non-PO invoices received directly from the supplier, Accounts Payable contact the relevant officer within the customer organisation to request authorisation, usually by means of email or signature, or sometimes via retrospective purchase order. Invoices received by the customer organisation are typically authorised via signature or email when sent on to Accounts Payable for processing.

The Finance Academy P2P Group is leading on the development of a *No PO No Pay* policy, with a planned implementation date of June 2018. In time, this should reduce the volume of non-PO invoices processed and therefore reduce the resource requirement and risks associated with non-PO invoices.

In the meantime, and for invoices exempt from the No PO No Pay policy, invoice approval workflow should be implemented as a means for obtaining authorisation for non-PO invoices. The workflow offers a more robust mechanism for invoice authorisation than the current arrangements as it would enable non-PO invoices to be subject to the same Oracle approval hierarchy as purchase orders.

2. Invoice Matching Arrangements

Suppliers are set up as a three-way match on Oracle which requires means that a purchase order invoice will only be paid when:

- the invoice matches the purchase order, subject to set tolerances; and
- items on the purchase order have been receipted on Oracle.

Invoice on hold reports identify a substantial number of low value invoice lines on receipting hold. One organisation alone currently has 3635 invoice lines on receipting hold, 869 of which have a value of less than £50 and the quantity invoiced agrees to the quantity ordered (i.e. there is no overbill issue).

The cost associated with investigating and receipting low value items must be balanced with the risk of payment for low value items which may not have been received.

Procurement should work with customer organisations to identify instances where it would be appropriate to use 2-way matching requirements, as there is little or no benefit to be gained from requiring the items to be receipted on Oracle. Onus should then be placed on the requestor to notify Procurement/Accounts Payable if items have not been received, at which point the invoice can then be disputed with the supplier.

3. Tolerances

Tolerances are set within the Oracle. However, they are not consistent across all organisations:

	Qty Ord	Price	Max Ship	Freight
ABUHB	*None*	10%	£5	£15
ABMUHB	*None*	10%	£5	£0
CVUHB	*None*	10%	£5	£25
CTUHB	*None*	10%	£5	£25
WHSSC	*None*	1%	*None*	£25
PHW	5%	10%	£5	£40
VEL	*None*	10%	£5	£40
HDUHB	*None*	10%	£5	£0
BCUHB	*None*	0.01%	*None*	£20
PtHB	*None*	0.01%	*None*	£20
WAST	*None*	1.0%	*None*	£20

The Finance Academy P2P Group was responsible for reviewing current arrangements with a view to reaching agreement for consistent application across all organisations.

In 2016/17, agreement was reached to set standard tolerance levels at 10% for price and £5 for max ship (meaning that the maximum tolerance on an invoice line is 10% of the unit price up to a maximum line value of £5). However, we are informed that these have not been implemented as some customer organisations back-tracked on the agreement, as detailed in the table above.

4. PSPP Adjustments & Disputed Invoices

There is variation in the process for calculating PSPP compliance figures across customer organisations, specifically in terms of:

- who determines what adjustments should be made (i.e. AP or customer organisation);
- the nature of adjustments made; and
- whether or not the adjustment is made on Oracle or on the PSPP report.

Marking an invoice as "in dispute" within Oracle stops the clock for PSPP purposes. This is undertaken by Accounts Payable on instruction from Procurement or the customer organisation. The criteria for marking an invoice as in dispute is not defined and therefore there is inconsistent use of this function across customer organisations.

Finding 1: Supplier Masterfile Access (O)	Risk
Two Accounts Payable (AP) Managers have access to the supplier masterfile via a generic login so segregation of duties is potentially compromised. The Supplier Maintenance Team (SMT) Team Leader had requested view only access in June 2017 for the purpose of checking bank account amendment alerts. However, full access was granted in error by eEnablement. The AP Managers and SMT Team Leader were seemingly unaware of this. Four individuals within Accounts Payable/Procurement were given access to the 'VEL AP NWSSP Supplier Maintenance' responsibility profile in error by eEnablement: iii. The responsibility profile was reactivated in error for three individuals who previously had access to the profile prior to the establishment of the Supplier Maintenance Team in 2015. The errors were identified and corrected prior to this audit. Oracle does not record reactivation dates (only original start and end dates) so we were unable to determine the period of access. iv. A Payments Officer was given access in error in January 2018. This was immediately end-dated following identification by Audit.	Fraudulent or erroneous amendments to the supplier masterfile, potentially resulting in financial loss to customer organisations.
Recommendation 1	**Priority level**
The SMTSUPERVISOR generic login should be changed to view-only or end-dated with immediate effect.	**Medium**
Requests for Oracle access should be scrutinised by eEnablement to ensure that they are appropriate and any potential conflicts impacting on segregation of duties are identified.	

Checks should be undertaken by eEnablement to ensure that allocations of responsibilities in Oracle have been accurately processed.	
Management Response 1	**Responsible Officer/ Deadline**
Agreed – Access has now been sorted, view only access is adequate	Noel Williamson / Rick Searing 30th April 2018

Finding 2 – Bank Account Amendment Alerts (O)	**Risk**
Following the Oracle audit report deficiencies identified in the 2015/16 Accounts Payable audit, a new control was introduced where Oracle automatically sends an email alert to a generic email address when supplier bank details are amended. The generic email inbox is monitored by the AP Managers in North Wales who also have access to the supplier masterfile via a generic login, so there is no segregation of duties (see Finding 1). Sample testing of supplier bank amendments identified two instances where an alert should have been generated but could not be located in the designated email inbox. The AP Manager advised us that a call was logged with Version 1 in January 2018 after no alert emails were received for a day.	Fraudulent or erroneous amendments to the supplier masterfile may not be detected, potentially resulting in financial loss to customer organisations.
Recommendation 2	**Priority level**
Management should explore alternative methods of identifying and reviewing amendments to bank details within the supplier master file. This could include, for example, the feasibility of generating a system report of all active and inactive bank accounts and identifying amendments based on the start and end dates.	**Medium**

Management Response 2	Responsible Officer/ Deadline
Agreed – The issues identified were historic and the Procurement Services eEnablement Team have now made access secure, so no one has access apart from users with the Supplier Maintenance Oracle responsibility. In addition, the BCU Systems Team have developed a 'Local' report. This report is to be looked at to see if an All Wales Report can be produced.	Noel Williamson / Rick Searing Complete 31st May 2018

Finding 3: Duplicate Invoice (O)	Risk
We identified one duplicate payment for £147 in February 2018 as a result of a reminder letter and final notice letter both being processed for payment. It relates to TV Licensing where the invoice number is the TV licence reference number which remains the same each year. The second transaction was identified as a potential duplicate by the FiscalTec forensic software however the AP Officer recorded the status as "investigated" and the reason code as "no error", so no action was taken to cancel the duplicate prior to payment. Accounts Payable have taken action to recover the overpayment.	Duplicate Payments
Recommendation 3	**Priority level**

The AP Officer should be provided with refresher training on the investigation of potential duplicate invoices identified by FiscalTec. Spot checks should be undertaken to assess the appropriateness of status and reason codes used so further errors can be avoided.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
Agreed – AP Management will remind staff that they should not be paying on a reminder / Final Notice letter and should only pay against an invoice. Annual reviews of the Status & Reasons codes is currently being undertaken to ensure that the codes are appropriate and will then be communicated and reinforced to all staff Further training is to be provided to ensure all AP Officers are following the procedures correctly. In addition, a review session has been arranged with FiscalTec on 25/4/18 to ensure we are using the functionality effectively	Alison Ruckley 30th April 2018

Finding 4: Supplier Maintenance Process (D + O)	**Risk**
The process document does not clearly set out the step-by-step process for requesting, processing and checking additions/amendments to the supplier masterfile. Sample testing of 55 additions/amendments to the supplier masterfile confirmed that all could be verified to supporting documentation. However, five instances were identified where the New Supplier & Amendments Form had not been completed for a new supplier set-up, as required by the procedure. In addition, four of the five One-Off Payment Request Forms reviewed contained bank details but had not been authorised by an AP Manager, as required by the procedure. Non-compliant requests should be rejected by	Poor quality requests for additions/amendments to the supplier masterfile.

the Supplier Maintenance Team. The SMT Team Leader advised that they have been asked by some organisations to accept data loads on the basis that checking is undertaken by the Health Board prior to sending to AP. This arrangement is not reflected in the process document and poses an increased risk of fraud here as there is no purchase order, no invoice received by AP and no evidence to confirm payee bank details.	
Recommendation 4	**Priority level**
The Supplier Maintenance Process should be revised to clearly set out the step-by-step process from the point of request by Accounts Payable/Procurement to the processing and checking of additions/amendments by the Supplier Maintenance Team. The document should clearly identify the circumstances in which each type of form should be used, and identify any exceptions to the rules.	**Low**
Where customer organisations request a dataload to be used as the supporting documentation for bank details, consider obtaining prior agreement from the organisations finance department as acknowledgement and acceptance of the associated risks.	
Management Response 4	**Responsible Officer/ Deadline**
Agreed – A review of the process and guidance will take place to address the comments above and would welcome input from Internal Audit in respect of the concerns being raised.	Noel Williamson 31st May 2018

Finding 5: Non-Purchase Order Invoices (O)	Risk
For two of the 86 non-PO invoices sampled evidence of authorisation to pay had not been retained with the invoice. Authorised signatory lists were available for 16 of the invoices reviewed, in nine cases the authorised signatory was verified to the signatory list and the remaining seven signatures were illegible.	Payments are made without due authority.
Recommendation 5	**Priority level**
Authorisation to pay non-PO invoices must be obtained from the customer organisation and evidence retained with the invoice.	**Low**
Management Response 5	**Responsible Officer/ Deadline**
Agreed – Further investigations will take place to recover the authorisation of the two invoices and staff will be reminded of the importance of securing authorisation prior to payment, and retaining evidence of this with the invoice.	Sarah Potter 30th April 2018

Finding 6: FiscalTec Software (D)	Risk
Within the AP South Team, matches which are confirmed duplicates or require further investigation are passed by the Payments Officer to the Query Team where they will be cancelled or placed on hold. There is a small risk that these invoices could be paid if this is not actioned immediately by the Query Team. There is a 'FiscalTec' hold category within Oracle however it is not used by all Payments Officers, with some instead using other manual hold categories (such as 'awaiting	Duplicate payments

authorisation'). Use of the FiscalTec hold enables all confirmed duplicates or matches 'to be investigated' requiring action by the Query Team to be easily identified within Oracle. It would also improve data quality as using the correct hold type will enable appropriate investigation.	
Recommendation 6	**Priority level**
Confirmed duplicates or matches marked as "to be investigated" within FiscalTec should be immediately placed on hold by the Payments Officer, prior to passing to the Query Team for investigation.	**Low**
The FiscalTec hold should be used for all confirmed duplicates or matches 'to be investigated' by the Query Team.	
Management Response 6	**Responsible Officer/ Deadline**
Agreed – The Payment Supervisors have been informed	Alison Ruckley Complete

Audit Assurance Ratings

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

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

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

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, which are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

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

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

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

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

Primary Care Services

Contractor Payments

(All Wales)

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Substantial Assurance


CONTENTS

Review reference:	NWSSP-1718-12
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Draft report issued:	29th March 2018
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Final report issued:	12th April 2018
Auditors:	James Quance, Head of Internal Audit Donna Morgan, Principal Auditor
Executive sign off:	Dave Hopkins, Director of Primary Care Services
Distribution:	Neil Frow, Managing Director Andy Butler, Director of Finance & Corporate Services Dave Hopkins, Director of Primary Care Services Nicola Phillips, Head of Engagement & Support Services James Goddard, Head of Transaction Services Sandra Preece, All Wales Contracts Manager

Sandra Williams, Processing Lead (MWW)
Julie Turner, Processing Lead (SE)

Committee: Velindre NHS Trust Audit Committee for NWSSP

ACKNOWLEDGEMENTS

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

1. EXECUTIVE SUMMARY

1.1 Introduction and Background

A review of Primary Care Contractor Payments processed by NHS Wales Shared Services Partnership (NWSSP) Primary Care Services was completed in line with the 2017/18 Internal Audit Plan.

The relevant lead for the assignment is Dave Hopkins – Director (Primary Care Services).

Primary Care Services is responsible for the reimbursement of primary care contractors in Wales for medical, dental, ophthalmic and pharmacy/prescribing services.

The audit sought to provide assurance to the Velindre NHS Trust Audit Committee for NWSSP and Health Boards in Wales that the arrangements in place for the processing of timely and accurate payments to primary care contractors are robust.

1.2 Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of controls in place to administer timely and accurate payments to primary care contractors.

The following objectives were reviewed:

All

- Adequate policies and procedures are in place and up to date.
- The All Wales Medical, Dental, Pharmaceutical and Ophthalmic Performers lists are monitored and accurately processed.
- Payment control sheets are fully completed and appropriately authorised.

General Medical Services

- Global sum and MPIG payments are accurately calculated and processed based on patient list size and the Statement of Financial Entitlement.
- Payments in respect of QOF, enhanced services claims and rent/water/rates are accurately processed and agree to supporting documentation where required.

General Dental Services

- Annual contractual activity as agreed with the Health Boards is promptly and accurately input into the Compass system.
- Contract changes/variations are authorised by Health Boards prior to processing.
- Additional payments (i.e. travel & subsistence, non-domestic rates) are accurately processed and supported by claim forms.
- Timely notification to Health Boards of payments awaiting authorisation on Compass.

General Ophthalmic Services

- Ophthalmic payments are processed in accordance with the correct Welsh Government rates.
- Payments are accurately processed and supported by vouchers.
- Ophthalmic vouchers are submitted for processing in a timely manner.
- Vouchers are fully completed by both the practitioner and patient.

Pharmacy & Prescribing Services

- Scripts submitted by Welsh dispensing contractors are recorded, sorted and scanned.
- Scripts are processed and checked to ensure accuracy.
- Quality audits are undertaken to identify errors.
- Payment schedules (FP47) are authorised appropriately and submitted in a timely manner.
- Payments made to pharmacists are accurate and supported by appropriate backing documentation.
- Stakeholders receive accurate and timely monthly reports.

1.3 Associated Risks

The risks considered in the review were as follows:

i. Procedural guidance to support the processing of contractor payments has not been documented.

ii. Payments are incorrectly processed resulting in under/overpayment of contractors.

iii. Payments are made without appropriate authorisation or supporting documentation.

iv. Information provided to stakeholders is inaccurate.

2 CONCLUSION

2.1 Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with establishment controls within the Primary Care Services Contractor Payments is **Substantial Assurance**.

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

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

2.2 Assurance Summary

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

Assurance Summary					
1	General Medical Services				✓
2	General Dental Services			✓	
3	General Ophthalmic Services				✓
4	Pharmacy & Prescribing Services				✓

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

2.3 Design of Systems/Controls

The findings from the review have highlighted no issues that would be classified as a weakness in the system control/ design for contractor payments.

2.4 Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/ control for contractor payments. This is identified in the management action plan as (O).

3. FINDINGS & RECOMMENDATIONS

3.1 Summary of Audit Findings

The key findings by the individual objectives are reported in the section below with full details in Appendix A:

Follow Up

Our follow-up of the nine previously agreed recommendations arising from the 2016/17 audit confirmed that all recommendations had been addressed and actioned.

General Medical Services

- Policies and procedures were available to all staff via SharePoint.
- We randomly tested a sample of inclusions on the Medical Performers List. Testing did not identify any issues.
- We found no issues in respect of the process for the review and investigation of patient list numbers. Good practice was noted as it was evident that patient data was adequately managed by PCS; ensuring that quarterly capitation numbers were fed accurately into the global sum.
- A sample of enhanced services payments were selected for testing. It was evident from our sample that all claims had been correctly recorded on the payments spreadsheet, calculated at the correct rate and accurately input on Exeter.
- In addition, a sample of seniority payments were selected for testing. It was evident from our sample that all applications were appropriately checked, and the correct start dates had been input for those GPs.
- A walkthrough of the process for Global Sum and Minimum Practice Income Guarantee (MPIG) calculations and payments confirmed that the process was robust.
- A sample of payments made in respect of the Quality Outcomes Framework (QOF) aspirations and achievements were found to have been correctly calculated and applied in line with the figures received by PCS from the relevant Health Board.
- In addition, a sample of payments of costs in relation to rent/ water/ rates were found to be supported by appropriate documentation and there was evidence of checks being carried out by PCS staff prior to payment. The robust payment system was supported by thorough processing and documentation processes within the department.

- A random sample of BACS control sheets were reviewed for the period under consideration, and all had been appropriately endorsed and authorised prior to the expected processing dates.

General Dental Services

- Adequate policies and procedures were established and available to all staff via SharePoint.
- With regards to the Dental Performers List, it was evident that there were some issues processing one of the dentist's applications. Further details are provided at **Finding 1 at Appendix A**.
- A sample of dental contract payment schedules were selected for testing to ensure they had been fully completed and data had been accurately transferred to the Compass system. All contracts reviewed were fully complete and accurate, with information corresponding to that held on the Compass system.
- A sample of payment amendment schedules were selected at random for testing across the relevant Health Boards for the financial year. All contract changes tested had been received and authorised by the Health Board and all variations input had been checked and matched the information in Compass.
- During our review of additional payments, we tested a sample of travel and subsistence forms. No issues were identified.
- Re-imbursement of non-domestic rates paid to a sample of providers were also tested and the associated information was found to be complete and supported by appropriate documentation.
- As part of the testing carried out within annual contracts and changes, a sample of dental contracts selected was examined to ensure that authorisations had been received back from the Health Board for payment. The testing revealed no instances of payments being made without the appropriate Health Board authorisations being received.
- BACS control sheets were reviewed for the period under consideration, and all had been appropriately endorsed and authorised prior to the expected processing dates.

General Ophthalmic Services

- It was evident that policies and procedures were established and available to all staff via SharePoint.
- A sample of inclusions on the Ophthalmic Performers Lists were tested. No issues were identified.

- A sample of the various GOS claim forms used by practitioners to claim funding for carrying out eye tests was tested to ensure forms had been fully and accurately completed and signed off by the patient, and where applicable, the practitioner.
- GOS 1, 3, 4, 5 and 6 forms submitted by opticians selected at random from across all seven Health Boards were tested to ensure that claim forms were being completed correctly by both the patient and practitioner. Testing did not identify any issues.
- From our selected sample of BACS control sheets, all had been appropriately endorsed and authorised prior to the expected processing dates.

Pharmacy

- Policies and procedures were established and available to all staff via SharePoint.
- We randomly tested a sample of pharmacies on the Pharmaceutical Performers Lists (these included changes to ownership and new contracts). Testing did not identify any issues.
- A walkthrough of pharmacy accounts confirmed that the process for completing PS002 and PS003 forms for all batches of prescriptions submitted was robust.
- During a walkthrough of one pharmacy's account we found one instance where the variance was in excess of 10% (the pharmacy had declared 2,371 forms, but the actual was 2,719). This was highlighted on the Registration App and discussed with the Pharmacy for processing the following month. No further issues had arisen.
- In respect of processing of prescriptions, we randomly selected Pharmacy accounts and tested at random one prescription per account. Pricing processing was found to be satisfactory, with the correct prices being applied throughout.
- It was evident that quality audits were being undertaken in accordance with procedures and Audit and Quality Control was a standing agenda item at monthly Processing and Audit meetings.
- Sample testing of FP47A(C) forms confirmed that a check report had been produced and verified to the figures on the FP47A(C) in all cases. Testing also confirmed that all FP47A(C) forms had been produced in a timely manner and had been appropriately authorised by an approved signatory.
- All BACS control sheets tested were found to be complete; authorised in

line with NWSSP and Health Board signatory lists, and reconciled with supporting documentation.

- FP47A(C) forms which summarise the monthly payments to pharmacists were found to be complete and accurate for the sample tested.
- A sample of monthly payments was selected for testing. In each case a payment control sheet had been fully completed and properly authorised, and payments reconciled to supporting documentation.
- Review of a sample of FP47A(C) payment schedules confirmed that all reconciled to the corresponding PD1 reports which had all been published. The PD1 reports had been published within the target dates set by Welsh Government.

3.2 Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**1**	**0**	**1**

Finding 1 – All Wales Dental Performers List *(O)*	**Risk**
During testing of a sample of new additions to the dental performers list it was evident that the appropriate checks had not been undertaken in a timely manner for one of the five applications. This dentist had been provisionally included on the List for a period of three months, until 21st June 2017. However appropriate references to allow Primary Care Staff to conclude their checks had not been undertaken within the 3 months provisional period as a result of errors by a member of staff. We were advised that the dentist continued to work for a practice within the Health Board area despite not having the appropriate approval. On 1st December 2017 Primary Care Services staff sought advice from the Health Board upon the realisation that the application had been neglected. Appropriate references were subsequently obtained, and the Health Board agreed to approve the application from 21st June 2017.	Unauthorised applicants work within the Health Board as a result of ineffective checks and authorisations.
Recommendation 1	**Priority level**
Primary Care Services staff should consider a quarterly review of its master performers lists at a senior level to ensure that any omissions of this nature are detected on a timely basis.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**

This omission was picked up by PCS and action has been taken not only to rectify this operational issue but also internal performance protocols have been triggered to address this matter with the responsible member of staff. All teams will be reminded of the need to ensure appropriate documentation is obtained and check lists are accurately completed and approved. Contract Managers will complete a random sample check on a quarterly basis in order to provide evidence that this was an isolated incident. Introduction of this additional quarterly check will commence June 2018 and will be maintained until March 2019. During April 2019 a review of any anomalies identified by this additional check will be completed, enabling PCS to make an informed decision on the continuation of this additional checking process.	Sandra Preece, All Wales Contracts Manager Initial deadline to inform all staff of requirements = June 2018. Follow up review deadline = April 2019

Follow-up of Previously Agreed Recommendations arising from 2016/17 report

Rep. Ref	Recommendation	Responsibility and timescale	Status
Medium Priority			
1	*2016/17 GOS Audit (Prev Rec 1)* PCS should ensure that DBS certificates are destroyed and disposed of securely once the decision has been made to reject or accept applicants on to the Approved Ophthalmic Performers List, or within six months of the form being received in accordance with government guidance and the Standard Operating Procedure.	Sandra Preece, All Wales Contracts Manager August 2017	Actioned
2	*2016/17 GDS Audit (Prev Rec 1)* PCS should ensure that DBS certificates are destroyed and disposed of securely once the decision has been made to approve or deny inclusion on the Approved Dental Performers List, or at the minimum within six months of a decision being made in accordance with the Standard Operating Procedure.	Sandra Preece, All Wales Contracts Manager May 2017	Actioned
Low Priority			
3	*2016/17 GMS Audit (Prev Rec 1)* Primary Care Services Staff should ensure that only officers with appropriate authority approve application forms.	Nicola Phillips, Head of Engagement & Support Services	Actioned

Rep. Ref	Recommendation	Responsibility and timescale	Status
		September 2017	
4	*2016/17 GMS Audit (Prev Rec 2)* Primary Care Services staff should ensure that: • all application forms have been signed and dated to evidence that they have been appropriately checked and authorised; and all applications are checked and authorised by different officers to ensure that an adequate segregation of duties is maintained.	Nicola Phillips, Head of Engagement & Support Services September 2017	Actioned
5	*2016/17 GOS Audit (Prev Rec 2)* PCS staff should ensure that: • the number of claim forms received is reconciled to the number claimed to avoid overpayment; • all claim forms are fully completed; • all claim forms are signed by the patient and where applicable the practitioner; and • Payment is withheld for any claim forms that are not properly completed or signed off, and these are returned to the claimant.	James Goddard, Head of Transaction Services September 2017	Actioned

Rep. Ref	Recommendation	Responsibility and timescale	Status
6	*2016/17 GDS Audit (Prev Rec 2)* PCS staff should ensure that travel and subsistence claims are complete, authorised and substantiated by supporting documentation.	Sandra Preece, All Wales Contracts Manager May 2017	Actioned
7	*2016/17 Pharmacy (Prev Rec 1)* A check should be carried out to ensure that all current pharmacies are included in the Differentials Check. Controls should be reviewed to ensure that all declarations are promptly added to the Registration App and the list of pharmacies on the App remains accurate and up to date.	James Goddard, Head of Transaction Services / Neil Jenkins, Head of Modernisation & Technical Services August 2017	Actioned
8	*2016/17 Pharmacy (Prev Rec 2)* PCS should ensure that separate staff undertake corrections of live errors and audit errors to ensure an appropriate segregation of duties.	Julie James / Huw Davies Professional Services Team Managers Immediately	Actioned
9	2016/17 Pharmacy (Prev Rec 3) PCS should ensure that PD1 reports are published within the agreed Welsh Government target dates.	Keith Jones, Services Manager Immediately	Actioned

Audit Assurance Ratings

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Prioritisation of Recommendations

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Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Contact details

James Quance (Head of Internal Audit) – 01495 332048
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GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Corporate Services

Non-Medical Education Training Budget

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Substantial Assurance


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Distribution:	Neil Frow, Managing Director Andrew Butler, Director of Finance & Corporate Services Martin Riley, Head of Finance
Auditors:	Matthew Smith, Senior Auditor Sophie Corbett, Audit Manager
Committee:	Velindre NHS Audit Committee for NWSSP

ACKNOWLEDGEMENTS

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

1. EXECUTIVE SUMMARY

1.1 Introduction

A review of the Non-Medical Education Training Budget managed by NHS Wales Shared Services Partnership (NWSSP) has been completed in line with the 2017/18 Internal Audit Plan.

NWSSP executes contracts with universities across Wales for the provision of undergraduate training. The budget is in excess of £94m for 2017/18 and funds university courses, bursaries, salaries, expenses and allowances for students.

Commissioning numbers were determined by NWSSP Workforce, Education & Development Services (WEDS) in agreement with the Welsh Government. Management of the budget and university contracts was undertaken by NWSSP Finance.

In November 2016, the Cabinet Secretary for Health, Wellbeing and Sport approved the establishment of a new body, Health Education and Improvement Wales (HEIW), from October 2018 to oversee workforce planning, workforce design and education commissioning for the health sector in Wales. WEDS will transfer to HEIW as part of the new arrangements.

The Director of Finance & Corporate Services has requested a review of the control environment, to include funding, payment processes, and performance monitoring arrangements, ahead of the transfer in October 2018.

1.2 Scope and Objectives

The overall objective of this audit was to determine the adequacy and effectiveness of the arrangements in place for the management of the Non-Medical Education Training Budget.

The specific objectives reviewed were:

- budgeted costs were consistent with planned activity and hence budget outturn;
- contracts and invoices were approved in accordance with the scheme of delegation;
- students numbers were monitored to ensure that funding was only provided in respect of current students; and
- contractor (university) performance was monitored and action taken where appropriate to address any issues identified.

The scope of the audit was restricted to the finance function and did not review the role of WEDS in respect of the non-medical education training budget.

The Student Awards Unit (bursaries) was also excluded from the scope of this review, as it was the subject of a separate audit in 2014/15, which reported substantial assurance.

1.3 Associated Risks

The risks considered in the review were as follows:

i. Failure to achieve end of year financial balance as a result of:
    a. inaccurate assumptions in the budget setting process; and/or
    b. poor financial control environment resulting in overspend.

2 CONCLUSION

2.1 Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the management of the Non-Medical Education Training Budget is **Substantial** Assurance.

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

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

2.2 Assurance Summary

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

					
1	Budget Development				✓
2	Contract Arrangements			✓	
3	Budget Monitoring/Reporting				✓
4	Performance Monitoring				✓

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

2.3 Design of System / Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the system/control design for the management of the Non-Medical Education Training Budget. These are identified in Appendix A as *(D)*.

2.4 Operation of System / Controls

The findings from the review have highlighted no issues that are classified as a weakness in the operation of the designed system/control for the management of the Non-Medical Education Training Budget.

2.5 Summary of Recommendations

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

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations:	**0**	**1**	**2**	**3**

3 SUMMARY OF AUDIT FINDINGS

We identified the following examples of good practice:

- Commissioning levels are informed by the workforce needs identified within Health Board IMTPs and priorities identified by the Welsh Government, and take account of existing students yet to graduate.

  For 2017/18, the following scenarios were costed and scrutinised by the Strategic Education Development Group (SEDG) prior to recommendation for Ministerial approval:

  - IMTP Scenario (£97.8m)
  - Same commissioning levels as 2016/17 (£90.2m)
  - WG Scenario 1 – same budget as 2016/17 (£85.4m)
  - WG Scenario 2 – budget increased to £91.6ms
  - NWSSP Scenario (£93.4m)

    This is the IMTP scenario adjusted to reflect a number of different factors including, but not limited to:

    - Health Board capacity for new students
    - University capacity for courses
    - Extent to which workforce requirements will be met by existing students graduating
    - Service change
    - Welsh Government priorities

  The NWSSP scenario was approved by the Minister in February 2017.

- Five-year contracts are in place with each university. Contract values are agreed on an annual basis via variation orders for each course. Agreement of student numbers, on which the contract values are based, is timed to take account of higher student attrition levels at the start of the academic year.

- Course fees are negotiated with universities on an annual basis, with the majority being below the £9,000 per annum benchmark. For 2017/18, a fee of £7,500 was successfully negotiated with each university for pre-registration nursing courses, which accounts for more than 50% of the total cost attributed to course fees.

- Student attrition data for bursary students is collated from monthly monitoring returns and used to inform contracted student numbers, performance dashboards and budget setting for future years.

- Contract monitoring meetings are held on a periodic basis with each University in addition to an annual performance review.

We identified one **medium** priority finding:

Contract Values for Spring Cohort Pre-Registration Nursing Students

There is a second cohort for pre-registration nursing students in March each year. Variation orders are approved prior to this and are therefore based on the number of permitted commissions rather than actual students enrolled.

Comparison of the student numbers per the 2016/17 variation orders (i.e. on which the funding is based) to the number of students actually recruited as per the monitoring returns identified an over-payment of £127,500 in 2016/17 due to Bangor University under-recruiting against its allocated commissions.

Funding arrangements for the March Pre-Registration Nursing cohort are not explicit within the overarching contract and there is no provision to revise the contract value or recover fees for student places not filled.

However, the signed variation orders state that:

"*A fee is payable for each student who commences the course during the contract price period i.e. on an enrolment basis*"

In March 2018, the Head of Finance wrote to the universities concerned to inform them of changes to the funding arrangements for the spring cohort. The Head of Finance advised that the overpayment to Bangor University will be recovered via invoice by then end of July 2018.

See Finding 1 at Appendix A

We identified two **low** priority findings:

Control Document

A control document was developed to facilitate the transfer of Workforce, Education & Development Services (WEDS) from NLIAH to NWSSP in April 2013. This is a comprehensive document setting out the procedures and controls in place for the development and administration of the non-medical education and training budget.

The document has not been updated since it was written in 2013, and whilst the principles are still relevant, it should be updated in preparation for the transfer to HEIW in October 2018.

See Finding 2 at Appendix A

Monitoring Returns

Monitoring returns are not required for salaried courses, which account for 17 of the 51 courses commissioned. Monitoring returns enable the collation of student attrition information, which informs contracted student numbers, performance dashboards and budget setting for future years.

See Finding 3 at Appendix A

MANAGEMENT ACTION PLAN

Finding 1: Contract Values for Pre-Reg Nursing Spring Cohort	Risk
Student numbers for the Pre-Registration Nursing spring cohort are based on allocated commissions as the variation order is agreed well ahead of the cohort commencing study. Analysis of the student numbers per the variation orders compared to the students actually recruited for the autumn cohort revealed an overpayment of £127,500 to Bangor University during 2016/17.	Payment to universities for students not recruited, resulting in overpayment
Recommendation 1	**Priority level**
Ensure that the overpayment to Bangor University is recovered. A tolerance level should be built into the overarching contracts to enable the clawback of fees if actual student numbers fall below an agreed percentage of allocated commissions, on which the contract values are based.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
Accepted and implemented. The system has already been revised. All University Deans were informed in the February 2018 contract meetings and a follow up letter has been issued to all Universities outlining the revised process. An invoice has been raised to reclaim the funding from Bangor University	Martin Riley June 2018

Finding 2: Control Document *(D)*	Risk
A control document was developed to facilitate the transfer of Workforce, Education & Development Services (WEDS) from the National Leadership & Innovation Agency for Healthcare (NLIAH) to NWSSP in April 2013. This is a comprehensive document setting out the procedures and controls in place for the development and administration of the non-medical education and training budget. The document has not been updated since it was written in 2013.	n/a
Recommendation 2	**Priority level**
The control document should be updated in preparation for the transfer to HEIW in October 2018.	**Low**
Management Response 2	**Responsible Officer/ Deadline**
Noted It is already planned that a similar document will be produced on transfer from NWSSP to HEIW. It should be noted that this budget / area of work is significantly different to core Velindre business. Therefore, the control document was written to inform the Velindre Board of the nature of the budget and the controls, processes and governance arrangements in place to manage it and to provide them with assurance on transfer from ABMu. Once transferred the Velindre and NWSSP FCPs etc… were adopted to manage the budget.	Martin Riley September 2018

Finding 3: Monitoring Returns *(D)*	Risk
Monitoring returns are not required for salaried courses, which account for 17 of the 51 courses commissioned. Monitoring returns enable the collation of student attrition information which informs contracted student numbers, performance dashboards and budget setting for future years.	Student attrition data for salaried courses maybe in inaccurate, potentially impacting on the robustness of the budget setting process for future years.
Recommendation 3	**Priority level**
Monitoring returns should be required for salaried courses.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
Agreed Attrition on salaried courses is very low, often zero so risk is low. However, it is recognised that, where appropriate, student monitoring returns will be helpful to budget management. An exercise across all salaried courses will be undertaken and where it is deemed appropriate student monitoring will be introduced for the 2018/19 academic year cohort.	Martin Riley September 2018

Audit Assurance Ratings

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

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

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

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

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

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

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

MEETING	Velindre NHS Trust Audit Committee for NHS Shared Services Partnership
DATE	24th April 2018
AGENDA ITEM	3.5
PREPARED BY	Simon Cookson, Director of Audit & Assurance
PRESENTED BY	Simon Cookson, Director of Audit & Assurance
TITLE OF REPORT	External Quality Assessment

TITLE OF REPORT

External Quality Assessment

PURPOSE OF REPORT

The report sets out the results of the External Quality Assessment of NWSSP's Audit & Assurance Services. The assessment was undertaken by the Chartered Institute of Internal Auditors.

1. INTRODUCTION

In February and March 2018 Audit & Assurance Services were subject to a formal External Quality Assessment. This assessment is required by the Public Sector Internal Audit Standards (PSIAS) and was undertaken by The Chartered Institute of Internal Auditors (IIA). Their report will be presented to the Velindre Audit Committee for Shared Services on 24 April 2018 and will subsequently be presented to the Audit Committees of all NHS Wales organisations. Copies will also be sent to all Audit Committee Chairs and Board secretaries.

2. RESULTS

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**.'"

The report notes a number of Key Achievements which are contained on page 4 of the report.

The report also includes:

- A SWOT analysis (page 6)
- a matrix measuring Audit & assurance's position against the IIA's criteria of effective internal audit (page 7)
- 2 suggestions for further improvement (page 8)
- a list of interviewees and comments (page 10)
- an analysis of the IIA's survey of Audit Committee Chairs and Board Secretaries (page 11).

The two suggestions for improvement cover (together with our response):

- As NHS organisations develop further their approach to Board Assurance, Internal Audit will have the opportunity to focus their work even more closely to key risks, taking into account the work of other assurance providers and the strength of the first and second lines of defence within individual organisations.
- There are potential opportunities to make our use of the TeamMate software more efficient and we will review the steps we undertake on our audits to identify where any efficiencies may exist.

NWSSP Audit & Assurance is rightly pleased with the results of the EQA and will seek to build on this performance to improve further the effectiveness of Internal Audit as part of a longer term Internal Audit and Assurance strategy for the NHS in Wales.

3. RECOMMENDATION

The Audit Committee are asked to:

- **NOTE** the attached report
- **AGREE** to it being circulated to all Audit Committee Chairs, Board Secretaries and to Welsh Government

Chartered Institute of Internal Auditors

EXTERNAL QUALITY ASSESSMENT (EQA) REPORT FOR

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

Prepared by Dr Sarah Blackburn on behalf of

The Chartered Institute of Internal Auditors

March 2018

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Disclaimer: The EQA Review was concluded in March 2018 and provides management and the Audit Committee with information about Audit and Assurances provided to the NHS in Wales as of that date. Future changes in environmental factors and actions taken to address recommendations, may have an impact upon the operation of Internal Audit in a manner that this report cannot anticipate. Considerable professional judgment is involved in evaluating. Accordingly, it should be recognised that others could draw different conclusions. This report is provided on the basis that it is for your information only and that it will not be quoted or referred to, in whole or part, without the prior written consent of Chartered IIA.

EXECUTIVE SUMMARY

NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Services is a Division of the NWSSP, and was formed in April 2011 to provide internal audit, specialist audit, and consultancy services to all Trusts and Health Boards across the NHS in Wales and to the NWSSP itself: a total of eleven client organisations. The Director of Audit and Assurance has eight Heads of Internal Audit reporting directly to him and a total of 56 team members. There are specialist teams providing assurance over Capital and Estates, and Information Management and Technology. We have not reviewed services provided to organisations outside NHS Wales.

This external quality assessment was conducted as a validation of the self-assessment carried out by NWSSP Audit and Assurance Services using the methods prescribed by Chartered Institute of Internal Auditors. We reviewed a wide range of documentary evidence, surveyed representative stakeholders and interviewed members of the Internal Audit teams and stakeholders. We have provided the Director of Audit and Assurance with our comments in a detailed standard-by-standard checklist as a separate document.

Conformance to the International Professional Practice Framework (IPPF) and to the Public Sector Internal Audit Standards (PSIAS)

The Institute of Internal Audit's (IIA's) International Professional Practice Framework (IPPF) includes the Definition of Internal Auditing, Code of Ethics, Core Principles and *International Standards*. The Public Sector Internal Audit Standards are wholly aligned with these standards. There are 64 fundamental principles to achieve with 118 points of recommended practice. It is our view that NWSSP Audit and Assurance Services conforms to all of these principles, as summarised in the table below, 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"**.

Summary of IIA Conformance	Standards	Does not Conform	Partially Conforms	Generally Conforms	Total
Definition of IA and Code of Ethics	Rules of conduct			12	**12**
Purpose	1000 - 1130			8	**8**
Proficiency and Due Professional Care (People)	1200 - 1230			4	**4**
Quality Assurance and Improvement Programme	1300 - 1322			7	**7**
Managing the Internal Audit Activity	2000 - 2130			12	**12**
Engagement Planning	2200 - 2600			21	**21**
	Total			64	**64**

Key Achievements

NWSSP Audit and Assurance Services has firm foundations based on an Internal Audit Charter, an Audit Manual and meticulous quality assurance processes. The International Standards (PSIAS) are embedded into the TeamMate audit software and auditors are reminded of the Standards and their ethical responsibilities at every stage of their audit work. The TeamMate software has also enabled a consistent and disciplined approach to audit work across different sites and audit clients. In one client organisation it has been shared with management to assist in the follow through of agreed actions.

NWSSP Audit and Assurance Services is well respected by management and the Audit Committees for its professionalism and is seen as a source of risk, control and governance advice. With a resource base of 57 including the Director of Audit and Assurance the team has a good spread of skills and can offer career development and specialist audits in Capital, Estates and Information Management and Technology. Specialist guest auditors including clinicians enable them to cover a wide range of operational risks. A scheme in conjunction with Swansea University has sourced new talent at the undergraduate level. There is a budget allocation to supplement in-house expertise through co-sourcing as appropriate.

There is an effective and consultative planning process including recognition of the current business strategy and good alignment to strategic risks. Audit Committee chairs have commented favourably on the flexibility of planning to accommodate changing needs for assurance.

The recipients confirm that NWSSP Audit and Assurance Services is delivering the required assurance (audit report ratings encompass all four grades of opinion) and a degree of advice and insight particularly in drawing together lessons learned and examples of good practice from all parts of NHS Wales and beyond.

Scope for Further Development

The Chartered Institute regards conformance to the IPPF as the foundation for effective internal audit practice. However, our EQA reviews also seek feedback from key stakeholders and we benchmark each function against the diversity of professional practice seen on our EQA reviews and other interviews with chief audit executives, summarised in an Internal Audit effectiveness matrix. We then interpret our findings into scope for further development based upon the wide range of guidance published by the Chartered Institute. It is our aim to offer advice and a degree of challenge to help internal audit activities continue their journey towards best practice and excellence.

In the following pages we present this advice in three formats.

- An analysis to recognise the accomplishments of the team and to highlight potential threats and opportunities for development.
- A matrix describing the key criteria of effective internal audit, highlighting the level NWSSP Audit and Assurance Services has achieved and hence the potential for further development.
- Some suggestions for further development which NWSSP Audit and Assurance Services could use as a basis for an action plan.

For us the main areas for discussion are around:

- Audit Coverage – links to strategic objectives and risks and other assurance providers.
- Achieving efficiency in the audit methodology.

We should stress, however, that the internal audit function generally conforms. The existence of opportunities for improvement, better alternatives, or other successful practices does not reduce a generally conforms rating.

Chartered Institute of Internal Auditors

SWOT analysis: NWSSP Audit and Assurance Services

What works well (Strengths)	What could be done better (Weaknesses)
• A highly competent, well qualified and technically proficient Director of Audit and Assurance who has successfully upgraded NWSSP Audit and Assurance Services • An audit service that is listened to, respected, trusted with the freedom to do its job. • A team with well qualified staff with a good mix of experience, knowledge and skills including IT, capital and estates and support for new qualifications and continuing professional development. • The professional in-house team is enriched with guest auditors, plus student secondees, supplemented by appropriate expert co-source partners • The team has a commitment to quality and continuous improvement. • There is extensive coverage of a wide range of risks across the client organisations and appropriate involvement in change and projects. • A well organised and structured audit methodology which is used consistently. • Written reports are effective with significant commitment of management to change. • The progress reports to the Audit Committee are clear and address significant issues. • General conformance to the IIA's professional practice framework: a solid foundation of IA quality	• Some stakeholders are concerned about the timeliness of internal audit reporting • Some written reports are very lengthy: consider whether all the detail included is necessary for full understanding of the risks and agreed actions.
• **What could deliver further value (Opportunities)**	• **What could stand in your way (Threats)**
• Use of Board Assurance Frameworks, when developed, to focus audit coverage and improve co-ordination with other assurance providers. • Whilst there is specialist coverage of capital and IMT risks, some client organisations would like clearer governance nationally and more audit coverage at the local level from NWSSP. • The introduction of a relevant IT audit analytical tool to provide more efficient and effective analytical review of data within assignments. • Refinement of methodology on TeamMate to streamline assignments • The Director of Audit and Assurance could explore further opportunities to share the NWSSP audit experience with the wider internal audit community through seminars, presentations etc. to raise its profile and help to attract potential recruits. • The Director of Audit and Assurance (who is a chartered public finance accountant) could consider validating his experience and raising the profile of internal audit (to attract potential recruits) by seeking a professional qualification as a chartered internal auditor. The Chartered IIA Competency Framework emphasises leadership skills as well as technical proficiency.	• Any delays to management development of Board Assurance Frameworks linked to objectives, risks and controls: these are needed to support more focused risk and assurance-based Audit Plans • Unclear governance requirements as regards Informatics in NHS Wales • Any tendency to present too much detail to the Audit Committees • Any unplanned and rapid turnover of the present staff since recruitment has been a challenge.

Chartered Institute of Internal Auditors

Internal Audit Maturity Matrix: Audit Team's Effectiveness highlighted

Assessment	IIA standards	Focus on performance, risk and adding value.	Coordination and maximising assurance	Operating with efficiency	Quality Assurance and Improvement Programme
Excellent	Outstanding reflection of the IIA standards, in terms of logic, flow and spirit. Generally conforms in all areas.	IA alignment to the organisation's objectives risks and change. IA has a high profile, is listened to and is respected for its assessment, advice and insight.	IA is fully independent and is recognised by all as a 3rd line of defence. The work of assurance providers is coordinated with IA reviewing reliability of other providers.	Assignments are project managed to time and budget using tools/techniques for delivery. IA reports are clear, concise and produced promptly.	Ongoing efforts by IA team to enhance quality through continuous improvement. QA&IP plan is shared with and approved by AC.
Good	The IIA Standards are fully integrated into the methodology – mainly generally conforms.	Clear links between IA engagement objectives to risks and critical success factors with some acknowledgement of the value added dimension.	Coordination is planned at a high level around key risks. IA has established formal relationships with regular review of reliability.	Audit engagements are controlled and reviewed while in progress. Reporting is refined regularly linking opinions to key risks.	Quality is regarded highly, includes lessons learnt, scorecard measures and customer feedback with results shared with AC
Satisfactory	Most of the IIA Standards are found in the methodology with scope to increase conformance from partially to generally conform in some areas.	Methodology requires the purpose of IA engagements to be linked to objectives and risks. IA provides advice and is involved in change but criteria and role require clarity.	The 3 lines of defence is model is regarded as important. Planning of coordination is active and IA has developed good working relationships with some review of reliability.	Methodology recognises the need to manage engagement efficiency and timeliness but further consistency is needed. Reports are informative and valued.	Clear evidence of timely QA in assignments with learning points and coaching. Customer feedback is evident. Wider QA&IP may need formalising
Needs improvement	Gaps in the methodology with a combination of non-conformances and partial conformances to the CIIA Standards.	Some connections to the organisation's objectives and risks but IA engagements are mainly cyclical and prone to change at management request.	The need to coordinate assurance is recognised but progress is slow. Some informal coordination occurs but reviewing reliability may be resisted.	Multiple guides that are slightly out of date and form a consistent and coherent whole. Engagement go beyond deadline and some are deferred	QC not consistently embedded across the function. QA is limited / late or does not address root causes
Poor	No reference to the IIA Standards with significant levels of non-conformance.	No relationship between IA engagements and the organisation's objectives, risks and performance. Many audits are adhoc.	IA performs its role in an isolated way. There is a feeling of audit overload with confusion about what various auditors do.	Lack of a defined methodology with inconsistent results. Reports are usually late with little perceived value.	No evidence of ownership of quality by the IA team.

Suggestions for Further Enhancement / Further Development

We offer some ideas to improve the effectiveness and efficiency of internal audit. They are presented in order of importance rather than in Standards order, and do not detract from the Generally Conforms opinion.

Standard 2010 Planning and Standard 2050 Coordination and Reliance	**Response & action date**
NWSSP demonstrates coverage by domain and by risks. Risk-based planning has been limited in some client organisations by the maturity of Board Assurance Frameworks (BAF) and their integration with risk registers. However, where BAF exist the Annual Audit Plans should be able to show a clear path from the Business plans, risk and assurance maps to the need for independent assurance to complement the first and second lines of defence, assessing the reliability of the work of other assurance providers.	We will continue to work with individual Health bodies and through the all-Wales Audit Committee Chairs and Board Secretaries Groups to support the introduction of comprehensive Board Assurance Frameworks and Corporate Risk Registers. The introduction of comprehensive Board Assurance Frameworks will then facilitate a more systematic assessment of where Boards obtain their assurances from which will enable a more focussed risk based plan that balances the assurance, advice and insight needs of each Health body. **Action date:** will vary by Health body and is largely driven by them individually, but expectation is that this will be in place for the 2019/20 audit planning process.
Standard 2210 Engagement Objectives	**Response & action date**
The audit assignment approach is traditional with control objectives and related risks – the Annual Plan links the audit back to its domain and/or relevant risk. The approach is hard wired into the TeamMate software which requires the auditor to list expected controls and then actual controls. The actual controls are evaluated for design adequacy and substantive testing only proceeds, if management has requested quantification of the impact. This is an efficient approach that eliminates waste. However, we discussed whether listing the expected controls is needed: if the expected controls are the documented Standard Operating Procedures then the auditor could just cross refer. If the expected controls are just an auditor's expectation, then that risks coming over as naïve and a textbook approach. It is also unnecessary as the evaluation of the actual controls is sufficient. We suggest looking again at the efficiency of TeamMate now it is bedded in, involving the auditors who use it daily to streamline the approach.	We will address this specific point within a wider review of the structure and efficiency of the TeamMate approach to seek opportunities to streamline further our methodology. **Action date:** September 2018.

IIA Grading definitions

Appendix 1

The following rating scale has been used in this report.

Overall Audit Grading	
Generally Conforms (GC)	The assessor has concluded that the relevant structures, policies, and procedures of the activity, as well as the processes by which they are applied, comply with the requirements of the individual Standard or element of the Code of Ethics in all material respects. For the sections and major categories, this means that there is general conformance to a majority of the individual Standards or elements of the Code of Ethics, and at least partial conformance to the others, within the section/category. There may be significant opportunities for improvement, but these must not represent situations where the activity has not implemented the Standards or the Code of Ethics, has not applied them effectively, or has not achieved their stated objectives. As indicated above, general conformance does not require complete/perfect conformance, the ideal situation, successful practice, etc.
Partially Conforms (PC)	The assessor has concluded that the activity is making good-faith efforts to comply with the requirements of the individual Standard or element of the Code of Ethics, section, or major category, but falls short of achieving some major objectives. These will usually represent significant opportunities for improvement in effectively applying the Standards or Code of Ethics and/or achieving their objectives. Some deficiencies may be beyond the control of the activity and may result in recommendations to senior management or the board of the organisation.
Does Not Conform (DNC)	The assessor has concluded that the activity is not aware of, is not making good-faith efforts to comply with, or is failing to achieve many/all of the objectives of the individual Standard or element of the Code of Ethics, section, or major category. These deficiencies will usually have a significant negative impact on the activity's effectiveness and its potential to add value to the organisation. They may also represent significant opportunities for improvement, including actions by senior management or the board.

Often, the most difficult evaluation is the distinction between general and partial. It is a judgement call keeping in mind the definition of general conformance above. The assessor must determine if basic conformance exists. The existence of opportunities for improvement, better alternatives, or other successful practices does not reduce a "generally conforms" rating.

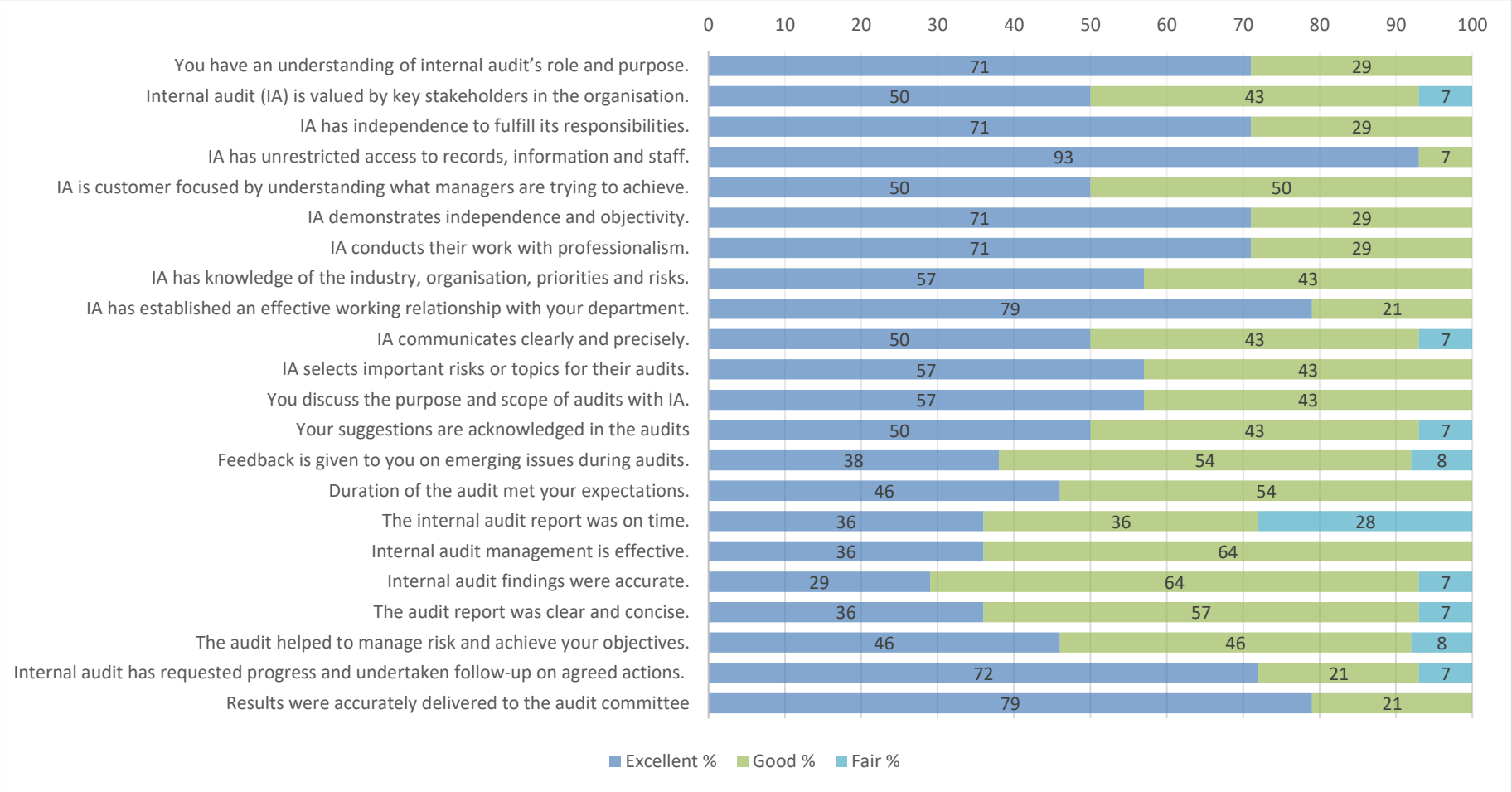
Stakeholder Interviews and Feedback

Interviewees	Title/Position
Neil Frow	Managing Director, NWSSP
Martin Veale	Audit Committee Chair Velindre / NWSSP
Ceri Stradling	Audit Committee Chair BCU
Martin Sollis	Audit Committee Chair ABMU
Kate Eden	Audit Committee Chair Public Health Wales
Pamela Wenger	Director of Corporate Governance ABMU
Jacqueline Maunder	Head of Corporate Services and Board Secretary NWSSP
IA Team members –	
Simon Cookson	Director of Audit and Assurance
Paula O'Connor	Head of Internal Audit (Swansea Team)
Neil Thomas	Deputy Head of Internal Audit (Swansea Team)
Emma Samways	Deputy Head of Internal Audit (Cardiff Team)
Kimberley Rowe	Principal Auditor (Cardiff Team)

A selection of comments from the interviews and the survey (p11):

- The internal audit services provided by the NHS Wales Shared Services Partnership (NWSSP) are professional and are scoped effectively and demonstrate effective compliance against the Chartered Institute of Internal Auditors International IPPF standards.
- The regular communication with the Chair of Audit Committee regarding the audit plan and its progress has improved in the last two years. Their willingness to adapt the plan and the scope of audits in light of specific issues is also recognised.
- The regular dialogue enables regular feedback on emerging risks and key priorities.
- The [audit] managers have been excellent in their approach. They always meet with us in person. You can challenge the recommendations and internal audit will explain why they made them.
- There needs to be a strengthened shared ownership and delivery against the IA plan. On occasions where key KPIs [deadlines] are missed this can often be a failure on the part of the organisation as opposed to IA function. Perhaps escalating when reviews are being excessively delayed.
- We should have one formal follow up process for NHS Wales

In addition to the interviews 14 people completed an anonymous survey giving their feedback on NWSSP Audit and Assurance Services.



These responses are referenced in the report. Overall the survey reflects a competent and effective internal audit service. The only area of potential concern is the timeliness of audit reporting.

MEETING	Velindre NHS Trust Audit Committee for NHS Shared Services Partnership
DATE	24th April 2018
AGENDA ITEM	4.1
PREPARED BY	Gillian Gillett, Financial Audit Manager, Wales Audit Office
PRESENTED BY	Gillian Gillett, Financial Audit Manager, Wales Audit Office
TITLE OF REPORT	Wales Audit Office Progress Report

TITLE OF REPORT

Wales Audit Office Progress Report

PURPOSE OF REPORT

To provide an update to the Audit Committee in relation to progress made by External Audit.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit Position Statement – **Velindre NHS Trust – NHS Wales Shared Services Partnership**

Date issued: April 2018

Document reference: APS042018

Contents

Progress update

About this document

1 This document provides the Velindre NHS Trust's Audit Committee for Shared Services with an update on current and planned Wales Audit Office work, together with information on the Auditor General's planned programme of NHS-related studies and publications.

Assurance arrangements

2 Details of the finalisation of our audit assurance arrangements for 2018 are set out in Exhibit 1.

Exhibit 1: assurance arrangements

Area of work	Current status
Assurance arrangements 2018	Presented to Audit Committee February 2018

Audit update

3 The progress of the audit assurance work detailed in our 2018 assurance arrangements report is set out in Exhibit 2.

Exhibit 2: audit work update

Area of work	Scope	Planned timetable	Current status
Audit assurance requirements			
Internal audit	Assess compliance with Public Sector Internal Audit Standards (PSIAS). Review annual audit plan and status of audits.	January 2018	Complete
Payroll	Document system, identify key controls and controls testing of exception reports.	March 2018	Complete
General Medical Service	Document system, identify key controls and controls testing of global sum payments (capitation lists and patient rates).	February / March 2018	Complete
Pharmacy & Prescribed drugs	Document system, controls testing of payments to pharmacists (checks undertaken by the	February / March 2018	Complete

Area of work	Scope	Planned timetable	Current status
	Professional Services Team and drug tariff rates).		
Accounts Payable & Public Sector Payment Policy	Document system and review the process of how PSPP works in NWSSP.	February / March 2018	Complete
Procurement	Review of contracts awarded with a value greater than £1 million	April 2018	Work planned for April 2018
Welsh Health Legal	Document an understanding of the system, evaluate the competence, capability and objectivity of NWSSP LARS staff and the appropriateness of the work. Test a sample of clinical negligence cases, reviewing the information collated on the Legal and Risk management system	January / February 2018	Complete
Nationally Hosted NHS IT systems – IT audit work	Review our understanding of the general IT controls and identify key controls. Review, document and evaluate the IM&T environment and application controls. Test a sample of IT controls.	January / March 2018	Complete
Reporting to NWSSP			
Nationally Hosted NHS IT systems	Summary of work and any matters arising that need to be considered by the NWSSP management	June 2018	Report planned for July
Manangement letter	Summary of work and any matters arising that need to be considered by the NWSSP management. This report will also include any issues relating to NWSSP identified by other Welsh health auditors.	June 2018	Report planned for July

NHS-related national studies

4 The Audit Committee may also be interested in the programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded by the National Assembly and are presented to the National Assembly's Public Accounts Committee to support its scrutiny of public expenditure.

5 Exhibit 3 provides information on the NHS-related or relevant national studies published in the last 12 months. It also includes all-Wales summaries of work undertaken locally in the NHS. Exhibit 4 provides information on studies currently underway.

Exhibit 3: NHS-related national studies recently published by the Wales Audit Office

Topic	Details
The National Procurement Service	We have examined whether the National Procurement Service is helping to deliver value for money in public spending and is fit for the future. Indicative figures show that public bodies in Wales spent £234 million through National Procurement Service frameworks and contracts in 2016-17, £222 million of which related to members' organisations. However, public bodies are not using NPS frameworks as much as anticipated, resulting in concerns over its funding, less than anticipated savings – £14.8 million reported for 2016-17 – and with many of its members dissatisfied. **Published: 30 November 2017** http://www.audit.wales/publication/national-procurement-service
District Nursing Services in Wales: A checklist for Board Members	We have produced a checklist with the aim of supporting NHS board members to seek assurance on how local district nursing resources are managed and the progress made to address our local audit recommendations. **Published: 7 December 2017** http://www.audit.wales/publication/district-nursing-services-wales

Topic	Details
Informatics systems in NHS Wales	We examined systems provided by the NHS Wales Informatics Service. The high-level vision for NHS informatics is clear and goes back more than a decade. Despite the clear vision, the NHS has not clearly prioritised resources available. There has not been an agreed plan for funding the delivery of the vision nor a clear timeframe. And there has been disagreement within the NHS about the balance between local discretion to develop new systems and the delivery of national systems across all of NHS Wales. Positively, the NHS is now moving towards greater clarity on these areas. The report also identifies weaknesses in the governance and oversight of NHS Wales Informatics Service. The report found that: there is a lack of independent scrutiny of NWIS; lines of accountability need to be clearer; and that reports on progress and performance have tended to be overly positive and did not paint a balanced picture. **Published: 10 January 2018** http://www.audit.wales/publication/informatics-systems-nhs-wales

Exhibit 4: NHS-related national studies currently underway by the Wales Audit Office

Topic	Details
Picture of public services	Report anticipated to be published April – May 2018
Diagnostic radiology – all Wales summary of local work	Report anticipated to be published April – May 2018
GP out of hours – all Wales summary of local work	Report anticipated to be published April – May 2018
Interpretation and translation services	Report anticipated to be published April – May 2018

Good practice

6 In addition to the audit work set out above, 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. Our Good Practice Exchange team also facilitates a programme of shared learning events. Exhibit 5 provides information on events, further details can be found on the Good Practice Exchange section on the Wales Audit Office website.

Exhibit 5: Upcoming events from the Good Practice Exchange

Event	Details
Moving from outputs to outcomes	This webinar will look at the background knowledge, awareness and behaviours necessary to move towards an outcomes focussed approach and will share how other bodies are moving forward with measuring their outcomes. The goals of the Well-being of Future Generations (Wales) Act 2015 require public services to evidence how their work improves the lives of the Welsh public. This means moving away from demonstrating the outputs of our work, which are easier to measure but tell us little, to demonstrating the outcomes of our work, which are more difficult to measure but tell us about the real difference that we make to people's lives. This seminar is aimed at staff who are designing, delivering and evaluating public services. **16 May 2018, 12:00pm – 1:30pm (webinar)** **https://www.wao.gov.uk/events/moving-outputs-outcomes**

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Gwefan: www.archwilio.cymru

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	24th April 2018
AGENDA ITEM	5.1
REPORT PREPARED BY	Craig Greenstock, Counter Fraud Manager
PRESENTED BY	Craig Greenstock, Counter Fraud Manager
TITLE OF REPORT	Counter Fraud Progress Report 31st March 2018

PURPOSE

The purpose of the Counter Fraud Progress Report is to provide the Audit Committee with and update report of all NHS Counter Fraud work undertaken, for the period ended 31st March 2018, within the Health Body. The report's style has been adopted, in consultation with the Finance Director, with the prime objective of informing, and updating, the Audit Committee members of the outline detail of significant changes in cases that have been worked on during the period, in addition to any current operational issues.

INTRODUCTION

In compliance with the Secretary of State for Health Directions on Countering Fraud in the NHS, regular progress update reports are required to be presented to the Health Bodies' Audit Committee, which should outline the current standing of any Counter Fraud and Corruption work carried out within the Health Body as at the date of the Audit Committee meeting.

The Local Counter Fraud Specialist (LCFS) to plan and agree, with the Finance Director, an Annual Work-Plan containing a suggested number of days that is a framework on which to build and develop robust Counter Fraud arrangements and which recommends, to the Health Bodies' Audit Committee, the resources necessary to undertake work effectively across the areas of action outlined in NHS Counter Fraud Policy and Procedures.

Fraud committed against the NHS has a financial impact, since the Health Body would have suffered an initial financial loss as a result of the subject's actions.

CURRENT POSITION

The work of the Health Body's Counter Fraud staff is undertaken in order to attempt reduce the level of fraud and/or corruption within NWSSP to a minimum and keep it at that level in order to free up resources for patient care.

Any negative publicity received as a result of media reports may have an effect on the reputation of the Health Body. However, by publicising any action taken against the individual(s) would also show that fraud committed against the NHS will not be tolerated and this may also serve as a deterrent to others.

ACTIONS/RECOMMENDATION TO THE AUDIT COMMITTEE

The Audit Committee is asked to:

- **RECEIVE** and **DISCUSS** the Counter Fraud Progress Report

NHS WALES
SHARED SERVICES PARTNERSHIP

Audit Committee - 24th April 2018

Counter Fraud Progress Report
as at 31st March 2018

CRAIG GREENSTOCK
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

NHS WALES SHARED SERVICES PARTNERSHIP

AUDIT COMMITTEE 24th APRIL 2018

COUNTER FRAUD PROGRESS REPORT

Mission Statement

To provide the NWSSP with a high quality NHS Counter Fraud Service, which ensures that any report of fraud is investigated in accordance with the Directions for Countering Fraud in the NHS and all such investigations are carried out in a professional, transparent and cost effective manner.

1. INTRODUCTION

1.1 In compliance with the Directions on Countering Fraud in the NHS, I detail below the standing of the current Counter Fraud and Corruption work carried out, by the nominated Local Counter Fraud Specialists, during the period ended 31st March 2018.

The Progress Report's style has been adopted, in consultation with the Velindre NHS Trust and NWSSP's Finance Directors, with the prime objective of informing, and updating, the Audit Committee members of the outline detail of significant changes in cases worked on during the period and any current operational issues.

Progress against the NWSSP Annual CF Work-Plan of **75days,** has been reported in **Appendix 1** and as at 31st March 2018, **75days of** Counter Fraud work has been undertaken and this has also been reported in **Appendix 1**.

Any significant changes in the progress/work undertaken are outlined in point 2 below**.**

2. CURRENT CASE UPDATE

There are currently five (5) cases currently under investigation which are at varying stages. Verbal updates on the progress made, to date, will be given to the Audit Committee.

3. PROGRESS AND GENERAL ISSUES

3.1 Fraud Awareness Presentations

During the year to date, a total of sixteen (16) separate fraud awareness sessions have been held in conjunction with staff and these include three (3) sessions given to Procurement staff in Cwmbran, two (2) sessions to Procurement staff in Bridgend in addition to eleven (11) separate Corporate Induction sessions carried out in Cardiff, Pontypool and Swansea respectively.

3.2 National Fraud Initiative 2016/17

Velindre NHS Trust and it's various hosted bodies, including NHS Wales Shared Services Partnership, are required, by law, to protect the public funds it administers. As part of that process, it may then share information provided to it with other bodies responsible for auditing or administering public funds, in order to prevent and detect fraud.

The Auditor General for Wales appoints the auditor to audit the accounts of the Trust Health Board and is also responsible for carrying out data matching exercises.

Data matching involves comparing computer records, held by one body, against other computer records held by the same or another body. This is usually personal information including any relevant payroll related information (e.g. names, dates of birth, national insurance numbers etc) and such computerised data matching then allows fraudulent claims and payments to be identified and then where a “match” is found it indicates that there is an inconsistency, which requires further investigation.

No assumption can be made at that time as to whether there is fraud, error or other explanation and so a full investigation is then carried out to determine whether there is any fraudulent acts or whether the “match” occurred as a result of an error and/or mistake.

The Auditor General currently requires the Trust together with all other NHS bodies in England and Wales plus many public bodies including Local Authorities to participate in a data matching exercise in order to assist in the prevention and/or detection of fraud. As part of that process, which is known as the National Fraud Initiative, the Auditor General requires the Trust to provide information it holds for this purpose and to provide particular sets of data to the Auditor General for matching for each exercise which are set out in the Auditor General’s handbooks and can be found at www.wao.gov.uk.

The use of data by the Auditor General in any such data matching exercise is carried out with statutory authority under its powers in part 3a of the Public Audit (Wales) Act 1998 and it does not require the consent of the individuals concerned under the Data Protection Act 1998.

Data matching by the Auditor General is subject to a Code of Practice. This may also be found at www.wao.gov.uk.

Velindre NHS Trust, as the hosted body, received a detailed report from NFI, in January 2017, which contained all relevant payroll and creditor related “matches” such as date of birth, NINO, home address and bank account details. As a result, the Counter Fraud department, assisted by Velindre NHS Trust staff together with both NWSSP Payroll and Accounts Payable staff, were then tasked to carry out a review of the required checks in order to identify any anomalies that required follow up and/or further investigation.

In previous NFI exercises the Velindre finance staff, in association with NWSSP, have undertaken the review. In February 2018 they however requested NWSSP Accounts Payable staff to undertake the review on their behalf. Accounts Payable were unable to meet the end of year deadline initially suggested by Velindre but agreed to produce the required information by the end of April. This is now largely complete and the full results of this exercise will be available shortly.

APPENDIX 1

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2017/18

AREA OF WORK	NWSSP	Days to Date
General Requirements		
Production of Reports to Audit Committee	3	3
Attendance at Audit Committees	3	3
Planning/Preparation of Annual Report and Work Programme	5	5
Annual Activity		
Creating an Anti Fraud Culture	4	4
Presentations, Briefings, Newsletters etc.	14	14
Other work to ensure that opportunities to deter fraud are utilised	2	0
Prevention		
The reduction of opportunities for Fraud and Corruption to occur	3	0
Detection		
Pro-Active Exercises (e.g. Payroll etc)	3	0
National Fraud Initiative 2016/17	2	5
Investigation, Sanctions and Redress		
The investigation of any alleged instances of fraud	30	33
Ensure that Sanctions are applied to cases as appropriate	4	4
Seek redress, where fraud has been proven to have taken place	2	4
TOTAL NWSSP	**75**	**75**

APPENDIX 2

COUNTER FRAUD ASSIGNMENT SCHEDULE 2017/18

Case Ref	Subject	Status	Open/Closed
SSP14.05	Unauthorised Sale of NHS Property	Crown Court Hearing (Suspended Sentence) - Civil Recovery (5k) still being made monthly	Open
SSP15/04	False Claim for Costs	Crown Court Hearing 18.10.17. Female defendant was sentenced to 2yrs in prison and male defendant sentenced to 6mths in prison. Ongoing POCA to recover total of £87k (£10k NHS + costs and £70k HMRC/LA).	Open
SSP16.04	False Claim for Costs	Magistrates Court Hearing 29.3.17 - Sentenced to a £200 Fine plus £400 Costs and £120 Compensation to be repaid - Suspended from the course.	Closed
SSP16.05	False Claim for Costs	Magistrates Court on 27.6.17 - Police caution issued. Compensation award of £4,000 plus costs. Subject removed from course by University..	Closed
SSP17.02	False Claim for Costs	No further action by CPS. Subject removed from course by University	Closed
SSP18.01	False Sickness Absence	Interview under Caution was carried out on 6.3.18. File has been submitted to CPS.	Open
SSP18.02	False Claim for Costs	No evidence to support allegation. No further action to be taken on advice from CPS.	Closed
SSP18.03	False Claim for Costs	No evidence to support allegation. No further action to be taken on advice from CPS.	Open but to be closed in Qtr 1 2018/19
SSP18.04	False Claim for Costs	Initial enquiries with Local Authority and University.	Open
SSP18.05	False Claim for Costs	Interview under caution planned for 13/4/18	Open

MEETING	Velindre NHS Trust Audit Committee for NHS Shared Services Partnership
DATE	24th April 2018
AGENDA ITEM	6.1
PREPARED BY	Marie-Claire Griffiths, Project Manager
PRESENTED BY	Andy Butler, Director of Finance & Corporate Services
TITLE OF REPORT	Integrated Medium Term Plan 2018-2021 Summary

TITLE OF REPORT

Integrated Medium Term Plan (IMTP) 2018-2021 Summary

PURPOSE OF REPORT

To provide the Audit Committee with a summary of the finalised IMTP for 2018-2021, **FOR INFORMATION**.

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Shared Services Partnership

Adding Value Through Partnership

Introducing our Integrated Medium Term Plan 2018-21

Journey to world class

Vision

Mission

Values

Goals

NWSSP Strategy Map

Adding Value Through Partnership

Our Vision

To be a recognised world class shared service through the excellence of our people, services and processes

Our Mission

To enable the delivery of world class Public Services in Wales through customer-focus, collaboration and innovation

Our Values

Listening & Learning

To constantly improve the quality, effectiveness and efficiency of all we do

Innovating

To encourage continuous improvement

Taking Responsibility

For decisions and making things happen

Working Together

With colleagues customers and supplier

Our Strategic Objectives

Value for money

Highly efficient and effective organisation

Deliver real term savings and service quality benefits to its customers

Customers

Open and transparent customer-focused culture

That supports the delivery of high quality services

Excellence

An organisation that delivers process excellence

Focus on continuous service improvement, automation and the use of technology

Staff

Appropriately skilled, productive, engaged and healthy workforce

Service development

Extend the range of high quality services provided to NHS Wales and Welsh public sector

Our Overarching Goals

1. We will promote a **consistency of service** across Wales by talking and listening to our partners
2. We will **extend** our services to increase value for money and innovation benefitting the people of Wales
3. We will continue to **standardise, innovate and modernise** our services delivery models to achieve prudent healthcare
4. We will encourage people to want to **work and stay** with us by attracting, training and keeping them
5. We will use our resources effectively so that as the need for our services grow we can maintain a **balanced financial plan**
6. We will provide **excellent customer service** and we will **maximise efficiency** by providing our services in one way across Wales
7. We will deliver a world class service and use our skills and expertise to help NHS Wales **tackle key issues**
8. We will support NHS Wales **meet their challenges** by **sharing good practice** and identifying opportunities

Welcome to this introduction to our integrated medium term plan for the next three years. In this booklet, we're going to explain how the Shared Services Partnership is working to support NHS Wales.

Our Vision

To be a recognised world class shared service through the excellence of our people, services and processes

Our Mission

To enable the delivery of world class Public Services in Wales through customer-focus, collaboration and innovation

Margaret Foster
Chair

Neil Frow
Managing Director

We recognise how important it is that our staff and service users understand our vision and plan. Over the next few pages you will find the key points so we can all work towards the same goals.

We are very proud of what has been achieved since we formed in 2011. Over the next three years and beyond we will continue to support NHS Wales by working together to increase efficiencies and improve quality.

We will continue to add value through partnership by developing, improving and extending our services to meet our customers' needs. We will develop a "trusted partnership" to support NHS Wales tackle key issues.

What is the Integrated Medium Term Plan?

Each year we identify the priorities and the actions we will be taking to improve and develop our services, and think about how we will continue to support the current and emerging priorities of NHS Wales. We describe these actions and priorities in a planning document, called the **Integrated Medium Term Plan** (IMTP).

We don't write our plan from scratch each year, but build on the previous year, updating it to reflect new priorities and responses to feedback from our customers, staff and other partners.

Each year our IMTP is agreed and approved by our Senior Management Team and the Shared Services Partnership Committee which has representatives from each health board and trust. The IMTP is submitted to the Welsh Government by the 31st of March deadline, to be reviewed as part of the Minister for Health and Sport and Wellbeing's approval of plans for the whole of NHS Wales.

Our Values

We have four organisational values:

Listening & Learning	***Innovating***	***Taking Responsibility***	***Working Together***
To constantly improve the quality, effectiveness and efficiency of all we do	To encourage continuous improvement	For decisions and making things happen	With colleagues customers and supplier

Our Strategic Objectives

It is our aim to provide shared services that are considered to be among the best in the world and have developed five strategic objectives to achieve this.

 Value for money	 Customers	 Excellence	 Staff	 Service development
Highly efficient and effective organisation Deliver real term savings and service quality benefits to its customers	Open and transparent customer-focused culture That supports the delivery of high quality services	An organisation that delivers process excellence Focus on continuous service improvement, automation and the use of technology	Appropriately skilled, productive, engaged and healthy workforce	Extend the range of high quality services provided to NHS Wales and Welsh public sector

About Us

1,900+ Staff

23 Sites

£300m+ Budget

95% of NHS Wales expenditure processed through NWSSP systems and processes

The NHS Wales Shared Services Partnership (NWSSP) is part of NHS Wales. We were formed in 2011 to provide high quality, customer focused professional, technical and administrative services to all the Trusts and Health Boards in NHS Wales. NWSSP was created to allow Health Boards and Trusts to focus on the delivery of front line services and providing excellent patient care.

We have extended and developed our range of services and we have made significant improvements in quality. We have generated over £26m in financial savings that have been reinvested in NHS Wales. We are continuing to work with NHS Wales and the wider public sector to identify opportunities where we can add more value.

Our Services to NHS Wales

If you would like to know more about each service you can read their delivery plans in section two the IMTP using the page numbers;

Audit and Assurance Services – we provide audit and assurance services to all health organisations in Wales *(page 80)*

Central Team e-Business Services – we centrally manage and support the All Wales Financial Ledger systems *(page 93)*

Digital Workforce Solutions – we manage the strategic electronic staff record (ESR) and workforce system programme *(page 105)*

Employment Services – we pay salaries and expenses and support the safe and timely recruitment of new staff *(page 119)*

Health Courier Services – we provide a wide range of courier services to hospitals, community services, health alliances, local health groups and General Practitioners *(page 150)*

Legal and Risk Services – we provide legal advice for all of the health bodies in Wales *(page 164)*

Primary Care Services - we provide a wide range of services to GPs, community pharmacies, dentists, opticians and appliance contactors *(page 179)*

Procurement Services – we source, contract, order and pay for the goods and services which the NHS needs everyday *(page 191)*

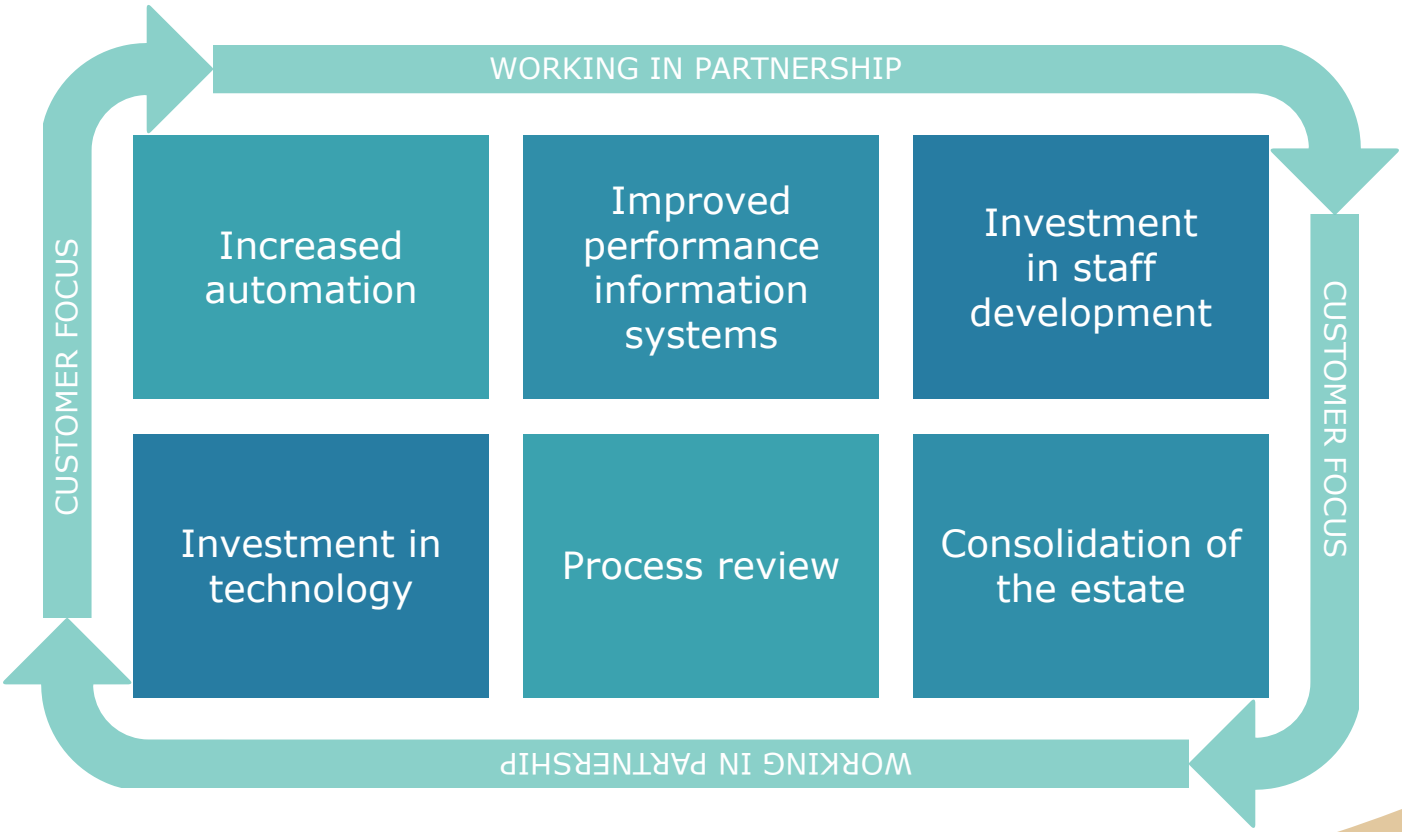
Single lead employer for GP Specialty Registrars – we provide a workforce service to GP Specialty Registrars as they undertake their training across NHS Wales *(page 138)*

Surgical Medical Testing Laboratory - we test medical devices to make sure they are safe and develop standards for manufacturers to comply with *(page 209)*

Specialist Estates Services – we provide advice and support to help NHS Wales provide modern, safe and efficient buildings and facilities *(page 221)*

Welsh Risk Pool – we manage financial risk arising from negligence claims or other losses through a pooled fund arrangement *(page 164)*

We have been making great progress in improving our services so we support our customers and listen to their needs. We have achieved this by increased automation, investment in technology, process review, the consolidation of the estate and most importantly the investment in staff development.



Our Overarching Goals

We have eight overarching goals that set our long-term strategy:

We will promote a **consistency of service** across Wales by talking and listening to our partners

We will **extend** our services to increase value for money and innovation benefitting the people of Wales

We will continue to **standardise, innovate and modernise** our services delivery models to achieve prudent healthcare

We will encourage people to want to **work and stay** with us by attracting, training and keeping them

We will use our resources effectively so that as the need for our services grow we can maintain a **balanced financial plan**

We will provide **excellent customer service** and we will **maximise efficiency** by providing our services in one way across Wales

We will deliver a world class service and use our skills and expertise to help NHS Wales **tackle key issues**

We will support NHS Wales **meet their challenges** by **sharing good practice** and identifying opportunities

Our Key Priorities for Action

We have set key actions of what we will do over the next three years matched to our five strategic objectives.

Value for money

- Generate over £2 million of direct savings
- Deliver over £100 million worth of professional influence benefits for NHS Wales
- Secure capital funding to invest in services to meet customer needs
- Deliver efficient processes and drive down costs

Customers

- Strengthen our relationships with our customers
- Work with customers to develop standard systems and processes
- Turn our data into information that helps NHS Wales make informed changes
- Lead and support the delivery of NHS Wales priorities

Excellence

- Strive for excellence in everything we do
- Provide standard modern and automated services
- Use our All Wales performance data to highlight and deliver improvement
- Invest in technology to increase the efficiency and quality of our services

Staff

- Provide staff with the skills they need to excel at work
- Make sure we attract and keep the best staff
- Support our staff so they feel happy and listened to in the workplace
- Ensure NWSSP is a "Great place to Work"

Service development

- Develop our services under five themes:

1. Supporting sustainable Primary Care
2. Sharing best practice and informing decisions
3. Workforce modernisation
4. Supporting service re-design
5. Once for Wales systems

What does this mean for me?

We are very proud of what has been achieved since we formed in 2011. Over the next three years and beyond we will continue to support NHS Wales by working together to increase efficiencies and quality.

Our staff and service users are critical to our success by working together we can become a world class organisation. There are some things that we can only deliver if we all contribute.

So what can you do?

- Create a positive customer experience by listening to each other
- Deal with your work efficiently and effectively
- Don't be scared to share your ideas, we want innovation
- Work together to standard processes and do things 'Once for Wales'
- Take pride in your work and go the extra mile
- If you see or receive good customer service tell the staff member
- Take the time to learn what works well and how you can help deliver the best service possible

We would like it if you could think about how you in your role can help Shared Services deliver world-class services to NHS Wales. Please make a personal pledge and think about how you can put it into action.

I pledge to...

Our Achievements

Overall we continue to make good progress in delivering our three-year plan. Here are some significant highlights of 2017-2018:

1. We have an approved and financially balanced IMTP
2. We have delivered significant professional influence savings for NHS Wales
3. We have been a key enabler in delivering the National Improvement Programme
4. We have provided national services and solutions to reduce variation helping our partners adopt the best practice
5. We have maintained service delivery during periods of organisational change
6. We have continued to deliver existing services whilst exploring new All Wales functions such as the Welsh Infected Blood Support Service
7. We have delivered our procurement savings targets
8. We have achieved a statutory and mandatory training compliance of above 85% for our staff
9. We have improved public sector pay policy performance across Wales and we have achieved the 95% target
10. We successfully rolled out ESR Employee Self Service to all GP Trainees
11. We supported 70,000 NHS Wales employees with ESR Self Service access
12. We established a single point of contact that current and future primary care medical staffing and nursing staff can utilise for training and employment opportunities
13. We managed the new Student Bursary Scheme to support commissioned training places
14. We developed the Store and Scan On Demand service within Primary Care Services reducing pressures on GP Practices estates
15. We substantially increased advertising vacancies for Primary Care sector
16. We eliminated paper payslips and administered e-payslips by April 2018
17. We received customer service excellence compliance + for the implementation of trac
18. We enabled NHS Wales customers to develop and maintain modern and safe environments through the support of best practice estates and facilities guidance
19. We provided training for clinical staff at all levels of experience and seniority at health bodies in Wales regarding the legal context of their practice
20. We worked with Health Board partners to ensure equitable access to transport within expected timeframes supporting timely processing of clinical results

Our Service Developments

NWSSP IMTP SERVICE DEVELOPMENT ROADMAP 2018-21

1 Supporting Sustainable Primary Care

- Electronic Transfer of Claims, using electronic messages used as the primary input for pricing
- GP patient record storage with routine and on demand access service
- Support the GP2GP electronic transfer of patient records
- Expansion of our Legal and Risk Services challenging SRA waiver limitations (Phase 1)
- End to End Recruitment Process to Primary Care Sector
- Payroll and Pension Process to all practices Primary Care Sector

2 Sharing Best Practice

- Support the development and roll-out of a Once for Wales Concerns Management System
- Support the roll-out of an innovative training style in Maternity and Obstetric services to inform better patient outcomes
- Programme of work to improve effective consent to treatment
- Efficiency through Automation and P2P process improvement project
- Turning our data into intelligent information to inform decisions

3 Workforce Modernisation

- Enhancing Single Point of Contact in support of 'train, work, live'
- Certificate of Sponsorship Management
- Supporting recruitment and retention healthcare students in partnership with universities
- Support the implementation of the All Wales Staff Bank
- Deliver phase 2 ESR Hire to Retire Programme of work
- Implement the ESR Occupational Health bi-directional interface
- Pay modelling to support strategic workforce efficiency and future consultation exercises
- Reducing recruitment timeline - 75 day process efficiencies
- Job Evaluation Collaborative

4 Supporting Service Redesign

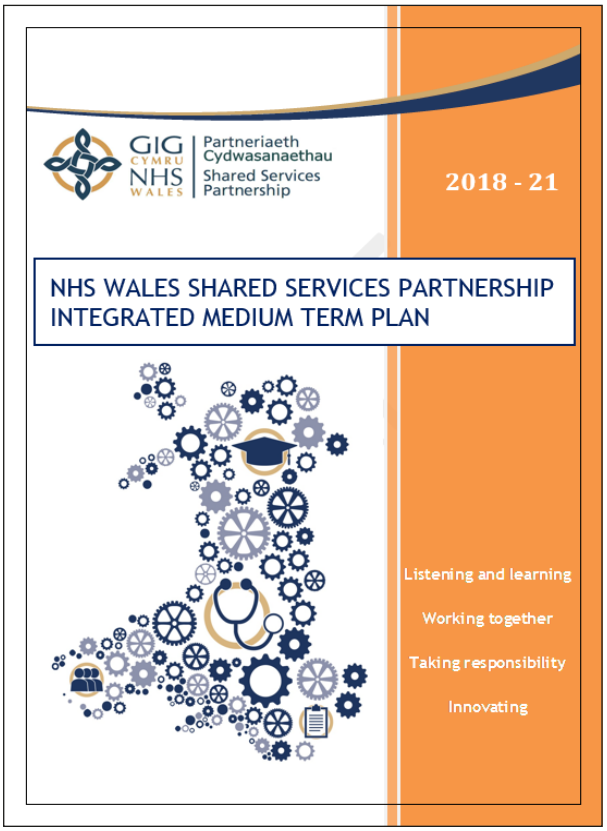
- A review of Stoma Care procurement and service delivery within Secondary Care
- Value Based Procurement, using patient experience and outcome to determine value
- Laundry Services redesign business case support
- Continuing Health Care project and improving benefits realisation on Care Homes Framework
- Establishment of HEIW
- Support working across the public sector through our systems and processes
- Supporting our partners to deliver transformation programmes

5 Once for Wales Systems

- Review opportunities and implement if appropriate further non-clinical systems
- Review opportunities and implement if appropriate centralised postal hubs
- Review opportunities and implement if appropriate VAT and PAYE advice
- Review opportunities and implement if appropriate printing and design facility and scanning service
- Review opportunities and implement if appropriate accounts receivable service
- Review opportunities and implement if appropriate role in supporting Welsh Language standards
- Further develop the Evidence Based Procurement Board

Collaboration ***Commitment*** ***WHAT WE NEED FROM OUR PARTNERS*** ***Co-production*** ***Consolidation***

Want to know more?



If you would like to know more you can find our full Integrated Medium Term Plan document on our website:

www.nwssp.wales.nhs.uk

Our website also has lots of information about the services we provide to NHS Wales.

The full Integrated Medium Term Plan is written in two sections. The first section provides you with the vision and plans for the organisation as whole. This section will show you as an organisation what Shared Services want to achieve over the next three years and how we are planning to support NHS Wales.

Each department has written their own plan of what they intend to do over the next three years. All of these plans are included in section two — if you would like to read just one department's plan then you can without reading the whole document.

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MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	24th April 2018
AGENDA ITEM	6.2
REPORT AUTHOR	Tim Knifton, Information Governance Manager
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
PRESENTED BY	Peter Stephenson, Head of Finance and Business Development

TITLE OF REPORT

Caldicott Principles Into Practice (C-PIP) Annual Out Turn Report 2017/18 and Improvement plan 2018/19

PURPOSE OF REPORT

The purpose of this report is to update the Audit Committee on the results of the annual online C-PIP self-assessment for 2017/18 that assesses NWSSP's current compliance with the Caldicott Principles.

1. BACKGROUND

Caldicott is a key element of the Information Governance agenda in Wales, providing organisations working in Health and Social Care with a set of recommendations and principles to help ensure that person and patient identifiable information (including that of patients, staff and service users) is adequately protected. Completion of the Caldicott Principles into Practice (C-PIP) assessment provides Information Governance and Caldicott Leads with a detailed, comprehensive list that highlights areas where improvements are required, and a benchmark for evaluating progress. NWSSP undertakes the annual online C-PIP self assessment to assess its compliance with the Caldicott Principles and produces a programme of work for continuous improvement. Progress is

monitored by the Information Governance Steering Group and assurance is provided to the Velindre Audit Committee for NWSSP.

2. INFORMATION GOVERNANCE

NWSSP takes Information Governance very seriously and has established arrangements in place to ensure that information is handled in a confidential and secure manner to ensure that the right information is available to the right people, when and where it's needed and is fairly processed for compatible purposes. Information Governance standards are maintained through:

- Information Governance Steering group meetings comprising of "Information Asset Owners" from each directorate with standing agenda items covering Data Protection, Freedom of Information, confidentiality breaches, information sharing protocols, information security and records management.
- Completing the annual Caldicott Principles into Practice (C-PIP) self-assessment.
- Participating in audits undertaken by the Information Commissioners Office (ICO) (including the Information Governance Training Audit which was circulated within NHS Wales).
- The Managing Director attending the National Informatics Management Board (NIMB) meetings.
- Attending the Velindre NHS Trust Information IG and IM Committee.
- Attending the NHS Information Governance Management Advisory Group (IGMAG) that reports to Welsh Government.
- Redevelopment of current Information Governance policies for a more specific NWSSP "fit".
- Identification of gaps in legislation and developing guidance for the organisation.
- Delivering face to face Information Governance training to staff.

The Director of Finance and Corporate Services is the lead officer in relation to Information Governance and is the appointed Senior Information Risk Owner (SIRO). Due to the hosting arrangements that are currently in place, the Caldicott Guardian for NWSSP is Mr Rhidian Hurle, Medical Director, NHS Wales Informatics Service.

Assurance is provided through a comprehensive programme of internal audit which provides assurance on the effectiveness of security controls. Data security risks are further managed through close working with the Informatics Service and regular Information Security reviews.

3. C-PIP SCORES

The Caldicott Out-Turn Report completed late in 2017 demonstrates that NWSSP has completed its annual requirement of developing work programmes.

When undertaking the online C-PIP self-assessment for the 2017 reporting period, NWSSP attained a C-PIP score of **96%**.

This is due to improvements in several areas but answers provided to the assessment reflect the current arrangements (for example – there is an Information Governance work plan that has been drafted but it is currently unapproved and therefore slightly reduces the organisation's score).

However, this year's assessment demonstrates that NWSSP continues to be in the **top level** of assurance on Caldicott and Information Governance compliance, however it is recognised that there is a realistic, small amount of work to be undertaken to further improve the assessment score.

This demonstrates that currently the organisation has a good level of assurance of Information Governance risks but it is recognised that there is still some work to be done. The table below demonstrates that the annual c-pip scores have improved every year.

Table 1: NWSSP C-PIP scores 2013-2017

Year	%Score
2013	83%
2014	87%
2015	94%
2016	93%
2017	96%

The Assessment

The Caldicott Assessment for 2017 highlights that many positive steps have been taken and currently, the work achieved since appointment of the Information Governance Manager reflects this. The assessment details that:

- There is an established Caldicott Guardian who provides regular updates to colleagues in respect of Information Governance;
- There is a dedicated Senior Information Risk Owner (SIRO) and Information Governance Manager within the NWSSP;

- There is an Information Governance Steering Group (furthermore known in this paper as the IGSG) to lead and support Information Governance issues across NWSSP's diverse services;
- The NWSSP Information Governance Manager represents the organisation at other forums (including All Wales Task & Finish Groups and the Information Governance Management Advisory Group);
- There is an Information Governance work plan in place that has been approved at the NWSSP Senior Management Team;
- There is a work plan in place to address the impending General Data Protection Regulation (GDPR);
- Information Asset Ownership has been established with an established register of IAOs and deputies (Information Asset Administrators or IAAs);
- There is currently a comprehensive set of policies and procedures in place that all staff have access to (use of Velindre NHS Trust policies);
- There is a developed suite of protocols giving the NWSSP ownership of their local Information Governance responsibilities;
- There are documented Records Management procedures in place;
- There is a formal programme in place to reduce the likelihood of any breaches of confidentiality including an approved breach reporting procedure;
- Confidentiality agreements have been included within formal contractual arrangements with all contractors and support organisations;
- There are documented processes in place to ensure that new processes undergo Privacy Impact Assessments (PIA) or a Privacy by Design process;
- There are appropriately trained and experienced staff in roles assigned to those with Information Governance responsibilities;
- Corporate inductions are completed with all staff on a monthly basis and this includes a session on Information Governance;
- An assessment and programme of training has been rolled out and the Information Governance Manager is progressing with giving "high risk" staff a face to face session within a biennial (2 year) period;
- Caldicott assessments are completed annually by the NWSSP Information Governance Manager;
- There is a comprehensive suite of handouts that provide staff with a précis of all Information Governance protocols and general information relating to IG;
- NWSSP has an up to date Data Protection registration entry (through Velindre NHS Trust);
- There is an Information Governance risk register established for the organisation with regular reporting;

- Arrangements under the Wales Accord of the Sharing of Personal Information (WASPI) have been approved and the statutory body has signed up on behalf of the NWSSP;
- There are clear procedures in place for responding to employee, patient and service user requests for their own information;
- There is restricted staff access to systems with access only to appropriate authorised systems;
- There are physical measures in place to secure access to buildings including CCTV and associated protocols;
- Password management processes are in place;
- Monitoring of access to systems and functionalities is established; and
- There is information in place to inform patients/services users of their individual rights including Privacy Notices.

It is worth noting that there has also been some positive progress made by the NWSSP Information Governance Manager in identifying the areas of the impending General Data Protection Regulation (GDPR) in May 2018 and how the organisation currently complies and where it requires change to improve.

The Improvement Plan

The Caldicott Improvement Plan 2018/19 provides the NWSSP with the detail of subsequent work programmes that need to be instigated over the course of the forthcoming year to address any areas that require development and to ensure that the NWSSP maintains and strengthens its compliance with Caldicott principles. The main areas that require focus are:

- **Business Continuity Management** – The organisation should be fully testing organisational Business Continuity and Disaster Recovery plans.

- **Encryption Arrangements** – The organisation must establish whether all "high risk" items that may contain Patient or Personal identifiable information (PII) are encrypted.

- **Information Management** – The organisation must continue to establish all information flows into and out of the organisation and legal basis for holding, processing data. This is also with due consideration given to flows containing Patient or Personal identifiable information (PII).

The NWSSP Information Governance Manager and the Information Governance Steering Group will monitor progress in respect of the improvement plan via a formal process.

It is worth noting that some of these recommendations have work plans that have already been progressed and the information management recommendation is estimated to be 80% complete.

4. GOVERNANCE & RISK

The Managing Director as "Accountable Officer" has overall responsibility for ensuring that NWSSP operates efficiently, economically and with probity.

The Managing Director is accountable to the Shared Services Partnership Committee (SSPC) in relation to those functions delegated to them by the Committee and is responsible for ensuring that that there are appropriate arrangements in place to comply.

5. RECOMMENDATION

The Audit Committee as asked to:

- **NOTE** the results of the annual online C-PIP self assessment to assess NWSSP's compliance with the Caldicott Principles.

NHS Wales Shared Services Partnership (NWSSP)

CALDICOTT: PRINCIPLES INTO PRACTICE (C-PIP)

OUT-TURN REPORT 2017/18 &

IMPROVEMENT PLAN 2018/19

Version No. 0 2
Status: Draft

Author: Tim Knifton
Approver: IGSG/SMT

Date: 5/10/2017
Next Review Date: October 2018

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Change Control

Version	Handler	Details	Date
V0.1	Tim Knifton	Review and comparison of 2016/17 assessment	October 2017
V0.1	Tim Knifton	Draft v0.1	October 2017
V0.1	IGSG	Tabled in October 2017 for approval	October 2017
V0.2	Tim Knifton	Content changed to reflect encryption arrangements in section CA3 and the improvement plan	January 2018

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EXECUTIVE SUMMARY

The objective of the NHS Wales Shared Services Partnership (known furthermore in this report as the NWSSP) Caldicott Out-Turn Report 2017/18 and the accompanying 2018/19 Improvement Plan is to demonstrate NWSSP's continued compliance with the Caldicott principles.

The NWSSP was established in 2012 and is a non-statutory, hosted organisation under Velindre NHS Trust.

To ensure effective governance this document has been completed to demonstrate how the NWSSP is complying with the Caldicott principles, in line with associated codes of practice and guidance.

The NWSSP complete the annual online C-PIP self-assessment to assess its compliance against the principles and to identify any subsequent work programmes that need to be instigated over the course of the forthcoming year to address any areas that require development and to ensure that NWSSP maintains and strengthens its compliance with the principles.

The **Outturn report 2017/18** provides the NWSSP with the assurance that compliance has already been measured within the organisation to ensure that there is compliance with the Caldicott principles.

These measurements demonstrate that:

- There is an established Caldicott Guardian who provides regular updates to colleagues in respect of Information Governance;
- There is a dedicated Senior Information Risk Owner (SIRO) and Information Governance Manager within the NWSSP;
- There is an Information Governance Steering Group (furthermore known in this paper as the IGSG) to lead and support Information Governance issues across NWSSP's diverse services;
- The NWSSP Information Governance Manager represents the organisation at other forums (including All Wales Task & Finish Groups and the Information Governance Management Advisory Group);
- There is an Information Governance work plan in place that has been approved at the NWSSP Senior Management Team;
- There is a work plan in place to address the impending General Data Protection Regulation (GDPR);
- Information Asset Ownership has been established with an established register of IAOs and deputies (Information Asset Administrators or IAAs);
- There is currently a comprehensive set of policies and procedures in place that all staff have access to (use of Velindre NHS Trust policies);
- There is a developed suite of protocols giving the NWSSP ownership of their local Information Governance responsibilities;
- There are documented Records Management procedures in place;

- There is a formal programme in place to reduce the likelihood of any breaches of confidentiality including an approved breach reporting procedure;
- Confidentiality agreements have been included within formal contractual arrangements with all contractors and support organisations;
- There are documented processes in place to ensure that new processes undergo Privacy Impact Assessments (PIA) or a Privacy by Design process;
- There are appropriately trained and experienced staff in roles assigned to those with Information Governance responsibilities;
- Corporate inductions are completed with all staff on a monthly basis and this includes a session on Information Governance;
- An assessment and programme of training has been rolled out and the Information Governance Manager is progressing with giving "high risk" staff a face to face session within a biennial (2 year) period;
- Caldicott assessments are completed annually by the NWSSP Information Governance Manager;
- There is a comprehensive suite of handouts that provide staff with a précis of all Information Governance protocols and general information relating to IG;
- NWSSP has an up to date Data Protection registration entry (through Velindre NHS Trust);
- There is an Information Governance risk register established for the organisation with regular reporting;
- Arrangements under the Wales Accord of the Sharing of Personal Information (WASPI) have been approved and the statutory body has signed up on behalf of the NWSSP;
- There are clear procedures in place for responding to employee, patient and service user requests for their own information;
- There is restricted staff access to systems with access only to appropriate authorised systems;
- There are physical measures in place to secure access to buildings including CCTV and associated protocols;
- Password management processes are in place;
- Monitoring of access to systems and functionalities is established; and
- There is information in place to inform patients/services users of their individual rights including Privacy Notices.

It is worth noting that there has also been some positive progress made by the NWSSP Information Governance Manager in identifying the areas of the impending General Data Protection Regulation (GDPR) in **May 2018** and how the organisation currently complies and where it requires change to improve.

Any shortfalls and areas that require improvements will be transferred and incorporated within 2018/19 NWSSP Caldicott Improvement Plan.
The **Caldicott Out-Turn Report 2017/18** demonstrates that the organisation has completed its annual requirement of developing work programmes and undertaking the online C-PIP self-assessment.

The C-PIP annual self-assessment score for the 2017/18 reporting period is **96%**, which is the same score on the previous year. Compliance in several areas since the appointment of a dedicated Information Governance Manager has improved and stabilised and the service has been made more prominent across the NWSSP in general.

This year's assessment demonstrates that NWSSP continues to be in the top level of assurance on Caldicott and Information Governance compliance, however it is recognised that there is a realistic, small amount of work to be undertaken to further improve the assessment score.

The **Improvement Plan 2018/19** provides the NWSSP with details of subsequent areas of work that need to be instigated over the course of the forthcoming year to address these areas of 'weakness' and to ensure that the NWSSP has continued compliance with the Caldicott principles. The three (3) areas requiring improvement going forward are:

- **Business Continuity Management –** The organisation should be fully testing organisational Business Continuity and Disaster Recovery plans.

- **Encryption Arrangements –** The organisation must establish whether all "high risk" items that may contain Patient or Personal identifiable information (PII) are encrypted.

- **Information Management –** The organisation must continue to establish all information flows into and out of the organisation and legal basis for holding, processing data. This is also with due consideration given to flows containing Patient or Personal identifiable information (PII).

Progress in respect of the improvement plan will be monitored via a formal process by the NWSSP Information Governance Manager and the Information Governance Steering Group.

This report sets out the main findings following completion of the 2017/18 Caldicott assessment, along with the key improvements that need to be considered.

1. NWSSP CALDICOTT OUT-TURN REPORT 2017/18

1.1 Introduction

Since the Caldicott Report was published in 1997 by Dame Fiona Caldicott, there have been significant changes to the legislation surrounding access to and use of patient information and subsequently new Codes of Practice have been published.

Each NHS organisation is required to have a Caldicott Guardian, who is a senior person with responsibility for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing. The Caldicott Guardian acts as the "conscience" of an organisation, actively supporting work to enable information sharing where it is appropriate to share, and advised on options for lawful and ethical processing of information.

The Caldicott Guardian, also has a strategic role, which involves representing and championing Information Governance requirements and issues at Senior Management Team level, and where appropriate, at a range of levels within an organisation's overall governance framework.

This report is produced annually for the Information Governance Steering Group, the Senior Management Team, Velindre Audit Committee, Velindre IG and IM&T Committee and other specific forums. This is to ensure that NWSSP provides an assurance that effective Information Governance procedures and compliance with the Caldicott Principles has been met.

1.2 The Role of the Caldicott Guardian

As a hosted organisation NWSSP does not have its own dedicated Caldicott Guardian in place, however the Director of Finance and Corporate Services is the appointed Senior Information Risk Owner (SIRO) and takes advice and support provided by the Information Governance Manager.

Information Governance is a key area of the Caldicott framework, this work is led through a dedicated Information Governance Steering Group (IGSG) that meets on a quarterly basis.

In terms of the Caldicott Guardian requirement, this is provided by Mr. Rhidian Hurle, Medical Director, NHS Wales Informatics Service (NWIS) which is another part of the hosted service arrangement.

1.3 NWSSP C-PIP Self-Assessment 2017/18

The "Caldicott - 'Principles into Practice' (C-PIP)" manual provides both Caldicott Guardians and their support staff with up to date information regarding their legal obligations and what arrangements must be in place to ensure that patient information is handled appropriately and confidentially.

All NHS organisations are required to annually assess their own compliance with the Caldicott Principles and produce a programme of work and a continual plan of improvement.

The Caldicott Principles into Practice ('C-PIP') self-assessment tool enables organisations to quickly evaluate their level of compliance and plan any developments or improvements that may required. The C-PIP self-assessment comprises of **41 standards** that are grouped into **6 sections**. The self assessment scales responses to questions on a likert scale and automatically generates a score against the relevant standard dependant on the options selected.

As part of the Caldicott annual programme of improvement, the NWSSP has self assessed itself against the Caldicott standards and the completed online assessment for 2017/18, the score and any additional comments are presented at **Appendix A** for information.

1.4 C-PIP Score

The scoring rating for the C-PIP self assessment is outlined in Table 1 below:

Table 1: C-PIP Scoring Matrix

Star Rating	C-PIP Score	
*****	**91-100%**	**Your responses to the assessment demonstrate an excellent level of assurance of information governance risks.**
****	76-90%	Your responses to the assessment demonstrate a good level of assurance of information governance risks; but there is still work to be done.
***	51-75%	Your responses to the assessment demonstrate a satisfactory level of assurance of information governance risks although there are some significant weaknesses which you should address.
**	21-50%	Your responses to the assessment demonstrate an insufficient level of assurance of information governance risks and a number of significant weaknesses which you need to be addressed.
*		Your responses to the assessment suggest an inadequate level of assurance of information governance risks should be addressed as a matter of urgency.

For the 2017 reporting period NWSSP scored **96%** (scoring 63.5 out of a possible 66*****) and the rating indicates that the "*responses to the assessment demonstrate an excellent level of assurance of Information Governance risks".*

*****This scoring includes an adjustment to reflect the non applicable answer given to question **IM7** that still bears a score within the toolkit although we have answered that it is not applicable to the NWSSP.

1.5 C-PIP Score Comparison

When comparing NWSSP's overall score against the **41** standards, NWSSP were:

- Fully compliant on **35**;
- Partially compliant on **3**; and
- Non applicable on **3**.

This demonstrates NWSSP has robust compliance with the Caldicott principles in a number of diverse areas; that include:

- The inclusion of confidentiality agreements within formal contractual arrangements with all contractors and support organisations;
- Appropriate assignment of Caldicott Guardian and Information Governance roles and responsibilities;
- An established culture of Information Governance Steering Group meetings that provide support and cascade information to the relevant Senior forums;
- Representation of the NWSSP at other forums (including All Wales Task & Finish Groups and the Information Governance Management Advisory Group);
- Preparation of work within Information Governance to comply with the rollout of the future General Data Protection Regulation (GDPR) in May 2018;
- An effective Information Governance training regime for all NWSSP staff;
- The assurance of effective reporting arrangements;
- The assurance that there are means to ensure information is dealt with legally, securely, efficiently and effectively; and
- The assurance that appropriate physical arrangements exist to control, secure and monitor access to patient identifiable information.

The assessment has also indicated a small number of areas where improvements can be made. This will be addressed in the improvement plan.

2. NWSSP CALDICOTT IMPROVEMENT PLAN 2018/19

2.1 Compliance

To ensure the continuing compliance and the subsequent need for improvement in respect of compliance with the Caldicott principles, the NWSSP must appropriately instigate a number of action points as detailed within the **NWSSP Caldicott 2018/19 Improvement Plan** which are presented in **Appendix B**, that provide an in depth analysis of all the necessary standards and their subsequent management action points.

A summary of the three (3) points that need to be addressed are:

- A fully tested organisational Business Continuity and Disaster Recovery plan must be developed and in place;
- Information flows into and out of the organisation must be mapped where the information contains Person or Patient Identifiable Information (PII). This should include accounting for the legal basis of use of said data; and
- Identification of those devices that are deemed to be "high risk" and require encryption that are not yet identified is completed by the Cyber Security project.

2.2 Responsibilities

The NWSSP Managing Director designated as "Accountable Officer" has overall responsibility for ensuring that NWSSP operates efficiently, economically and with probity.

Responsibility for the implementation and monitoring of progress against the Caldicott (C-PIP) improvement plan is discharged to the Director of Finance and Corporate Services, supported by the Information Governance Manager and the Head of Corporate Services. The Information Governance Manager is responsible for the completion of the assessment and writing this report once the answers have been provided. This is usually completed following a review of the previous assessment and if any progress has been made on the improvement plan.

The Senior Management Team (SMT) also has collective responsibility for ensuring that there are effective Information Governance procedures in place across NWSSP.

Work is co-ordinated through the Information Governance Steering Group and disseminated to the Senior Management Team (SMT) as required.
This will provide the appropriate organisational framework to progress work and to provide management with additional reporting and monitoring mechanisms.

2.3 Timescale

The NWSSP will progress the points outstanding that are made in the improvement plan over this financial year and regular updates will be monitored via the appropriate organisational forums in conjunction with the Information Governance Manager.

There will be requirements placed upon the organisation to complete a new annual assessment in 2018 and ensure that any outstanding issues from the existing plan are either appropriately transferred and incorporated within any future/revised plans or marked as complete and therefore, not included in the register but noted as compliant.

3. Summary

This report, once approved, will be presented to the Senior Management Team (SMT), updated at the Information Governance Steering Group (IGSG) and provided for information at the Velindre NHS Trust Information Governance & IM&T Committee (as hosting organisation).

Actions will be monitored by the Information Governance Manager and senior leads (including the SIRO) to ensure continual progress and compliance with the Caldicott Principles.

NWSSP Caldicott Assessment 2017/18

Number	Assessment Standard	NWSSP Response	Score	Comments
Section 1 – Governance The organisation must assign Caldicott and Information Governance responsibilities				
G1	Has your organisation appointed a Caldicott Guardian?	Compliant	2/2	The hosting statutory organisation (Velindre NHS Trust) has an appointed Caldicott Guardian who is appropriately trained and receives updates on all aspect of Information Governance. Caldicott Guardianship for NWSSP is provided by Mr Rhidian Hurle, Caldicott Guardian at NHS Wales Informatics Service (NWIS). Mr Hurle is a senior member of staff and sits on the management board and/or equivalent of the organisation. Within the NWSSP, Andy Butler – Director of Finance & Corporate Services is the appointed SIRO (Senior Information Risk Owner) and is supported by the work of the NWSSP Information Governance Manager.
G2	Does your organisation have an Information Management Strategy that has been approved by the Board or equivalent?	Compliant	1/1	This strategy has been approved by the Senior Management Team and IT Steering Group and is up to date.

Number	Assessment Standard	NWSSP Response	Score	Comments
G3	Is Information Governance included within the responsibilities of a Board within your organisation and does it receive regular reports from Information Governance?	Compliant	1/1	The NWSSP has its own dedicated Information Governance Steering Group (IGSG) that meets on a quarterly basis and provides an update to the Senior Management Team (SMT) after each meeting. Information Governance is included as a regular item on the agenda for the SMT. The NWSSP Information Governance Manager circulates/cascades information to appropriate staff within the organisation at other times when required. Reports are cascaded to Trust forums as and when required.
G4	Is there an Information Governance work plan, sponsored by the Caldicott Guardian and approved by the Board or its equivalent?	Compliant	1/1	There is a high level work plan and a plan for GDPR compliance in place which is documented and has been tabled at the IG Steering Group and the Senior Management Team. The Caldicott Guardian is aware of the work of the NWSSP IG function.

Number	Assessment Standard	NWSSP Response	Score	Comments
G5	Has the Records Management Policy and implementation plan been approved by the Board or its equivalent, communicated to appropriate staff and reviewed on a regular basis?	Compliant	1/1	The current Velindre policy has been communicated to all members of staff, who have access to it via the intranet and have been made aware of any changes to the policy as and when appropriate. The NWSSP Information Governance Manager has written a specific Records Management protocol for the organisation which has been approved by the IGSG and the SMT. This has also been completed for a wide range of Information Governance protocols that forms a comprehensive suite. These are also currently under review on an All Wales basis.
G6	Do mechanisms and guidelines exist to ensure that any decision taken by a patient or service user to restrict the disclosure of their personal information are appropriately respected?	Compliant	2/2	Currently, there are appropriate mechanisms in place within NWSSP to ensure compliance with legislation and responsibilities defined under the Data Protection Act 1998, the Caldicott Report 1997/2013 and other associated legislation and codes of practice. In preparation for the General Data Protection Regulation (GDPR), there are several privacy notices approval or under development for Patients, Service Users and Employees.

Number	Assessment Standard	NWSSP Response	Score	Comments
G7	Is information risk management included in the organisation's wider risk assessment and management framework?	Compliant	2/2	A robust risk framework is in place whereby all staff are provided with a facility to electronically report any new potential risks to NWSSP through the Datix incident management system. The NWSSP Information Governance Manager has identified and scored risks relating to IG and this has its own register which is reviewed and updated as required. Any risks categorised as being "red" are discussed at the SMT for consideration whether the risk need to be captured on the overarching corporate risk register. Corporate risk features as a standing agenda item for SMT and the Audit Committee.
G8	Does the organisation have documented and accessible information security incident reporting, investigation and resolution procedures in place that are explained to all staff?	Compliant	2/2	Information Security incidents are recorded via the Datix Incident Reporting System using a predefined set of codes. Incidents are communicated to necessary organisational forums and all relevant heads and line managers are notified if it occurs in their service areas. The NWSSP IG Manager has a developed Confidentiality Breach Incident Reporting procedure in place following approval by the IGSG and SMT.

Number	Assessment Standard	NWSSP Response	Score	Comments
G9	Does the organisation have formal contractual arrangements with all contractors and support organisations that include their responsibilities in respect of information security and confidentiality?	Compliant	2/2	Contracts include necessary aspects of information security & confidentiality responsibilities.
G10	Does the organisation ensure that all new services, projects, processes, software and hardware comply with information security, confidentiality and Data Protection requirements?	Compliant	2/2	Under the memorandum of cooperation the geographical location of NWSSP staff members determines the IT support provided. Compliance is therefore determined by the provider organisation. However the NWSSP IT team will expedite any issues to the local IT support providers.
Section 2 – Management **The organisation must have core policies in place for Caldicott and Information Governance.**				
Number	**Assessment Standard**	**NWSSP Response**	**Score**	**Comments**
M1	Where staff have been assigned Information Governance roles, are they appropriately qualified & trained?	Compliant	5/5	The NWSSP has an appointed Information Governance Manager. Along with the Senior Information Risk Owner (SIRO) they have received training and have the relevant experience and qualifications in order to undertake the role.
M2	Was the organisations last assessment of performance against the Caldicott Standards completed within the last year?	Compliant	1/1	The assessment is completed on an annual basis and was completed last year. This was last approved in January 2017.

Number	Assessment Standard	NWSSP Response	Score	Comments
M3	Does the organisation have a comprehensive Records Management Policy for corporate and medical records?	Compliant	1/1	As a hosted organisation under Velindre NHS Trust, NWSSP relies on the overall Trust policy that provides a formal procedure on basic Records Management. The NWSSP Information Governance Manager has written a specific protocol for the organisation which has been agreed and approved at the IGSG and the SMT. Work has already been completed on NWSSP repositories within the organisation, namely Companies House and Oldway Centre.
M4	Does the organisation have an accurate and up to date Notification to the Information Commissioner under the Data Protection Act 1998?	Compliant	1/1	The NWSSP's registration falls under the statutory authorities' (Velindre NHS Trust) where notification is reviewed, updated where required and renewed annually with the latest renewal facilitated every December by the NHS Wales Informatics Service (NWIS) Information Governance colleagues.

Number	Assessment Standard	NWSSP Response	Score	Comments
M5	Is Data Protection comprehensively addressed either in a dedicated policy or by its incorporation into another policy?	Compliant	1/1	An overall Trust policy for Data Protection is in place and is part of a suite of documents that relate to Information Governance. The NWSSP Information Governance Manager has written a specific Data Protection and Confidentiality protocol for the organisation which has been agreed and approved at the IGSG and the SMT. This has been completed for a wide range of Information Governance protocols which form a comprehensive suite and provide the NWSSP with ownership of individual IG responsibilities. There are several National working groups that are concentrating on all Wales NHS Information Governance Protocols in line with planning for the impending GDPR.

Number	Assessment Standard	NWSSP Response	Score	Comments
M6	Is Information Security comprehensively addressed either in a dedicated policy or by its incorporation in a wider security policy?	Compliant	1/1	The policy has been approved by the Velindre NHS Trust Board and has been communicated to all members of staff, who have access to and been made aware of any changes to the policy. The NWSSP Information Governance Manager has written a specific Information Security protocol for the organisation which has been agreed and approved at the IGSG and the SMT and will be circulated to all staff subject to approval of an Equality Impact Assessment. This is has been completed for a wide range of Information Governance protocols which will form a comprehensive suite once complete and provide the NWSSP with ownership of their own IG protocols.
M7	Does the organisation have an up to date Business Continuity and Disaster Recovery Plan?	Partially Compliant	1/2	The SMT approved a project work stream to review Business Continuity processes and workshops have been held to address Business Continuity and Disaster Recovery. Individual departments have their own plans in place at present. However, the NWSSP scores partial as these have not been tested.

Number	Assessment Standard	NWSSP Response	Score	Comments
M8	Is a comprehensive confidentiality statement included within all established staff and non-staff contracts?	Compliant	1/1	All established staff contracts going forward consist of a comprehensive confidentiality statement which has been reviewed by the NWSSP Information Governance Manager. This is as follows: *"You must, at all times, be aware of the importance of maintaining confidentiality and security of information gained by you during the course of your duties. This will, in many cases, include access to personal information relating to service users. You must treat all information, whether corporate, staff or patient information, in a discreet and confidential manner in accordance with the provisions of the Data Protection Act 1998 and organisational policy".*
M9	Does the organisation have arrangements in place to include staff responsibility for the following areas? • Confidentiality • Records Management • Information Security • Data Protection • Freedom of Information	Compliant	2/2	All aspects relating to Information Governance are included in job descriptions for those responsible. All staff working within the NWSSP are provided with Information Governance handouts and booklets that educate and inform everyone of their responsibilities when handling identifiable data including a summarised version of all specific IG protocols.
Section 3 – Information for Patients and Service Users				

The organisation must have an active information campaign in place to inform patients about the use of their information.				
Number	**Assessment Standard**	**NWSSP Response**	**Score**	**Comments**
IP1	Does the organisation have appropriate procedures for recognising and responding to patient and service user requests to access their own records?	Compliant	2/2	There is currently a procedure in place that handles Subject Access requests and this is the responsibility of the Information Governance Manager. In line with the impending General Data Protection Regulation (GDPR), this document is currently being updated to ensure that any enhanced rights will also be reflected.
IP2	Do you tell patients and service users about the ways in which their information will, or may be used?	Compliant	2/2	In line with the impending General Data Protection Regulation (GDPR), the NWSSP Information Governance Manager is leading a Task & Finish Group on Individual's Rights which is concentrating on Patients, Children & Vulnerable adults. This is to be approved in November 2017 by the Information Governance Management Advisory Group (IGMAG). A privacy notice already exists for NWSSP staff that was approved earlier in 2017.

Section 4 – Training and Awareness The organisation must assess Information Governance training needs and ensure that role specific information is provided to all staff.				
Number	**Assessment Standard**	**NWSSP Response**	**Score**	**Comments**
TA1	Does your organisation have a mechanism for addressing Information Governance for new staff at induction?	Compliant	2/2	All new employees are required to complete the Mandatory PADR Training Framework which comprises of ten mandatory online training (e-Learning) modules that include a dedicated module on Information Governance. There is a work plan in place for Corporate Induction. There is an established, monthly Corporate Induction programme in place and this includes a session on Information Governance as an introduction for all new starters.

Number	Assessment Standard	NWSSP Response	Score	Comments
TA2	Have you conducted an analysis of Information Governance training needs?	Compliant	2/2	NWSSP participated in the Information Commissioner's Information Governance training audit across NHS Wales in 2015 and the feedback received was positive with minor recommendations to strengthen IG training. The actions were completed. There is a 2017 audit currently ongoing to address the previous 2015 audit recommendations and progress made by the NWSSP. This has currently been submitted by the Information Governance Manager. All new employees are required to complete the Mandatory PADR Training Framework which comprises of ten mandatory online training modules that includes a dedicated module on Information Governance. The module must be completed every 2 years. The percentage completion rates for the IG module are presented to each SMT meeting within the Finance & Performance report. Further face to face training for all staff across NWSSP is currently ongoing and is a rolling programme for all staff employed within the organisation. This will be required to be completed every 2 years by all staff.

Number	Assessment Standard	NWSSP Response	Score	Comments
TA3	Do you provide information governance training to staff, other than at induction?	Compliant	2/2	NWSSP participated in the Information Commissioner's IG Training Audit across NHS Wales in 2015 and the feedback received was positive with minor recommendations to strengthen training. An action plan to address the recommendations was devised and completed following monitoring by the IG Steering Group. A corporate induction programme is also in place. All new employees are required to complete the Core Skills Training Framework which comprises of ten mandatory online training modules, which includes a dedicated module on Information Governance. The module must be completed annually. The percentage completion rates for the IG module are presented to each SMT meeting within the Finance & Performance report. Face to face training currently stands at over 1,000 employees since January 2016.

Number	Assessment Standard	NWSSP Response	Score	Comments
TA4	What percentage of your staff have undertaken an Information Governance training session?	Compliant	1/1	The compliance rate for the online "Information Governance" module within the statutory and mandatory PADR training framework was **87.5%** for the whole of NWSSP to the **September 2017**. The compliance rate is slightly lower than average due to the configuration of some services within NWSSP which are currently going through training workshops to ensure 100% compliance with all ten core training modules (Health Courier Services for example). This is also partly due to those staff that do not have easy access to a computer during their working day. It is to note that face to face training is not represented in the compliance rating above.

Section 5 – Information Management The organisation must ensure that information is dealt with legally, securely, efficiently and effectively.				
Number	**Assessment Standard**	**NWSSP Response**	**Score**	**Comments**
IM1	Have information flows been comprehensively mapped and has ownership for information assets been established?	Partially Compliant	1/2	There is a developed process in place for Information Asset Ownership (IAO) which is a standing agenda item on the IGSG. There is an established register of departmental IAOs and the deputies (IAAs), and the NWSSP has a clear plan of work and protocol documentation in place to ensure that this will as close to full compliance in future. A fair amount of information flows have been mapped and further work is commencing to make this as comprehensive as possible.

Number	Assessment Standard	NWSSP Response	Score	Comments
IM2	Does the organisation have policy and procedures in place to ensure the security of paper and electronic records in transit?	Compliant	2/2	The NWSSP Information Governance Manager has written a specific protocol for the organisation which has been agreed and approved at the IGSG and the SMT and has been uploaded to the NWSSP intranet following the Equality Impact Assessment completed in December 2015. This has been completed for a wide range of Information Governance protocols for NWSSP and currently form a comprehensive suite. However, National Policies are being evaluated on an All Wales basis for all IG protocols, procedures and policies.
IM3	Has the organisation made progress in implementing the Wales Accord for the Sharing of Personal Information (WASPI)?	Compliant	2/2	Yes, the Accord has been signed at Velindre NHS Trust level on behalf of NWSSP and any new Information Sharing Protocols (ISP's) are developed using the WASPI templates. It should be noted that the WASPI service is now funded and the responsibility of NHS Wales Informatics Service (NWIS).
IM4	Is there awareness of the organisation's responsibilities when transferring personal data outside of the European Economic Area (EEA)?	Compliant	1/1	NWSSP has notified the transfer of personal data on the Data Protection register and arrangements are in place to recognise transfer requirements.

Number	Assessment Standard	NWSSP Response	Score	Comments
IM5	Does the organisation have a strategy to ensure the correct NHS number is recorded for each active patient and service user, and that it is used routinely in clinical communications?	Compliant	2/2	Where the NWSSP comes into contact with patient data that includes use of the NHS number, the requirements for the use of such information is held within a policy developed by NWIS and ratified by the Patient Safety Board.
IM6	Does the organisation have paper health records of a standard design?	Not applicable	1/1	Although the NWSSP does not have paper health records and is therefore 'Not applicable', the statutory organisation (Velindre NHS Trust) has adopted a standard design and this is reviewed via the VCC Health Records Group.
IM7	Does the organisation have documented procedures on the identification and resolution of duplicate or confused patient records?	Not applicable	0/1	As per the answer given in IM6, the NWSSP is answering as 'Not applicable', it has been stated by the statutory organisation that a robust system is in place to prevent and identify duplicate records in Velindre. The scoring still applies but this will be adjusted to reflect the answer given.
IM8	Does the organisation have processes and procedures in place to enable it to regularly monitor, measure and trace paper health records?	Not applicable	1/1	The NWSSP also has answered 'Not applicable' as it does not routinely use Health Records. Velindre NHS Trust have a tracking system in place and this is fully utilised. Regular monitoring is undertaken by their Health Records Manager.

Section 6 – Controlling Access to Confidential Information The organisation must have arrangements in place to control and monitor access to information.				
Number	**Assessment Standard**	**NWSSP Response**	**Score**	**Comments**
CA1	Is there a Confidentiality Code of Conduct (or equivalent) which provides staff with clear guidance on the disclosure of patient/service user identifiable information?	Compliant	2/2	A programme is in place to support compliance with the code i.e. set within training & induction and supported by contractual Terms & Conditions. As well as this, there is clear guidance in many forms provided by the NWSSP Information Governance Manager including handouts and guides to good practice.
CA2	Are processes in place to ensure that contractors understand their responsibilities regarding confidentiality and information security?	Compliant	1/1	Work has been undertaken to ensure that all contractors understand their responsibilities. This is written into contracts and specifications.
CA3	Has the organisation made progress with encryption of devices containing personal identifiable information (PII) in line with the Encryption Code of Practice for NHS Wales' organisations (2009)?	Partially Compliant	1.5/2	NWIS supports 85% of Shared Services' laptop and desktop estate. Whole disk encryption is applied to all these machines. The remaining 15% of our estate is supported by Health Board and Trust IT departments. These will be subject to the same policies as that organisation applies to its own machines. All organisations encrypt laptops but there may be differences in approach to desktops It is expected that data stored on servers, backup devices and tapes will be reviewed as part of an ongoing Cyber Security project

Number	Assessment Standard	NWSSP Response	Score	Comments
CA4	What controls are in place to restrict staff access to patient/service user identifiable information?	Compliant	2/2	Appropriate defined and documented (Microsoft Access Protocols) access rights are in place and agreed for all staff.
CA5	Are there physical access controls in place for relevant buildings?	Compliant	2/2	All NWSSP offices have the necessary physical security measures in place that are proportionate to the sensitivity of the information. The use of additional key coded systems are also in operation within a number of offices as well as the requirement for any visitors to appropriately 'sign in' for purposes of health and safety as well as security. CCTV is also utilised across a number of buildings that the NWSSP occupy. Additional security measures are also in place. The NWSSP Information Governance Manager has also developed protocols that reflect CCTV assessments taken from work within the Surveillance Camera Commissioner's (SCC) guidance and assessment tools.

Number	Assessment Standard	NWSSP Response	Score	Comments
CA6	What password management controls are in place for information systems that hold patient/service user information?	Compliant	1/1	Specific systems are protected by Microsoft Access protocol and the use of NHS Wales Active Directory (NADEX) with staff receiving regular forced password change prompts to change their details. In addition they are continually reminded of the importance to keep their passwords confidential with any sharing strictly prohibited and reference to password policy also defines minimum standards. Access to any PII is on a strict need to know basis with password entry and with access to specific folders and directories requiring the necessary authorisation which is dependent on the department that the staff member works for.
CA7	Has the organisation established appropriate confidentiality audit procedures to monitor access to Patient Identifiable Information (PII)?	Compliant	2/2	Responsibility for monitoring and auditing access to Person/Patient identifiable information (PII) has been assigned. Procedures are implemented and action is taken where confidentiality processes have been breached. Audit procedures are regularly reviewed and updated as necessary; this is explained in the use of All Wales Email, Internet and Social Media policies. The NWSSP Information Governance Manager also provides this guidance in his face to face training sessions.

Number	Assessment Standard	NWSSP Response	Score	Comments
CA8	Does the organisation have appropriate policies in place to cover risks associated with off-site working using electronic and manual records containing person identifiable information (PII)?	Compliant	1/1	The NWSSP Information Governance Manager has developed a protocol for taking information offsite that includes an agreement and a risk assessment to complete that depends on the amount and type of information being taken from NWSSP premises. This is also reflected in summarised handouts for staff working within the NWSSP and all IG training provided as part of the IG Managers objectives.

Appendix B

NWSSP Caldicott Improvement Plan 2018/19

Assessment Standard		Management Action	Responsible Directorate	Objective Owner	Implementation Date	Progress (Traffic Light)	Comments	Cross Reference (H & C Stds & Other)
IM1	Have information flows been comprehensively mapped and has ownership for information assets been established?	Establish **ALL** information flows into and out of the organisation considering flows containing PII. This includes accounting for all legal basis for use of data held by the NWSSP (i.e. retention, processing, sending, sharing, etc.).	ALL	Corporate Services	By May 2018		The NWSSP has introduced a process of Information Asset Ownership (IAOs/IAAs) with a clearly defined action plan is currently being rolled out across the NWSSP.	Standard 3.4 – Information Governance & Communications Technology 3.5 Records Keeping – IM&T
M7	Does the organisation have an up to date Business Continuity and Disaster Recovery Plan?	A fully tested Business Continuity and Disaster Recovery Plan	ALL	Corporate Services	May 2018		NWSSP need to test its individual BC and DR plans to ensure that they are effective.	Standard 3.4 – Information Governance & Communications Technology 3.5 Records Keeping – IM&T

Assessment Standard		Management Action	Responsible Directorate	Objective Owner	Implementation Date	Progress (Traffic Light)	Comments	Cross Reference (H & C Stds & Other)
CA3	Has the organisation made progress with encryption of devices containing personal identifiable information (PII) in line with the Encryption Code of Practice for NHS Wales organisations (2009)?	Identify contact point and determine what "high risk" devices have been encrypted	ALL	Corporate Service/ IT/NWIS	May 2018		It is expected that data stored on servers, backup devices and tapes will be reviewed as part of an ongoing Cyber Security project.	Standard 3.4 – Information Governance & Communications Technology 3.5 Records Keeping – IM&T

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	24th April 2018
AGENDA ITEM	6.3
REPORT AUTHOR	Roxann Davies, Compliance Officer
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
PRESENTED BY	Roxann Davies, Compliance Officer

TITLE OF REPORT

Audit Committee Forward Plan 2018-19

PURPOSE OF REPORT

To provide a summary of items expected to be presented at forthcoming Audit Committee meetings, scheduled for 2018-19.

Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Forward Plan 2018-19

Month	Standing Items	Audit Reports	Governance	Minutes/Chairs Reports/Annual Reports
Q1 2018/19 **5 June 2018**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** -As outlined in the Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register Annual Governance Statement Health and Care Standards Review of NWSSP Risk Management Protocol	Minutes & Matters Arising Head of Internal Audit Opinion and Annual Report Results of Audit Committee Effectiveness Survey Well-being of Future Generations (Wales) Act 2015 Annual Report Information Commissioner's Office Training Audit Action Plan
Q2 2018/19 **24 July 2018**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**External Audit** -WAO Report on NWSSP 2017/18 **Internal Audit** -As outlined in the Internal Audit Operational Plan -Quality Assurance & Improvement Programme	Governance Matters Tracking of Audit Recommendations Corporate Risk Register	Minutes & Matters Arising Counter Fraud Work Plan Counter Fraud Self Review Tool Submission Counter Fraud Annual Report Draft Internal Operational Plan Audit Committee Annual Report Review of Audit Committee Terms of Reference

Q3 2018/19 **23 October 2018**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**External Audit** -Wales Audit Office – Proposed Audit Work 2018/19 **Internal Audit** -As outlined in the Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register Health and Care Standards Assurance Maps	Minutes & Matters Arising Health & Care Standards Action Plan Review of Standing Orders Review of Raising Concerns (Whistleblowing) Policy Directorate Assurance Mapping Review Forward Plan
Q4 2018/19 **February 2019**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** -As outlined in the Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register	**Pre-meet between Audit Committee Chair, Independent Members, Internal and External Auditors and Local Counter Fraud** Minutes & Matters Arising Review of Standing Orders
Q1 2019/20 **April 2019**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** -As outlined in the Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register Annual Governance Statement Health & Care Standards Caldicott Principles Into Practice Annual Report	Minutes & Matters Arising Audit Committee Effectiveness Survey Well-being of Future Generations (Wales) Act 2015 Annual Report