Bundle Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership 9 July 2019

0	Presentation on Audit Committee Effectiveness - Rox Davies (1.30pm - 2.00pm)
1	PART A - STANDARD BUSINESS (2.00pm - 4.00pm)
1.1	Welcome & Opening Remarks (Verbal) - Chair
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1.3	Declarations of Interest (Verbal) - Chair
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3.6	Internal Audit Position Statement - James Quance 3.6 NWSSP Internal Audit Progress Report July 2019.pdf
4	ASSURANCE, RISK & GOVERNANCE
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4.6	Audit Committee Annual Report - Rox Davies

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4.7 Review of Audit Committee Terms of Reference - Rox Davies

4.7 Review of Audit Committee Terms of Reference July 2019.docx

4.7 Appendix 1 NWSSP Audit Committee Terms of Reference July 2019 (Clean Version).docx

4.8 Declarations of Interest (Verbal) - Rox Davies

5 COUNTER FRAUD

5.1 NHS Wales Fighting Fraud Strategy - Peter Stephenson

5.1 Cover Fighting Fraud Strategy.doc

5.1 Appendix 1 Fighting Fraud Strategy V6.pdf

5.2 Counter Fraud Annual Report 18-19 - Craig Greenstock

5.2 NWSSP Counter Fraud Annual Report 2018-19.doc

5.3 Counter Fraud Self-Review Submission Tool - Craig Greenstock

5.3 NWSSP Counter Fraud Self Review Submission Tool.pdf

5.4 Counter Fraud Work Plan 19-20 - Craig Greenstock

5.4 NWSSP Counter Fraud Workplan 2019-20.doc

5.5 Counter Fraud Progress Update - Craig Greenstock

5.5 NWSSP Counter Fraud Progress Update.doc

5.5 Appendix 1 NWSSP Counter Fraud Progress Update.doc

5.6 Counter Fraud Lessons Learned - Craig Greenstock

5.6 NWSSP Counter Fraud Lessons Learned.doc

5.6 Appendix 1 NWSSP Counter Fraud Lessons Learned.doc

6 ITEMS FOR INFORMATION

6.1 Audit Committee Forward Plan - Rox Davies

6.1 Audit Committee Forward Plan.docx

6.2 NHS Counter Fraud Procurement Brief (Verbal) - Andy Butler

6.3 Welsh Language Standards Update (Verbal) - Peter Stephenson

6.4 WAO Audit ISA260 Report - Gillian Gillett

6.4 WAO Financial Statements Audit ISA260 Report.pdf

6.5 Freedom of Information Request Annual Report

6.5 NWSSP Freedom of Information Request Annual Report 2018-19.doc

6.6 Caldicott Principles Into Practice Annual Report

6.6 NWSSP Caldicott Report 2018-19.pdf

7 ANY OTHER BUSINESS (Prior Approval Only)

7.1 Meeting Review (Verbal) - Chair

8 DATE OF NEXT MEETING: Tuesday 22 October 2019 from 14:00-16:00 at NWSSP HQ, Boardroom, Unit 4-5 Charnwood Court, Heol Billingsley, Parc Nantgarw, CF15 7QZ

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

MINUTES OF MEETING HELD TUESDAY 9 APRIL 2019
14:00 – 16:00
BOARDROOM, NWSSP HQ, NANTGARW
Part A

ATTENDANCE	**DESIGNATION**	
INDEPENDENT MEMBERS:		
Martin Veale (Chair)	Chair & Independent Member	
Phil Roberts (PR)	Independent Member	
Ray Singh (RS)	Independent Member	
ATTENDANCE	**DESIGNATION**	**ORGANISATION**
ATTENDEES:		
Neil Frow (NF)	Managing Director	NWSSP
Margaret Foster (MF)	NWSSP Chair	NWSSP
Andy Butler (AB)	Director of Finance & 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)	Corporate Services Manager	NWSSP
Gareth Price	Personal Assistant	NWSSP
Oliver Rix	Graduate Management Trainee	NWSSP
Nigel Price (NP) *(part-meeting only)*	Local Counter Fraud Specialist	Cardiff & Vale UHB
Gillian Gillett (GG)	Audit Representative	Wales Audit Office

Item		**Action**
1. STANDARD BUSINESS		
1.1	**Welcome and Opening Remarks** The Chair welcomed Committee members to the April 2019 Audit Committee meeting.	
1.2	**Apologies** Apologies were received from: • Craig Greenstock, Local Counter Fraud Specialist, Cardiff & Vale University Health Board • Mark Osland, Director of Finance, Velindre University NHS Trust	

Item		Action
1.3	**Declarations of Interest** No declarations were received.	
1.4	**Unconfirmed Minutes from meeting on 22 January 2019** The minutes of the meeting held on the 22 January 2019 were **AGREED** as a true and accurate record of the meeting.	
1.5	**Matters Arising from meeting on 22 January 2019** It was noted that all matters arising were completed.	
2. COUNTER FRAUD		
2.1	**Counter Fraud Position Statement** NP provided an update on the Position Statement and assured the Committee that not much had changed from the previous report. There are currently two open investigations; a long-term investigation due to the large amount to be repaid and another, in which all the payments have been repaid. In relation to the National Fraud Initiative, all the checks have been completed and first results of matches will be fed back in September. NP confirmed that guidance had been circulated from NHS Counter Fraud concerning procurement and the Chair requested the guidance be brought to the next Committee meeting. AB highlighted the need to focus on the prevention agenda and had been in discussions with CG surrounding support of more positive, pro-active work taking place in NWSSP. The Chair confirmed that it would be useful to capture lessons learned from cases and whether any processes have changed as a result investigations and findings.	**NP/CG** **NP/CG**
3. ASSURANCE, RISK AND GOVERNANCE		
3.1	**Governance Matters** AB provided an update on Governance Matters and confirmed that there had been no departures from the Standing Orders. During the period from January to March 2019, a total of 10 contracts had been undertaken for NWSSP. In relation to All-Wales contracting activity, there had been four single quote actions, four single tender actions and two invitations to competitively quote. AB circulated a hard-copy addendum with figures concerning stores write-offs, showing the amount had decreased significantly	

Item		Action
	with £316 worth of stock having been written off during January and February 2019. AB was pleased to report that NWSSP submitted a nil return to Welsh Government concerning Limited Assurance Audit Reports generated.	
3.2	**Tracking of Audit Recommendations** RD confirmed the current position for the tracking of audit recommendations. There were 32 reports covered in the review, of which; six reports had achieved Substantial Assurance, 18 reports had achieved Reasonable Assurance, zero reports had been awarded Limited Assurance or No Assurance and eight reports were generated with Assurance Not Applicable. The report included 167 recommendations for action, with 146 implemented, 17 not yet due and 4 recommendations that had proposed Revised Deadlines for approval by Committee, requesting an extension to the timescale until 30 June 2019. The Committee resolved to **APPROVE** the Revised Deadlines.	
3.3	**Corporate Risk Register** PS presented the Corporate Risk Register and reminded Committee that the format had been split into two sections; risks for action and risks for monitoring. There were currently 2 red risks on the Register: • The long-standing risk regarding the demise of the Exeter system, whereby conversations were in progress with Northern Ireland and from a legal perspective, but there were still potential issues if that was to be the preferred solution in terms of costs; and • The risk regarding the impact of a no-deal Brexit. PS confirmed that a risk had been removed from the Register in relation to Payroll as this had been largely mitigated by the Bridgend boundary change. It was noted that risk A9 would need to be populated in due course and Committee appreciated this this risk had been recently added to the Register, following a formal Senior Management Team meeting.	**PS**

Item		Action
3.4	**Draft Annual Governance Statement** PS explained that the Statement was still in a draft format, although it was close to completion. The remaining sections to be finalised were the Audit Committee Effectiveness Survey Results, Head of Internal Audit Opinion outcome and sustainability figures as at year-end. The Committee noted it was a positive draft Statement. There were no limited or zero assurance internal audit reports to declare, the attendance at Committees has increased and the updated Risk Appetite Statement had been included, however it was noted that the majority of the content does not change from year to year as the template is prescriptive. The Chair queried whether there was an Action Plan for the Health and Care Standards Self-Assessment score, to address actions to progress to level 4 and PS confirmed that this would be brought to the next Committee meeting. It was confirmed that any suggested amendments to the draft Statement be sent through to PS for inclusion, by 16 May 2019.	**PS/RD** **PS/RD** **All**
3.5	**Audit Committee Effectiveness Survey** RD explained that the Survey would be issued using the set of benchmark questions developed last year, which aligned with the Audit Committee Handbook and our host, Velindre University NHS Trust. The key themes of the Survey were; compliance, internal control and risk management, internal and external audit, counter fraud and Committee leadership. RD confirmed that the Survey link would be circulated to Committee Members to complete by email and that it would close on Friday 10 May 2019, as this timescale aligned with the Annual Governance Statement completion. RD agreed to present the findings of the Survey at the July meeting.	**All** **RD**
4. EXTERNAL AUDIT		
4.1	**Wales Audit Office Position Statement** GG presented the WAO Position Statement, which set out progress against the work plan and highlighted that the majority of work had been completed; since the preparation and issue of Committee papers, the procurement work had also been finalised.	

Item		Action
	It was noted that the NHS Nationally Hosted IT Systems Assurance work was likely to be finished by the end of April, with the findings being presented to Committee in July. GG confirmed there were no significant concerns to bring to the attention of the Committee at this time and flagged that there was a good practice event in May which Committee Members may be interested in attending.	**AS/GG**
5. INTERNAL AUDIT		
5.1	**Internal Audit Position Statement** JQ reported good progress had been made against the work plan, with Internal Audit having issued 13 final reports and 6 being well-advanced work in progress. JQ reporting that there was a delay in obtaining management responses from Workforce and Organisational Development, largely due to the appointment of a new Director and Deputy to post. The Chair accepted this but noted that he would not expect to see the trend reoccur next year.	
5.2	**Recruitment and Retention Advisory Report** JQ confirmed that the Advisory Report was prepared upon request and the overall conclusion found pockets of good practice. The scope of the audit was to identify any recommendations for improvement in looking more strategically across NWSSP, as some of the challenges faced were consistent throughout the organisation. The report made 3 findings, with multiple recommendations made within the areas of management reporting, exit interviews and strategy. The Chair requested that management responses be explicit in stating whether they recommendations were Agreed or Not Agreed, at the outset.	**Internal Audit**
5.3	**General Ophthalmic Services Internal Audit Report** SC1 stated that the NHS Protect Ophthalmic Loss Measurement Exercise had sought to measure patient and contractor ophthalmic claims. The purpose of the review was to review the progress made in implementing the action plan agreed by the All Wales Counter Fraud Steering Group.	

Item		Action
	The findings highlighted substantial assurance, with 10 recommendations identified, of which 6 had been completed and 4 were ongoing. It was noted that some actions were not within the gift of NWSSP to implement, but rather sat with Welsh Government.	
5.4	**Business Continuity Planning Internal Audit Report** The review of Business Continuity Planning was completed in line with the 2018/19 Internal Audit Plan and achieved Reasonable Assurance. The findings highlighted 3 recommendations for action; 1 high priority, 1 medium priority and 1 low priority, which related to both physical and cyber security. The timescale for implementation was agreed as 30 June 2019.	
5.5	**Risk Management and Assurance Internal Audit Report** The review of Risk Management and Assurance achieved Substantial Assurance. The report found that the approach to risk management was positive and relatively mature, with established processes in place to ensure that corporate or organisational risks should be identified, mitigated, managed and monitored. The findings highlighted 2 recommendations; 1 medium and 1 low priority.	
5.6	**Employment Services Payroll Internal Audit Report** The review of Payroll Services achieved Reasonable Assurance and found there was additional work required to review pay award processes and the establishment of Health Education and Improvement Wales (HEIW) payroll. The findings highlighted 6 medium priority recommendations, of which 5 were reoccurring from the 2017-18 audit findings.	
5.7	**Review of Internal Audit Operational Plan 2019-20** JQ informed the Committee that the Operational Plan had been developed in accordance with Public Sector Internal Audit Standard. This result was achieved by meeting with each Director, an assessment of the Corporate Risk Register and considering additional documentation. The report was signed off by the SMT. The Committee were content to **APPROVE** the Internal Audit Operational Plan, on the basis that should further changes be required, they would be brought back to Committee to be considered for approval.	

Item		Action
6. ITEMS FOR INFORMATION		
6.1	**Audit Committee Forward Plan** Item received for Committee information only.	
6.2	**Review of Procedure for NHS Staff to Raise Concerns** Item received for Committee information only.	
6.3	**NWSSP Counter Fraud Policy** Item received for Committee information only.	
7. ANY OTHER BUSINESS (Prior Approval Only)		
7.1	**Any Other Business (Prior Approval Only)** No further items were raised during the meeting.	
7.2	**Meeting Review** The Chair conducted a review of effectiveness of the meeting and the observations of Committee Members were very positive.	
DATE OF NEXT MEETING: Tuesday, 9 July 2019 from 14:00-16:00 NWSSP Boardroom HQ, Charnwood Court, Nantgarw		

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

Actions arising from the meeting held on 9 April 2019			
2.1	CG/AB	**Counter Fraud Position Statement** • Update to be provided on NHS Counter Fraud Guidance regarding procurement • Lessons learned from cases and whether any processes have changed as a result investigations and findings to be captured and included in report	**Complete** – AB to provide verbal update and lessons learned to be included, going forward
3.3	PS	**Corporate Risk Register** • Risk A9 to be populated, in due course, as recently added to the Register	**Complete** – Risk now mitigated and removed from Register
3.4	PS/All	**Draft Annual Governance Statement** • Sections to be finalised were the Audit Committee Effectiveness Survey Results, Head of Internal Audit Opinion outcome and sustainability figures as at year-end • Action Plan for the Health and Care Standards to be brought to next Committee meeting • Any suggested amendments to be provided by 16/05/2019	**Complete** – Final AGS and Health & Care Standards Action Plan are agenda items
3.5	RD/All	**Audit Committee Effectiveness Survey** • Survey link to be circulated to Committee Members to complete by 10/05/2019 • Results to be presented at the July Committee meeting	**Complete** – Agenda item to present findings
4.1	AS/GG	**Wales Audit Office Position Statement** • NHS Nationally Hosted IT Systems Assurance work would be finished by the end of April, with the findings being presented to Committee in July	**Complete** – Agenda item to present findings
5.2	IA	**Recruitment and Retention Advisory Report** • Management responses be explicit in stating whether recommendations were Agreed or Not Agreed, at the outset	**Complete** – Action shared with Internal Audit

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Nationally Hosted NHS IT Systems – **Velindre University NHS Trust – NHS Wales Shared Services Partnership**

Audit year: 2018-19

Date issued: June 2019

Document reference: 1351A2018-19

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

The team who delivered the work comprised Andrew Strong, Paul Cunningham and Gareth Lewis.

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The IT controls we examined assured us that financial values produced by the systems for 2018-19 were likely to be free from material misstatement, although some controls could be strengthened.

Summary report

Detailed report

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Summary report

Summary

1 NHS bodies in Wales are responsible for preparing financial statements that give a true and fair view of the state of their financial affairs as at 31 March 2019. They must ensure that they are properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made thereunder by Welsh Ministers. NHS bodies are also responsible for preparing Annual Governance Statements in accordance with guidance issued by HM Treasury and the Welsh Government.

2 The Auditor General is responsible for providing an opinion on whether each NHS body's financial statements represent a true and fair view of the state of its financial affairs as at 31 March 2019.

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

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

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

5 International Auditing Standard (ISA) 315 requires us to obtain an understanding of the general IT and application controls of the financial systems used by NHS Wales. As part of the National Hosted NHS IT Systems audit plan, the Wales Audit Office reviewed the above-mentioned systems during 2018-19 and followed up our prior audit recommendations in these areas. This work reviews the ICT environment and application controls that are applied to the National Hosted NHS IT Systems solely for the purposes of providing assurance for NHS audit opinions. We have taken the opportunity to identify actions that, in our view, would help NHS Wales improve its governance and use of these systems.

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

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

7 We have therefore undertaken a review that sought to answer the question:

'Can auditors be assured that the IT system controls are such that financial values are likely to be free from material misstatement?'

8 We concluded that the IT controls applied to the Prescription Pricing, National Health Application Infrastructure, Oracle Financials systems and ESR Payroll systems administration managed by NHS Wales Shared Services, were sufficiently effective to allow financial auditors to take assurance that financial values produced by the systems for 2018-19 were likely to be free from material misstatement. However, NWSSP could strengthen some controls.

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

- the Prescription Pricing System's controls support the production of information that is free from material misstatement, although, the server operating system environment should be updated by January 2020;
- the National Health Application and Infrastructure Service system's controls support the production of information that is free from material misstatement, however, system replacement plans and agreeing NHS Wales system availability after decommissioning are yet to be agreed;
- the Oracle FMS's IT controls support the production of information that is free from material misstatement, although, information security controls need review; and
- the ESR Payroll's Shared Services system administration controls support the production of information that is free from material misstatement.

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

Detailed report

The Prescription Pricing System's controls support the production of information that is free from material misstatement, although, the server operating system environment should be updated by January 2020

11 We have identified no significant IT application or infrastructure issues likely to result in a material misstatement within the Prescription Pricing System. However, we identified some issues that should be addressed by Primary Care Services in order to minimise the potential for future application and infrastructure system risks. From our IT work in 2018-19, we have identified a number of recommendations to NWSSP for improvement. These are outlined below:

- update the Windows Server 2008 to a supported platform (for example, Windows Server 2012 or higher) by January 2020 and establish a roadmap to complete this action. NWSSP operates the Prescription Pricing system on a SQL Server 2008 environment which is de-supported by the manufacturer in January 2020. Therefore, from January 2020 the manufacturer will not be providing software updates to this environment and any potential security vulnerabilities could be exploited.
- test the Prescription Pricing systems IT Disaster Recovery plans at least annually.
- strengthen the Service Level Arrangement (SLA) with NWIS to include details of the responsibilities for NWIS to take daily backups of the Prescription Pricing systems data and confirm that daily checks are undertaken to monitor the data backup has been successfully completed.

12 In 2017-18, we identified one recommendation to replace and re-procure the SQL server 2008 support and maintenance contract over the Prescription Pricing system server set up. NWSSP has completed the re-procurement in 2018 to replace the arrangement that expired in February 2018.

13 In 2016-17, we identified recommendations for improvement for the Prescription Pricing system. The NWSSP has made good progress to address these by:

- updating and documenting in June 2018 IT Disaster Recovery and Business Continuity plans for the Prescription Pricing systems; and
- performing internal penetration testing in July 2018 on the Prescription Pricing System hardware and software.

14 Further details of our findings and progress against actions for the Prescription Pricing System agreed with Primary Care Services officers can be found in Appendix 1.

The National Health Application and Infrastructure Service system's controls support the production of information that is free from material misstatement, however, system replacement plans and system availability after decommissioning are yet to be agreed

15 We have identified no significant issues within the NHAIS system likely to result in a material misstatement. However, we have identified some issues that should be addressed by NWSSP in order to minimise the potential for future application and infrastructure system risks. From our work in 2018-19 we have identified one recommendation to NWSSP for improvement. These are outlined below:

- update the Windows Server 2008 to a supported platform (for example, Windows Server 2012 or higher) by January 2020 and establish a roadmap to complete this action. NWSSP operates the NHAIS IT system backup servers on a Window Server 2008 environment which is de-supported by the manufacturer in January 2020. Therefore, from January 2020 the manufacturer will not be providing software updates to this environment and any potential security vulnerabilities could be exploited.

16 In 2017-18, we identified a number of recommendation for improvement for the NHAIS. The NWSSP has made some progress to address these actions in 2018 -19 by:

- updating and testing the NHAIS backup procedures and IT Disaster Recovery plans to ensure they work as intended;
- discussing with NWIS the Service Level Agreement (SLA) for the support and maintenance of the NHAIS application and infrastructure, to make responsibilities and functions more detailed, although these remain ongoing pending the NHAIS system replacement plans;
- documenting a standard operating procedure for how the systems administrator creates, amends and removes user access accounts to the NHAIS system;
- completing a regular review, for example, annually, of the user access accounts to NHAIS to ensure these are appropriate to job function; and
- working to plan the replacement of the ageing NHAIS servers used in the NHAIS system replacement project some of which are approaching ten years old and the in-house support and maintenance cover arrangements.

17 In 2016-17, we identified a number of recommendation for improvement for the NHAIS. The NWSSP has made some progress to address these actions by:

- discussing with NHS Digital to arrange and agree the NHAIS replacement plans. NWSSP has planned to make a formal decision later in 2019 on the preferred solution for replacing NHAIS GMS processing, subject to Velindre NHS Trust approval. NWSSP plans to implement the preferred payments processing solution in early 2020. Work is underway with NHS England and NHS Digital on a contingency plan from April 2020 onwards. This is required to ensure system continuity so NHS Wales will have continued use of NHAIS whilst the replacement systems are implemented.
- strengthening NHAIS password reset controls to verify and authenticate the user credentials.

18 Further details of our findings and progress against actions for the NHAIS system agreed with Primary Care Services officers can be found in Appendix 1.

The Oracle FMS's IT controls support the production of information that is free from material misstatement, although information security controls need review

19 We have identified no significant IT application or infrastructure issues likely to result in a material misstatement within the Oracle FMS. However, we identified some issues that should be addressed by Shared Services in order to minimise the potential for future application and infrastructure system risks. From our work in 2018-19, we have identified a number of recommendations to NWSSP for improvement. These are outlined below:

- ensure those NHS organisations who did not attend the November 2018 Oracle FMS IT Disaster Recovery (DR) test participate in the November 2019 scheduled test. The November 2018 IT DR test was the first test to be undertaken on the new Oracle hardware platform. In addition, the newly formed Health Education and Improvement Wales should also attend the testing.
- strengthen the IT controls over the Services and Accommodation Centre (SAC) data centre where the primary Oracle FMS hardware is hosted. NWSSP can address this by replacing the room Uninterruptible Power Supply which is end-of -life and ensuring the Oracle FMS servers are operating at an appropriate temperature.

- improve the IT controls over the Cardiff Royal Infirmary data centre where the Oracle FMS secondary and backup servers are hosted. NWSSP can address this by installing additional air conditioning units in the room and redirecting the room CCTV camera onto the direction of the data centre door.

20 In 2017-18, we identified a number of recommendations for improvement for the Oracle FMS. The NWSSP has made some good progress to address these actions by:

- reviewing the Oracle backup hardware and server racking arrangements in the Cardiff Royal Infirmary (CRI) data centre so they better fit the racks available.
- scheduling and completing an IT Disaster Recovery test on the Oracle FMS service for November 2018.
- completing an internal vulnerability assessment in late 2018 of the new Oracle FMS infrastructure implemented mid March 2018 to identify any potential security threats.
- initiating a gap analysis assessment to the Information Security Management Standard (ISO 27001) to identify potential improvement areas. CTES should then formally consider and decide whether the Oracle service aims for a formal ISO 27001 accreditation.
- initiating a review to consider and complete accreditation to the Information Technology Service Management (ISO 20000) standard for service management.

21 Further details of our findings and progress against actions for the Oracle FMS agreed with Shared Services can be found in Appendix 1.

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

22 The Electronic Staff Record (ESR) Payroll system is managed and hosted nationally by IBM on behalf of NHS England and NHS Wales under a managed service contract. We have reviewed the ESR Payroll systems administration controls (payroll elements only) managed by NWSSP. This responsibility includes managing user access to the payroll system in Wales by the NWSSP Employment Services staff who process the Welsh NHS organisations' payrolls. In addition to

seeking to place reliance on the International Standard on Assurance Engagements (ISAE) 3000 report of the IBM Service Auditor noted below, Wales Audit Office IM&T auditors have reviewed the controls in place over the ESR Payroll systems administration managed under a delegated authority by NWSSP, Employment Services.

23 We have not identified any significant IT issues likely to result in a material misstatement within these ESR Payroll systems' administration controls. From our work in 2018-19, we have identified no recommendations to NWSSP for improvement.

24 In 2017-18, we identified a number of recommendations for improvement. NWSSP has made progress against these actions by:

- completing a more frequent review of ESR payroll user access rights to ensure these are appropriate to job functions. NWSSP has set these reviews to every six months commencing with the review in July 2018.
- documenting and formally agreeing an access permissions and functionality matrix used to help establish ESR payroll access profiles to enforce segregation of duties. NWSSP uses this matrix to help structure the review of core ESR payroll user access in the scheduled user access review.

25 We sought to place reliance on the ISAE 3000 report of the IBM Service Auditor, PwC, on the general IT controls applied at IBM. PwC conducted the review in accordance with the ISAE 3000 'Assurance Engagements Other Than Audits or Reviews of Historical Financial Information'. For the period 1 April 2018 to 31 March 2019, PwC concluded that the ESR payroll general IT controls and environment were suitably designed and operated effectively. PwC has not identified in their 2018-19 work any improvement areas or recommendations to the IT controls used by the NHS ESR Central Team and IBM.

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

Recommendations

27 Exhibit 1 sets out the recommendations that we have identified in 2018-19. NWSSP should take action to address these recommendations. The appendix to this report sets out progress made against all the previously reported recommendations that remain in progress and ones that have been completed in 2018-19.

Exhibit 1: 2018-19 recommendations

Recommendations
Prescription Pricing System IT controls
R 2019.1 Update the Windows Server 2008 to a supported platform (for example, Windows Server 2012 or higher) by January 2020 and establish a roadmap to complete this action. R 2019.2 Test the Prescription Pricing systems IT Disaster Recovery plans at least annually. R 2019.3 Strengthen the Service Level Arrangement (SLA) with NWIS to include details of the responsibilities for NWIS to take daily backups of the Prescription Pricing systems data and confirm that daily checks are undertaken to monitor the data backup has been successfully completed.
National Health Application and Infrastructure Services IT controls
R 2019.4 Update the Windows Server 2008 to a supported platform (for example, Windows Server 2012 or higher) by January 2020 and establish a roadmap to complete this action.
Oracle FMS IT controls
R 2019.5 Ensure those NHS organisations who did not attend the November 2018 Oracle FMS IT Disaster Recovery (DR) test participate in the November 2019 scheduled test. R 2019.6 Strengthen the IT controls over the Services and Accommodation Centre (SAC) data centre by replacing the room UPS which is end-of -life and ensuring the Oracle FMS servers are operating at an appropriate temperature. R 2019.7 Improve the IT controls over the CRI data centre by installing additional air conditioning units in the room and redirecting the room CCTV camera onto the direction of the data centre door.

Appendix 1

Issues and recommendations arising from the review of National Hosted NHS IT Systems in prior audit years and in 2018-19 – NHS Wales Shared Services Partnership

Exhibit 2: issues and recommendations

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
Prescription Pricing System – IT controls work						
2016-17.1	IT DR plans that include the Prescribing Services Systems are out of date and should be updated.	Update the IT DR plan that covers the Prescribing Services Systems, and test the plans to ensure they work as intended.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Completed** NWSSP has completed a Business Impact Assessment and a DR Plan. NWSSP presented the DR plan to the SMT in July 2018.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
Prescription Pricing System – IT controls work						
2016-17.3	Whilst external penetration testing is performed on the NHS network infrastructure, internal penetration testing on the Community Pharmacy hardware and software used, has not been recently performed. Increased risk of vulnerabilities within the Community Pharmacy hardware and software may remain undetected, and this could increase the risk of unauthorised access to patient identifiable prescription information.	Perform internal penetration testing on the Community Pharmacy hardware and software on a regular basis, for example, at least annually.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Completed** NWSSP completed a penetration test on the PPS in July 2018.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
Prescription Pricing System – IT controls work						
2017-18.1	At the time of our fieldwork in March 2018 Primary Care Services has commenced plans to approve the re-procurement for the SQL 2008 server support and maintenance. The SQL server 2008 support and maintenance contract over the Prescription Pricing system server set up expired at the end of February 2018.	Replace and re-procure the SQL server 2008 support and maintenance contract over the Prescription Pricing system server set up that expired in February 2018.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Completed** NWSSP has approved capital allocation in 2018-19. NWSSP has procured an extended support for existing servers in Q2 2018.
2018-19.1	The Prescription Pricing system operates on a SQL Server 2008 environment which is de-supported by the manufacturer in January 2020. This means from January 2020 the manufacturer will not be provided software updates to this environment and any potential	Update the Windows Server 2008 to a supported platform (for example, Windows Server 2012 or higher) by January 2020 and establish a roadmap	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Ongoing** The new server environment has been built and was handed over to PCS on 12 June. PCS is in the process of migrating systems onto the new environment and would expect to have this

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
	security vulnerabilities could be exploited;	to complete this action.				aspect complete by 30th June. A period of testing will be followed by the identification of a two-day out-of-hours change window. This is currently planned for completion by 27 August, 2019.
2018-19.2	An IT Disaster Recovery (DR) plan has been documented for the Prescription Pricing system. However, the IT DR plan is only scheduled to be tested every two years.	Test the Prescription Pricing systems IT Disaster Recovery plans at least annually.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Complete** Schedule has since been amended to annual. Next scheduled test is March 2020.
2019-19.3	A Service Level Arrangement (SLA) with NWIS is in place which covers responsibilities and accountabilities over the Prescription Pricing system. Documentation can be strengthened of the details over the responsibilities for NWIS to take daily backups of the Prescription Pricing systems data and confirm that daily checks are undertaken to confirm and monitor the backup has successfully been completed.	Strengthen the Service Level Arrangement (SLA) with NWIS to include details of the responsibilities for NWIS to take daily backups of the Prescription Pricing systems data and confirm that daily	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Ongoing** PCS are already on the distribution list for the daily notification of backup status delivered automatically by the backup software and check the notifications as part of the daily task schedule.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
		checks are undertaken to confirm and monitor the backup has successfully been completed.				Formal inclusion of this arrangement in the NWSSP-NWIS SLA will require a change notice to be raised by NWSSP Business Systems and Informatics.
National Health Application and Infrastructure Services – IT controls work						
2017-18.3	NHS England are planning to decommission NHAIS from April 2018. NWSSP should arrange and agree with NHS England and NHS Digital a contingency plan from April 2018 onwards to ensure, for an agreed period of time, NHS Wales access to the NHAIS system to ensure system availability. This is required so NHS Wales can carry on using NHAIS whilst replacement systems are implemented or developed in NHS Wales.	Arrange and agree with NHS England and NHS Digital a contingency plan from April 2018 onwards to ensure for an agreed period of time continued access to the NHAIS system to ensure system availability. This is required so Wales can carry on using NHAIS whilst replacement systems are implemented and developed in NHS Wales.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Ongoing** Timescales for the decommissioning of NHAIS in England & Wales have been extended to 2020-21. Support agreements are in place with NHS Digital for 2019-20. It should also be noted that discussions are on-going with regard to further extensions of these agreements in line with the revised decommissioning plan for Wales.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
National Health Application and Infrastructure Services – IT controls work						
2017-18.2	The NHAIS backup procedures and IT Disaster Recovery (DR) plans would benefit from being updated for changes to the IT infrastructure set up and support arrangements. Once updated these plans should be tested to ensure they work as intended.	Update and test the NHAIS backup procedures and IT Disaster Recovery plans to ensure they work as intended.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Completed** NWSSP has updated a DR plan. NWSSP has completed restores to the test environment in early 2018.
2018-19.3	A Service Level Agreement (SLA) is in place between NWSSP and NWIS for the support and maintenance of the applications and infrastructure, for example, NHAIS. These responsibilities and functions to be completed and delivered for NHAIS service support and service delivery can be made more detailed and documented.	Clarify and expand the Service Level Agreement with NWIS for the support and maintenance of the NHAIS application and infrastructure.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Ongoing** NWSSP has planned to review the SLA when options for NHAIS replacement are confirmed. NWSSP plan to complete the action in 2019-20.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
National Health Application and Infrastructure Services – IT controls work						
2017-18.4	The NHAIS system administrators uses this system manager access privilege to create, amend and remove user access accounts on the NHAIS system. However, the process the systems administrator uses to create, amend and remove user access accounts to the NHAIS system is not documented.	Document procedures for the process the systems administrator uses to create, amend and remove user access accounts to the NHAIS system.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Completed** NWSSP has completed this action in late 2018.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
National Health Application and Infrastructure Services – IT controls work						
2017-18.5	There is no regular review, for example, annually, of the user access accounts to NHAIS to ensure these are appropriate to job function. Any review performed is infrequently or 'ad hoc'.	Complete a regular review, for example, annually, of the user access accounts to NHAIS to ensure these are appropriate to job function.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Completed** NWSSP has completed this action in late 2018 by undertaking a review of access.

New issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
National Health Application and Infrastructure Services – IT controls work						
2018-9.4	The NHAIS IT system backup servers operates on a Window Server 2008 environment which is de-supported by the manufacturer in January 2020. This means from January 2020 the manufacturer will not be provided software updates to this environment and any potential security vulnerabilities could be exploited.	Update the Windows Server 2008 to a supported platform (for example, Windows Server 2012 or higher) by January 2020 and establish a roadmap to complete this action.	**Medium**	**Yes**	**Dave Hopkins, PCS Director**	**Ongoing** NWIS are in the process of developing a plan to upgrade all Windows Servers from WS2008. These servers are included in that plan. NWSSP will be notified of the upgrade date when the plan in complete.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
Oracle Financial Management System – IT controls work						
2017-18.9	Indicators are collected and measured on the delivery and performance of the Oracle FMS service. However, these are not routinely reported to the Oracle Strategy Development Group (STRAD) on a quarterly basis to allow performance against service level targets to be monitored and challenged.	Prepare a summary dashboard of the key performance indicators of the Oracle FMS service and Central Oracle Team responsibilities, for example, the set up of new suppliers, Oracle transaction times and IT service issue calls raised and closed. Report these performance indicators to the Oracle Strategy Development Group on a quarterly basis for assurance and scrutiny of the FMS Service provided.	**Medium**	**Yes**	**Said Shadi, Associate Programme Director**	**Completed** CTES report indicators regarding service availability, performance and response times to the Oracle STRAD Group. CTES completed this action from the end of 2018.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
Oracle Financial Management System – IT controls work						
2017-18.7	The Cardiff Royal Infirmary (CRI) data centre hosts the Oracle backup servers. CTES was managing the upgrade of this Oracle hardware in early 2018. However, we identified during our fieldwork that the new Oracle servers installed for the March 2018 implementation did fit the racks but the door could not be closed and locked. Furthermore, the servers were not spaced out across the whole server racks so potentially circuit overloading may occur and potential overheating. This issue was raised on the day of the audit fieldwork in February 2018 and it was a known issue.	Install larger racks for the new Oracle hardware so the racks doors can be closed and the servers should be spread out across the top and bottom half of the racks to avoid potential overheating and overloading of circuits.	**Medium**	**Yes**	**Said Shadi**, Associate Programme Director	**Completed** CTES has ensured the new rack was successfully installed in April 2018 and all the new infrastructure re-installed. No heating issues have been reported since fine tuning of fan speeds on relevant servers.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
Oracle Financial Management System – IT controls work						
2017-18.9	The last IT Disaster Recovery (DR) test on the Oracle FMS service was in July 2017. NWSSP plan the annual scheduled IT DR test for every November. However, due to the Oracle FMS hardware upgrade completed in March 2018 this was put on hold until the new IT infrastructure was deployed.	Schedule and complete an IT Disaster Recovery test on the Oracle FMS service for June or July 2018.	**Medium**	**Yes**	**Said Shadi**, Associate Programme Director	**Completed** CTES has completed the annual IT DR test following the migration onto the IT infrastructure in November 2018.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
Oracle Financial Management System – IT controls work						
2017-18.10	NWSSP last completed an internal vulnerability assessment of the Oracle FMS and infrastructure set up in September 2017. The Oracle hardware was upgraded in March 2018. NWSSP should plan and schedule an internal vulnerability assessment of the new Oracle FMS infrastructure set up implemented mid March 2018 to identify any potential security threats.	Plan and schedule an internal vulnerability assessment of the new Oracle FMS infrastructure set up implemented mid March 2018 to identify any potential security threats.	**Medium**	**Yes**	**Said Shadi**, Associate Programme Director	**Completed** CTES has completed an IT penetration test for the new IT infrastructure was in March 2018. CTES completed a further penetration test in Q2 2018 as part of the first change release cycle post go-live onto the new infrastructure. NWSSP has completed all critical recommendations from this testing.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2018**
Oracle Financial Management System – IT controls work						
2017-18.11	CTES has not completed and documented a gap analysis assessment of the Oracle FMS to the Information Security Management Standard (ISO 27001) to identify potential improvement areas. It is good security management practice to assess and baseline a comparison to the ISO 27001 standard. CTES should then formally consider and whether the Oracle service aims for a formal IS027001 accreditation.	Complete a gap analysis assessment to the Information Security Management Standard (ISO 27001) to identify potential improvement areas. CTES should then formally consider and decide whether the Oracle service aims for a formal IS027001 accreditation.	**Medium**	**Yes**	**Said Shadi**, Associate Programme Director	**Ongoing** CTES has contracted the support and management of the Oracle FMS services to Version 1 Solutions Ltd who are ISO 27001 accredited. CTES will be completing a gap analysis by the end of August 2019. CTeS to attend external training in July, this could not be undertaken any earlier due to previous course cancellations. The outcome will be a set of recommendations to implement during 2020-21

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2018**
Oracle Financial Management System – IT controls work						
2017-18.12	CTES provides FMS services to the consortium of Welsh NHS organisations. It is good practice IT service management to conform or be accredited to the Information Technology Service Management (ISO 2000) standard. CTES should consider the benefits to complete accreditation to the Information Technology Service Management (ISO 2000) standard for service management.	CTES should consider whether it aims to complete accreditation to the Information Technology Service Management (ISO 2000) standard for service management.	**Medium**	**Yes**	**Said Shadi**, Associate Programme Director	**Ongoing** CTES has included work to obtain ISO 20000 on the division work plan. CTES has initiated work and this continues to be progressed albeit slowly due to high priority business deliverables. The aim is to implement the policies and processes to achieve accreditation by April 2020.

New issues identified during IT audit work					
Issue	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
Oracle Financial Management System – IT controls work					
2018-19.5 The November 2018 IT Disaster Recovery test was the first test to be undertaken on the new Oracle hardware platform. However, not all NHS organisations attended the scheduled test as planned. In addition, the newly formed Health Education and Improvement Wales should also attend the next testing as they were formed later in 2018.	Ensure those NHS organisations who did not attend the November 2018 Oracle FMS IT Disaster Recovery (DR) test participate in the November 2019 scheduled test.	**Medium**	**Yes**	**Said Shadi**, Associate Programme Director	**Ongoing** All apart from two organisations all participated in the annual Business Continuity/Disaster Recovery (BCDR) test in November 2018. The remaining two organisations are expected to partake in the BC DR scheduled for November 2019.
2018-19.6 The Services and Accommodation Centre (SAC) data centre hosts Oracle FMS hardware which the main or primary system operates on. However, on the day of our fieldwork we identified that:	Strengthen the IT controls over the Services and Accommodation Centre (SAC) data centre by replacing the room UPS which is end-of -life and ensuring the	**Medium**	**Yes**	**Said Shadi,** Associate Programme Director	**Ongoing** CTeS in conjunction with Version 1 have been monitoring the temperatures of the servers. The temperature status of all servers are included in the monthly service reports. To date the servers remain within

New issues identified during IT audit work					
Issue	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
• the SAC data centre room Uninterruptible Power Supply (UPS) is approximately 13 years old and considered end-of -life. This should be replaced. • the area directly behind the Oracle FMS servers was hot and CTES should check whether these were operating at an appropriate temperature. CTES should consider installing additional air conditioning or zone temperature reduction controls.	Oracle FMS servers are operating at an appropriate temperature or install additional air condition at the back of the Oracle FMS servers.				acceptable tolerances and the situation continues to be monitored. Waiting for confirmation from CAV UHB on plans to upgrade their UPS in SAC. The situation remains under review.
2018-19.7 The Cardiff Royal Infirmary (CRI) data centre hosts Oracle FMS hardware which the	Improve the IT controls over the CRI data centre by	**Medium**	**Yes**	**Said Shadi,** Associate Programme Director	**Completed** There are now upgraded N+1 AC units installed in the room.

New issues identified during IT audit work					
Issue	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
secondary or backup system operates on. However, on the day of our fieldwork we identified that: • there were only two air conditioning units in the room so there was no redundancy or spare capacity, for example, in the event of one unit failing; and • the data centre room CCTV camera, located in the corridor outside the room, was not directed onto the main access door.	installing additional air conditioning units in the room and redirecting the room CCTV camera onto the direction of the data centre access door.				The CCTV in the corridor has been reported to Security to determine whether it can be fixed. Notwithstanding this, there is now a CCTV unit in the CRI data room and reporting back separately to our network for remote monitoring.

Issues identified during IT audit work						
Ref	**Issue**	**Recommendation**	**Priority**	**Agreed**	**Trust responsibility and actions – NWSSP**	**Current status – June 2019**
ESR Payroll systems administration – IT controls work						
2017-18.14	Complete a review of ESR payroll user access rights provided to ensure these are appropriate to job functions complete should place more frequently, for example, every 6 months. During our audit fieldwork in March 2018 NWSSP indicated that these reviews had moved during 2017 from 12 month to every 6 months with the next 6 month review planned for July 2018.	Review the shared services payroll access on a regular basis, for example, every six months, to ensure access is appropriate to job function.	**Medium**	**Yes**	**ESR System Administrator**	**Completed** Employment Services has reviewed payroll user access in line with the Payroll User Responsibility Profile User Access Matrix in July 2018. Employment Services has now scheduled to review the user access every six months.

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Auditor General for Wales

Management Letter – **NHS Wales Shared Services Partnership**

Audit year: 2018-19

Date issued: June 2019

Document reference: **1328A2019-20**

Contents

Our work did not identify any significant issues that would prevent us relying on services provided by NHS Wales Shared Services Partnership (NWSSP) although improvements could be made in some areas.

Summary report

Appendices

Summary report

Introduction

1 In January 2019, we presented a paper to the Velindre University NHS Trust's (the Trust) Audit Committee for Shared Services – **2019 Audit Assurance Arrangements – NHS Wales Shared Services Partnership**. The paper set out the external audit assurance arrangements, in line with the requirements of International Standards on Auditing (UK and Ireland) (ISAs) relevant to those services provided by the NHS Wales Shared Services Partnership (NWSSP).

2 The local audit teams of each individual health body are responsible for providing an opinion on health body financial statements, and determine what work is required on NWSSP services. Auditors decide whether testing of the key controls within the system, or substantive testing of the figures produced by the system, provides the required assurance in the most efficient way.

3 In this report we set out all the matters relevant to the services NWSSP provides, that we and the local audit teams of individual health bodies identified. This report sets out the findings and recommendations in respect of:

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

4 We will report the detailed findings from our review of the nationally hosted NHS IT Systems separately.

Issues arising from the audit

5 Our work did not identify any significant issues that would prevent us relying on services provided by NHS Wales Shared Services Partnership (NWSSP) although improvements could be made in some areas.

Audit and Assurance Services

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

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

Primary Care Services

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

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

9 Our testing covered the primary care teams in Swansea and Mamhilad and the CPPS team in Companies House and found that the controls tested were operating effectively and could therefore be relied upon.

General pharmaceutical services – controls over prescriptions

10 The Professional Services Team (PST) carry out sample checks to test the accuracy of prescriptions input (both automatic and or manual) and undertake 100% checks over processed scripts for 'verification' and 'high-cost' items. Our testing found that the PST were undertaking these checks but due to the way in which pharmacies are grouped into codes (with Hywel Dda and Powys grouped together) and the lower number of pharmacies within the Powys Health Board region, the PST had only included one Powys pharmacy within their quality assurance checks in the period April to December 2018.

11 One recommendation for improvement has been made which is documented in Appendix 1 (Recommendation 1).

Employment Services

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

13 All-Wales exception reporting parameters were agreed and implemented in July 2018 and our testing found that, except for the Public Health Wales weekly payroll, exception reports were produced but internal control procedures were not being followed in all cases:

- testing of monthly exception reports for the Cardiff and Vale payroll team found that three of the 15 tested did not have evidence of senior officer review (Cardiff & Vale payroll month 8, HEIW payroll months 8 & 9). In addition, the same officer had undertaken the initial and final review of three of the exception reports tested (Velindre payroll month 3, PHW payroll month 6, HEIW payroll month 10) and not all entries on a further three

exception reports had evidence of review (Cwm Taff payroll months 3 & 9, HEIW payroll month 10).

- testing of weekly exception reports for the Cardiff and Vale payroll team found that 15 of the 60 tested did not have evidence of senior officer review (Cwm Taff payroll weeks 1, 17 and 22, Velindre payroll weeks 2, 9, 10, 13, 14, 17, 18, 26, 32, 33, 37 and 38). In addition, the same officer had undertaken the initial and final reviews of 8 of the exception reports tested (Cardiff & Vale payroll weeks 19 and 33, Cwm Taff payroll weeks 4, 6, 8, 11, 12 and 13) and explanations for variances were not recorded on a further seven exception reports, although there was evidence of review (Cardiff & Vale payroll weeks 19, 20, 32, 33, 34 & 35 and Cwm Taff payroll week 17). A further two exception reports could not be tested as they had not been run (Velindre payroll weeks 3 and 20).
- testing of monthly exception reports for the Aneurin Bevan payroll team found that three of the six tested did not have evidence of senior officer review (Powys payroll months 2, 3 and 8). In addition, two of these exception reports were not always annotated as to how an exception query had been resolved (months 2 and 3).
- testing of weekly exception reports for the Aneurin Bevan payroll team found that the same officer had undertaken the initial and final reviews of three of the 20 exception reports tested (Aneurin Bevan payroll weeks 3, 12 and 15).

14 One recommendation for improvement has been made which is documented in Appendix 1 (Recommendation 2).

Procurement Services

15 Local health body audit teams did not plan to place reliance on the key controls within the accounts payable system, instead undertaking substantive testing of the figures produced by the system. Our work was therefore limited to documenting the information flows within the accounts payable system operated within NWSSP – Procurement Services (PS) located within Companies House, Cardiff.

Legal and Risk Services

16 Local audit teams of each health body need to consider ISA 500 – Audit evidence – to assess the adequacy of Legal and Risk Services as a management expert for the purposes of the audit. To aid this evaluation, we considered the arrangements in place against the requirements of ISA 500. Based on the work we undertook, we did not identify any issues that would prevent us relying on NWSSP – LARS's work as a management expert.

17 Controls are in place to mitigate against any threats to objectivity, although three staff who either qualified or started in year had not completed a declaration of interests form. This therefore weakens the controls in place to mitigate any threats

to objectivity. The Director of L&RS has informed us that new starters will be asked to complete the declaration of interest form as part of their induction process going forward.

18 One recommendation for improvement has been made which is documented in Appendix 1 (Recommendation 3).

Recommendations arising from our 2018-19 financial audit work

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

Appendix 1

Recommendations arising from our 2018-19 audit work

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

Exhibit 1: recommendations

Para	Issue	Recommendation	Priority	NWSSP responsibility and actions	Completion date
NWSSP – Primary Care Services					
10	The PST had only included one Powys pharmacy within their quality assurance checks.	R1 NWSSP – PCS should allocate a separate code to each health board to enable the PST to select pharmacies for sample checking from all health board areas.	Low	Accepted, PCS at present allocate by the old Dyfed/Powys cohort of community pharmacies. From May prescription processing this will be allocated on the present 7 LHB model with a defined percentage allocated equally at all LHB levels.	31 July 2019
NWSSP – Employment Services					
13	Internal control procedures for review of exception reports were not being complied with.	R2 NWSSP – ES should ensure that internal control procedures for reviewing exception reports are complied with.	Medium	Presentations held with staff to re-iterate the exception and checking process. A revision of the checking process is planned to enable an electronic controlled process that will ensure segregation of officers in respect of checking and sign-off and completion of the checking report.	31 August 2019

Para	Issue	Recommendation	Priority	NWSSP responsibility and actions	Completion date
NWSSP – Legal and Risk Services					
17	New starters had not completed a declaration of interest form.	R3 New starters should be asked to complete the declaration of interest form as part of their induction process.	Low	This will be included as part of the formal induction process and will be referenced in the office Manual.	30 September 2019

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

Date issued: July 2019

Document reference: APS201907

Contents

Progress update

About this document

1 This document provides the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership 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 2019 are set out in Exhibit 1.

Exhibit 1: assurance arrangements

Area of work	Current status
Assurance arrangements 2019	Presented to Audit Committee January 2019

Audit update

3 The progress of the audit assurance work detailed in our 2019 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 2019	Complete
Payroll	Update our understanding of the payroll system and identify key controls. Controls testing of exception reports.	March 2019	Complete

Area of work	Scope	Planned timetable	Current status
General Medical Service	Update our understanding of the general medical system and identify key controls. Controls testing of global sum payments (capitation lists and patient rates).	January – March 2019	Complete
Pharmacy & Prescribed drugs	Update our understanding of the pharmacy contract and prescribed drugs systems. Controls testing of payments to pharmacists (checks undertaken by the Professional Services Team and drug tariff rates).	January – March 2019	Complete
Accounts Payable & Public Sector Payment Policy	Update our understanding of the accounts payable system and undertake any substantive or controls testing as determined by local audit teams. Review the process of how PSPP works in NWSSP	January – March 2019	Complete
Procurement	Review of contracts awarded with a value greater than £1 million	April 2019	Complete
Welsh Health Legal	Assess the competence, capability and objectivity of NWSSP LARS staff (as required by ISA 500) Update our understanding of the systems used to record legal cases, the assumptions and methods used to populate Quantum reports. Test a sample of clinical negligence cases, reviewing the information collated on the Legal and Risk management system.	December 2018 – January 2019	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 – April 2019	Complete
Reporting to NWSSP			

Area of work	Scope	Planned timetable	Current status
Nationally Hosted NHS IT systems	Summary of work and any matters arising that need to be considered by the NWSSP management	January - April 2019	Complete – presented to Audit Committee July 2019
Management 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 2019	Complete - presented to Audit Committee July 2019

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 recently published NHS-related or relevant national studies published since the previous Audit Position Statement. 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
Counter-Fraud Arrangements in the Welsh Public Sector	Fraud is prevalent across all sectors including the public sector. Every pound stolen from the public sector means that there is less to spend on key services such as health, education and social services. At a time of austerity, it is more important than ever for all public bodies in Wales to seek to minimise the risk of losses through fraud. This guide is intended as an overview for the Public Accounts Committee, but is of interest to a wider audience. **Published 11 Jun 2019** **http://www.audit.wales/publication/counter-fraud-arrangements-welsh-public-sector**

Topic	Details
NHS Wales Finances Data Tool	Discover trends in NHS Wales finances using our interactive data tool. Data used in the tool has been taken from Welsh Government budgets, NHS bodies' independently audited financial statements and from monthly financial data submissions from the NHS bodies to the Welsh Government. **Published 12 Jun 2019** **http://www.audit.wales/publication/nhs-wales-finances-data-tool**

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

Topic	Anticipated publication date
Integrated Care Fund	Report to be published 2019
Primary care services – summary of findings across Wales	Report to be published 2019

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
Making an Equal Wales a Reality	This seminar is the starting point of knowledge sharing and knowledge gathering around this topic over the next two years for the Wales Audit Office. An all Wales study, the focus of which is being determined, will follow in early spring, reporting in 2021 with a follow up event. This topic cuts across all public services in Wales and will therefore be relevant to all policy makers as well as to those who design and engage with public services. This will be a unique opportunity to hear about what is needed to achieve a More Equal Wales from different perspectives. A More Equal Wales from the Wellbeing for Future Generations (Wales) Act 2015 and the Welsh Public Sector Equality Duty are fundamental to creating better outcomes for the people of Wales. Acknowledging that inequality affects everyone and has a direct negative impact on people with a range of characteristics, the aim of this seminar will be to focus on what procurement, governance, employment practices and provision of services can do to contribute to more positive outcomes. **12 Sept 2019: 9:00am - 1:00pm Cardiff** **19 Sept 2019: 9:00am - 1:00pm Llanrwst** http://www.audit.wales/events/making-equal-wales-reality
How technology is enabling collaborative working across public services	More information not available yet, however, the link below will be updated in due course. **17 Oct 2019: time and venue to be confirmed** **24 Oct 2019: time and venue to be confirmed** http://www.audit.wales/events/how-technology-enabling-collaborative-working-across-public-services
Violence against women, domestic abuse and sexual violence	More information not available yet, however, the link below will be updated in due course. **5 Dec 2019: time and venue to be confirmed** **10 Dec 2019: time and venue to be confirmed** http://www.audit.wales/events/violence-against-women-domestic-abuse-and-sexual-violence

Event	Details
Accountability and governance in partnership services	More information not available yet, however, the link below will be updated in due course. **13 Feb 2020: time and venue to be confirmed** **27 Feb 2020: time and venue to be confirmed** http://www.audit.wales/events/accountability-and-governance-partnership-services

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Shared Services Partnership
Audit and Assurance Services

NHS Wales Shared Services Partnership

HEAD OF INTERNAL AUDIT OPINION & ANNUAL REPORT 2018/19

May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

Assurance Rating

Reasonable Assurance

CONTENTS

Report status: FINAL
Final report issued: 30 May 2019
Author: Head of Internal Audit
Executive Clearance: Neil Frow, Managing Director
Audit Committee: 9th July 2019

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

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

This report sets out the Head of Internal Audit opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance in comparison to the plan and an assessment of conformance with the Public Sector Internal Audit Standards (these are the requirements of Standard 2450).

1.2 Head of Internal Audit Opinion

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

In my opinion, NWSSP 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. Several significant matters require management attention with **low to moderate impact on residual risk** exposure until resolved.

1.3 Delivery of the Audit Plan

The internal audit plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee. Regular audit progress reports have been submitted to the Audit Committee during the year.

Our External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors, and our Quality Assurance and Improvement Programme have both confirmed that our internal audit work 'generally conforms' to the requirements of the Public Sector Internal Audit Standards for 2018/19. We are now able to state that our service 'conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

The report summarises the outcomes from the internal audit plan undertaken in the year and recognising audit provides a continuous flow of assurance includes the results of legacy audit work reported subsequent to the prior year opinion, if applicable.

The audit coverage in the plan agreed with management has been targeted towards providing assurance to NHS Wales on the adequacy and effectiveness of internal controls operated by Shared Services in processing transactions on behalf of partner organisations. In addition to this external assurance flow the audit plan has also examined aspects of corporate governance, risk management and control within NWSSP as an entity hosted by Velindre NHS Trust.

More specifically we give reasonable assurance or greater to the majority of the internal financial controls operating within NWSSP and these findings have been taken into account by partner organisations and Wales Audit Office (WAO) in the external audit of the financial statements.

Management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where appropriate.

Please note that our assessment across each of the domains has takes into account, where appropriate, the number and significance of any audits that have been deferred during the course of the year (of which there were none in 2018/19).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

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

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

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives.
- The purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards.
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

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

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

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

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

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer which underpin his own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the completion of the Annual Governance Statement, and may also be taken into account by partner organisations, by Velindre NHS Trust as host, and by WAO in the context of their external audit.

The overall opinion by 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 Managing Director in reviewing effectiveness and supporting the drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The assurance rating framework for expressing the overall audit opinion was refined in 2013/14 in consultation with key stakeholders across NHS Wales. In 2016/17, following further discussion with stakeholders, it was amended to remove the weighting given to three of the eight domains when judging the overall opinion. The framework applied in 2016/17 has been used again to guide the forming of the opinion for 2018/19.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions as clarified in 2012/13 has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix C**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion.

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

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

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

 - + Reasonable	The Shared Services Partnership 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.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any *limited* or *no-assurance* reports issued during the year and the significance of the recommendations made.

2.4.2 Basis for Forming the Opinion

In reaching the overall opinion, the Head of Internal Audit has applied professional judgement.

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

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module; and
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations.

As stated above, these detailed results have been aggregated to build a picture of assurance across the NWSSP. These include the following:

NATIONAL AUDITS:

The results of national audits receive greater weighting when considering the overall annual opinion due to the extent of the audit work undertaken, the scope of the reviews and their significance with regard to the control environment operated by NWSSP.

- All four Primary Care Services all Wales audits – General Medical Services, General Pharmaceutical Services (including Prescribing), General Dental Services and General Ophthalmic Services were given substantial audit assurance ratings.
- Under the Procurement Services directorate, the all Wales audit of the Accounts Payable function was given a reasonable audit assurance rating.
- The all Wales audit of Payroll Services, under the Employment Services directorate, was also given a reasonable assurance rating.

NWSSP SPECIFIC AUDITS

- Audits of corporate governance areas; Information Governance (GDPR) and Risk Management and Assurance received a substantial assurance rating and Business Continuity Planning and Welsh Language Standards received a reasonable assurance rating.
- Two reviews of specific services were undertaken. Health Courier Services, and Welsh Infected Blood Support Service both received a reasonable assurance rating.
- The review of Actions Undertaken in Response to the NHS Protect Ophthalmic Loss Measurement Exercise Report received a substantial assurance rating.
- Two reviews of operational areas were undertaken. Cwmbran Stores and Patient Medical Records both received a reasonable assurance rating.
- The audit of the BACS Bureau new development received a reasonable assurance rating.

- Two reviews of workforce themes were undertaken. Recruitment and Retention was an advisory review and therefore did not receive an assurance rating. Annual Leave Management received a reasonable assurance rating.
- Within Capital & Estates, the review of Primary Care Rental Reimbursement Reviews received reasonable assurance.
- Service Change and the Primary Care Payments System were kept under review but did not proceed to full audits during the year. These areas will continue to be monitored by the Head of Internal Audit in order to ensure that risk based assurance may be provided as developments require.

2.4.3 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based internal audit plan. In accordance with auditing standards and with the agreement of senior management and the NWSSP Committee, internal audit work is deliberately prioritised according to risk and materiality and therefore the major transaction processing systems operated by NWSSP as a service organisation. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.4.4 Period covered by the Opinion

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

Any audit work reported to draft stage has been included in the overall assessment, all other work in progress will be rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2018/19 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment. Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide limited scope update on the current condition of control and a measure of direction of travel.

2.5 Statement of Conformance

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

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

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at NWSSP in conformance with the Public Sector Internal Audit Standards for 2018/19.

Our conformance statement for 2018/19 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2018/19 which will be reported formally in the Summer of 2019;
- the results of the work completed by Wales Audit Office; and
- the results of the External Quality Assessment undertaken by the IIA.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2018/19 QAIP report. There are no significant matters arising that need to be reported in this document.

2.6 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the NWSSP Committee need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the NWSSP's own performance management and assurance framework and will include, but are not limited to:

- Direct assurances from management on the operation of internal controls through the upward chain of accountability;
- Internally assessed performance against the Health & Care Standards;
- Results of internal compliance functions including Local Counter-Fraud and risk management; and
- Reviews completed by external regulation and inspection bodies including the Wales Audit Office.

3. DELIVERY OF THE INTERNAL AUDIT PLAN

3.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Where relevant, audits which remain to be reported and reflected within this Annual Report will be reported alongside audits from the 2019/20 operational audit plan.

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

3.2 Service Performance Indicators

In order to be able to demonstrate the quality of the service delivered by Internal Audit, a range of service performance indicators supported by monitoring systems have been developed. These have become part of the routine reporting to the Audit Committee during 2018/19. The key performance indicators are summarised in **Appendix B**.

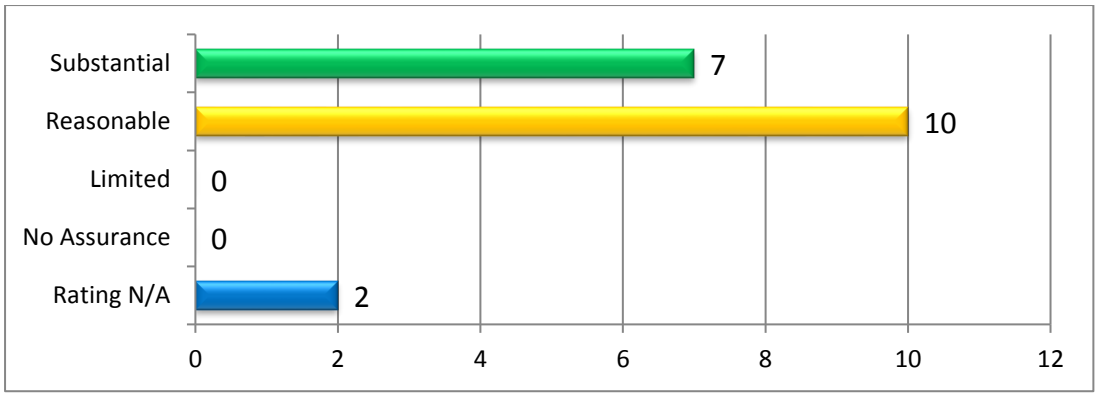
4. RISK BASED AUDIT ASSIGNMENTS

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

4.1 Overall summary of results

In total **19** audit reviews were reported during the year. Figure 1 below presents the assurance ratings and the number of audits derived for each.

Figure 1 Summary of audit ratings



The assurance ratings and definitions used for reporting audit assignments are included in **Appendix C**.

In addition to the above, there was one audit (IT Systems – virtualised environment) which was work in progress at the time of this annual report.

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

4.2 Substantial Assurance

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

Review Title	Objective
General Pharmaceutical Services (including Prescribing)	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of payments made to Pharmacists.
General Medical Services	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of GMS payments.
General Ophthalmic Services	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of GOS payments.
General Dental Services	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of GDS payments.
Risk Management and Assurance	The overall objective of this audit was to evaluate and determine the adequacy and effectiveness of internal controls in operation for risk management and assurance.

Review Title	Objective
Actions Undertaken in Response to the NHS Protect Ophthalmic Loss Measurement Exercise Report	This audit sought to verify the actions taken in response to the NHS Protect report, as reported to the Velindre University Trust Audit Committee for NWSSP in July 2018.
Information Governance & General Data Protection Regulation (GDPR)	This review sought to establish how GDPR arrangements have been embedded within the organisation and to provide assurance that the arrangements at the operational level are extant and thus that the organisation is enabling compliance with GDPR.

4.3 Reasonable Assurance

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

Review Title	Objective
Employment Services – Payroll (all Wales report)	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Payroll.
Accounts Payable (all Wales report)	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of the Accounts Payable function.
Business Continuity Planning	This audit sought to provide assurance over the key areas of business continuity planning.

Review Title	Objective
Cwmbran Stores	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place over the management of inventory at Cwmbran Stores.
Patient Medical Records	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the retention and management of 'live' patient medical records and to assess whether anticipated benefits are being realised.
Welsh Language Standards	This audit sought to provide assurance to the NWSSP that the arrangements in place for ensuring compliance with the requirements of the Welsh Language Standards are managed appropriately.
Health Courier Services	The overall objective of this audit was to evaluate and determine the adequacy of the governance arrangements within Health Courier Services.
Welsh Infected Blood Support Scheme	The overall objective of this audit was to assess the adequacy and effectiveness of the processes and controls in place for the management and administration of WIBSS to ensure that payments were appropriate, timely and accurate.
Annual Leave Management	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place over the management of annual leave.
Primary Care Rental Reimbursement Reviews	The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of NWSSP: SES, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

4.4 Limited Assurance

There are no audited areas in which the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively.

4.5 No Assurance

There are no audited areas in which the Board has **no assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively, or where action remains to be taken to address the whole control framework with high impact on residual risk exposure until resolved.

4.6 Assurance Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach or the advisory nature of the review.

Review Title	Objective
Recruitment and Retention	The objectives of this advisory review focussed on ensuring whether services within NWSSP with known recruitment and retention issues are maximising their use of recruitment and retention initiatives and in particular are adopting alternative approaches where others have been unsuccessful.
BACS Bureau	The overall objective of this audit was to evaluate and determine the adequacy of the key controls in place within the BACs Bureau and processing regions for the preparation, authorisation and processing of payment files.

5. ACKNOWLEDGEMENT

In closing, I would like to acknowledge the time and co-operation given by directors and staff of NWSSP to support delivery of the Internal Audit assignments undertaken within the 2018/19 plan.

James Quance

Head of Internal Audit

Audit and Assurance Services

NHS Wales Shared Services Partnership

May 2019

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

	Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with WAO, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
23000 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

PERFORMANCE INDICATORS

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2018/19	G	June 2018	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2018/19	G	95%	100%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	74%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20 %	10%<v<20%	v<10%

Key: v = percentage variance from target performance

Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	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	 - + 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.
Limited assurance	 - + Amber	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	 - + Red	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.

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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The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

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.

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Quality Assurance and Improvement Programme

Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Review reference:	NWSSP-1819-QAIP
Report status:	Final
Final report Issued:	25 June 2019
Executive sign off:	Simon Cookson, Director of Audit & Assurance
Distribution:	Neil Frow, Managing Director Andrew Butler, Director of Finance & Corporate Services Velindre Audit Committee for Shared Services (9 July 2019) Board Secretaries

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.

Please note
This report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Audit Charter and Terms of Reference, approved by the Audit Committee. Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the NHS Wales Shared Services Partnership and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction

This paper sets out the Quality Assurance and Improvement Programme (QAIP) for 2018/19 and the approach and work for 2019/20.

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

2. Approach

Audit & Assurance's Quality Manual states:

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

Last year we have had the mandatory External Quality Assessment (EQA) which was undertaken by The Chartered Institute of Internal Auditors (the organisation that sets the International Standards for Internal Audit) – Section 2.1.

The internal assessments will cover:

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

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

4. Results of Audit Satisfaction Surveys (a survey is sent after each audit) (2.4)
5. Key performance Indicator Outcomes (2.5)
6. Audit Committee assessments of their own effectiveness that include Internal Audit (2.6)
7. Wales Audit Office review (WAO) with recommendations for improvement (2.7)
8. Head of Internal Audit/Head of SSu 'Conformance Statements' (2.8)
9. Formal meetings with Chairs of Audit Committees and Board Secretaries (2.9)
10. Other relevant Information (2.10 & Sections 3.1 to 3.2).

2.1 Quality Reviews

A total of 26 file reviews were undertaken on 2018/19 audits (22 in 2017/18). All were undertaken by the Director of Audit & Assurance (DAA). The audits reviewed were:

No.	Health Body	Audit	Team	Rating
1	Aneurin Bevan	Patient Discharge Process	South East Wales	Limited
2	Aneurin Bevan	Medical Records Digitisation	IM&T	Reasonable
3	ABM	Corporate Legislative Compliance	Swansea	Reasonable
4	ABM	Princess of Wales Delivery Unit Governance Review	Swansea	Limited
5	Betsi Cadwaladr	West Locality Compliance with Budget Setting Methodology	North Wales	Reasonable
6	Betsi Cadwaladr	WAO Hospital Catering & patient Nutrition Follow-up	North Wales	Limited
7	Cardiff & Vale	Legislative / Regulatory Compliance	South Central Wales	Limited
8	Cardiff & Vale	PCIC CB – District Nursing Rotas	South Central Wales	Reasonable
9	Cwm Taf	Facilities Directorate Review – Management Arrangements	South Central Wales	Reasonable
10	Cwm Taf	Raising Concerns	South Central Wales	Limited
22	Cwm Taf	Prince Charles Hospital Redevelopment	Capital & Estates	Limited
11	Hywel Dda	Treasury Management	Carmarthen	Substantial
23	Hywel Dda	Accounts Receivable	Carmarthen	Reasonable
24	Hywel Dda	Charitable Funds	Carmarthen	Substantial
12	Hywel Dda	IM&T Security Policy & Procedures Follow-Up	IM&T	Reasonable
13	Powys	Dental Services – Monitoring of the GDS Contract	South East Wales	Limited

14	Powys	Putting Things Right – Lessons Learned (Midwifery)	South East Wales	Reasonable
21	Powys	Capital Systems	Capital & Estates	Reasonable
15	PHW	Directorate Review: Operations & Finance	South Central Wales	Reasonable
16	Velindre	Health & Safety Review	South Central Wales	Reasonable
17	WAST	111 Service Provision	South East Wales	Reasonable
18	HEIW	Core Financials – Financial Accounting	South Central Wales	Reasonable
26	HEIW	Core Financials – Budgetary Control	South Central Wales	Reasonable
19	NWSSP	Business Continuity Planning	South East Wales	Reasonable
20	NWIS	Business Continuity	IM&T	Reasonable
25	NWIS	Change Control	IM&T	Limited

22 of the files were chosen at random from a list of completed audits for each HB/Trust as at the end of February 2019. The remaining 4 were chosen because either the organisation was new to Internal Audit or because we were auditing a particularly sensitive or high risk area.

The files were reviewed between February and April 2019 by the DAA using the 2018/19 QR checklist which links to the Public Sector Internal Audit Standards.

Overall, the results were positive and demonstrated a high level of quality consistent with recent years. However, in a small number of instances, discussions were needed with the Head of Internal Audit to confirm findings and a number of exceptions were noted. The exceptions will continue to be built into the TeamMate approach going forward and we intend to rerun training on the use of TeamMate in 2019/20 for all staff.

The exceptions, communicated to the Heads of Internal Audit/Head of SSu in April 2019, are covered at Appendix C.

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

2.2 Internal Audit Quality Assurance Framework (IAQAF)

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

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

The section covers 5 areas, each with a number of good practice statements. For each area, Audit & Assurance needs to decide whether, in terms of the statements, it conforms fully, generally, partially or not at all. Conforming fully or generally is considered appropriate to be able to state that the PSIAS are being complied with. The summary results are:

- Remit (4 statements) – 'fully conforms'
- Reporting Lines (7 statements) – 'generally conforms'
- Independence (9 statements) 'fully conforms'
- Risk based plan/audit strategy (11 statements) – 'generally conforms'
- Integration with other assurance providers (4 statements) – 'fully conforms.'

To enable NWSSP Audit & Assurance to receive a 'fully conforms' assessment, two key actions are needed:

- Update audit approach documentation to reflect approach in NHS Wales through NWSSP/Director of Audit & Assurance arrangements
- Aspects of the risk based plan could be stated more effectively in the audit plan template.

The specific actions to address these points will be both discussed and agreed with key stakeholders – Board Secretaries and Chairs of Audit.

2.3 External Quality Assessment Follow-Up

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

The IIA noted that:

"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."

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 noted a number of 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 confirmed 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."

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

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

All HIAs have been asked to focus on this during audit planning for 2019/20 but there still remains the issue of Board Assurance Frameworks needing further development to clearly identify the work of other assurance providers and the strength of the first and second lines of defence within individual organisations. We are also working on a suite of Quality KPIs for 2019/20 and beyond that will include measures such as the % of time spent on corporate risks.

2). Achieving efficiency in the audit methodology

We are, at present, going through an exercise to determine if TeamMate will remain as our audit software going forward. Until we make that decision we have decided not to change our audit methodology unless there are changes to the PSIAS that we need to respond to.

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

2.4 Audit Satisfaction Surveys

Audit satisfaction surveys are submitted to HBs/Trusts at the conclusion of each audit. Response rates are relatively low although this does differ by organisation. Copies of the survey are retained on the individual audit files. A summary of the response rates and findings are included in each Head of Internal Audit Opinion.

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

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

2.5 Key Performance Indicators

At the end of May 2019 (when Final opinions are issued), KPIs for 2018/19 showed:

KPI	SLA	Target	Overall
Audit plans agreed [2018/19]	√	100%	100%
Audit opinions/annual reports compiled [2017/18]	√	100%	100%
Audits reported over total planned audits	√	Target	100%
		Actual	98%
Work in progress	No	N/A	2%
Report turnaround fieldwork to draft reporting [10 days]	√	80%	95%
Report turnaround management response to draft report [15 days]	√	80%	68%
Report turnaround draft response to final reporting [10 days]	√	80%	99%

In 2018/19 we have delivered 370 outputs to support the Head of Internal Audit Opinions for the 13 NHS Bodies we audit (7 Health Boards, 3 Trusts, HEIW, NWSSP and NWIS).

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

During 2019/20 we will be looking to introduce and begin monitoring a number of Quality based KPIs around areas such as the impact of implemented audit recommendations.

2.6 Audit Committee self-assessments

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

2.7 Wales Audit Office (WAO) review

Each year, Wales Audit Office (WAO) undertakes an overview of Internal Audit as part of their work programme. The relevant extracts from this year's Management Letter, presented to the Velindre Audit Committee for Shared Services (July 2019) are included below.

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

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

In addition, the Director of Audit & Assurance meets regularly with both WAO NHS leads and the Velindre audit team to ensure that internal audit's work is co-ordinated, where appropriate, with the work of WAO. Heads of Internal Audit also meet regularly with the relevant WAO leads for each health Board and Trust to ensure work if co-ordinated effectively.

2.8 Conformance self-assessments

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

Overall, there are very few highlighted areas of 'partial compliance' (and none of 'does not comply') from the self-assessments either form ticking a specific box or from the narrative. This is an improvement on previous

years and reflects, in part, the successful outcome of the External Quality Assessment in March 2018.

Areas of focus highlighted were:

1). Still more to do on having IM&T skills even distributed across all teams although we have a dedicated IM&T team who undertake work at all bar one audit. The one remaining audit has two members of staff (including the Head of Internal Audit) who lead on our Technology work and have the appropriate IM&T skills.

Action: We anticipate increasing our resource in the area of IM&T to meet demand from both audit teams and NWIS (as we anticipate an increased audit plan in 2019/20).

2). We do not measure the cost of assurance against the benefits formally.

Action: In 2019/20 as part of a move to more quality based KPIs we will be undertaking specific work in a couple of areas to measure the cost and impact/benefits of assurance work.

3). Some HIAs noted that they report to the AC rather than the Board so assessed conformance as partial.

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

4). With likely changes to our audit software we will need to adjust our document retention policy during 2019 so this was raised as an area we need to resolve.

Action: This will be signed off formally during 2019/20.

2.9 Formal meetings with Chairs of Audit Committees and Board Secretaries

During 2018/19 the Director of Audit & Assurance met with the Board Secretaries and Chairs of Audit Committee groups on the following occasions:

- Board Secretaries: 22 June and 14 December 2018
- Chairs of Audit Committee: 26 September 2018 and 27 March 2019.

Areas discussed included:

- Recommendation monitoring and tracking
- Quality based KPIs

- The all-Wales audit of Ambulance handovers
- Themes emerging from audit work across NHS Wales
- External Quality Assessment
- Internal Audit Strategy.

Further meetings are planned in 2019/20. In addition, the Director of Audit & Assurance has also met with a number of Chairs, Finance Directors, Executive Directors and full Boards during the course of the year.

2.10 Audit Approach

There were no changes to our audit approach in 2018/19 as we undertook an exercise in the previous year to update our Audit Approach (Quality Manual) to reflect previous QAIP findings and changes to the Public Sector Internal Audit Standards from 1 April 2017.

3. Other Quality Assurance and Improvement Areas

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

The Director of Audit & Assurance is an observer on the Public Sector Internal Audit Standards Advisory Board, a member of the Wales Public Sector Heads of Internal Audit Forum, and a co-opted member of the CIPFA Wales Council. He is also an Independent Member of the Audit Committee of Bristol City Council. One Head of Internal Audit is the Independent Chair of the Audit Committee at Swansea City Council.

3.2 QAIP Approach for 2019/20

The QAIP approach for 2019/20 will include (in addition to the standard areas):

1. A further part of the IAQAF approach

2. Follow up of the EQA and previous QAIPs.

APPENDIX A

IAQAF

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

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

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

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

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

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

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

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

- **Fully Conforms** the reviewer concludes that the internal audit service fully complies with each of the statements of good practice.
- **Generally Conforms** means the reviewer has concluded that the relevant structures, policies, and procedures of the internal audit service, as well as the processes by which they are applied, at least comply with the requirements of the section in all material respects. For the sections and sub-sections, this means that there is general conformance to a majority of the individual statements of good practice, and at least partial conformance to the others, within the sub-section. As indicated above, general conformance does not require complete/perfect conformance
- **Partially Conforms** means the reviewer has concluded that the internal audit service falls short of achieving some elements of good practice but is aware of the areas for development. These will usually represent significant opportunities for improvement in delivering effective internal audit. Some deficiencies may be beyond the control of the service and may result in recommendations to senior management or the board of the organisation.
- **Does Not Conform** means the reviewer has concluded that the internal audit service is not aware of, is not making efforts to

comply with, or is failing to achieve many/all of the objectives and good practice statements within the section or sub-section. These deficiencies will usually have a significant negative impact on the internal audit service's effectiveness and its potential to add value to the organisation. These will represent significant opportunities for improvement, potentially including actions by senior management or the board.

- An overall assessment of the performance of the internal audit service in conforming to good practice should be made using the same scale.

APPENDIX B

Purpose and Positioning

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

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

Reporting lines

Statements of good practice	Assessment	Evidence
• The Board reviews and approves the appointment of the Chief Audit Executive (CAE) • Reporting lines for the CAE support independence, with functional reporting to the Board • The AO/Board agree the strategy/plans of the internal audit service • The CAE or their representative attend all Board and/or senior management meetings, particularly where key issues are discussed relating to governance, risk management or control across the department and its ALBs • The CAE meets regularly with the Accounting Officer • The AO/Board Chair routinely see and consider the outputs of the internal audit service • The Board is routinely updated with internal audit status and activity reports		Formal appointments are made by the Director of Audit & assurance as a part of his remit but these are discussed and agreed beforehand with individual NHS organisations. Reporting lines and access support independence and functional reporting. The Audit Committee approved the annual Internal Audit plan. Relevant Board/Senior Management Team meetings are attended but not every single Board/SMT is attended. Head of Internal Audit has regular meetings with Directors of Governance (Board Secretary) and Audit Committee Chairs. The Audit Committee receives all Internal Audit outputs and our work is summarised in the Annual Governance Statement signed by the Chair of the Board and the AO. A separate annual opinion is also produced for each NHS organisation. Progress reports are produced for each Audit Committee and key messages are shared with the Boards.

	Fully conforms
√	**Generally conforms**
	Partially conforms
	Does not conform

Associated references

PSIAS:

1100 Independence and Objectivity

1110 Organisational Independence

1111 Direct Interaction with the Board

2010 Planning

2060 Reporting to Senior Management and the Board

Remedial actions	Target date	Responsibility
Update audit approach documentation to reflect approach in NHS Wales through NWSSP/Director of Audit & Assurance arrangements.	September 2019	Director of Audit & assurance

Independence

Statements of good practice	*Assessment*	*Evidence*
Internal audit's position within the organisation is clearly established including authorisation for access to records, personnel and physical properties relevant to the performance of engagements	√ **Fully conforms** **Generally conforms** **Partially conforms** **Does not conform**	Included in the Internal Audit Charter
The internal audit service is entirely free of executive responsibilities such that it can provide independent and objective assurance and is not part of the direct control framework		We have no Executive responsibilities in any organisation other than the Director of Audit & Assurance is part of NWSSP's Management Team
Conflict of interests are identified, appropriately managed and avoided including those transferring to internal audit from elsewhere in the organisation	***Associated references*** **PSIAS:**	Full disclosure undertaken annually
Audit personnel are routinely rotated on assignments	**Code of Ethics** **1100 Independence and Objectivity**	Yes
Audit personnel do not have any conflicting operating responsibilities or interests	**1110 Organisational Independence** **1120 Individual Objectivity**	Covered and monitored under the annual declarations of interest process
Consultancy work that internal audit may undertake is clearly defined and agreed by the Audit and Risk Assurance Committee	**1130 Impairment to Independence or Objectivity**	Yes, this is reported in the progress reports and we have a separate consulting protocol
Areas which have been the recipient of internal audit 'consultancy' work are subject to audit review by personnel independent of the consultancy work		Yes, this is built in to the Protocol
The CAE, at least annually, confirms to the Accounting Officer/Board the organisational independence of the internal audit activity		Yes, confirmed in the Annual Report.
The CAE notifies the appropriate parties if independence or objectivity is impaired in fact or appearance		This is built into the Internal Audit Charter and would be reported.

Risk based plan

Statements of good practice	*Assessment*	*Evidence*
A risk based internal audit plan has been developed which: • considers the relative risk maturity of the organisation • considers the risk appetite as defined by management • includes an assessment of optimal resources and skills required to deliver both the audit assurance and consultancy work, including identification of specialist skills, which may be required • is clearly designed to enable the CAE to deliver an annual opinion on the effective of Governance, risk management and the system of control • has been approved by the Accounting Officer and Board • has been promulgated to all relevant parties including members of the audit team, excluding any restricted information for senior managers only • is subject to regular review to ensure that it remains appropriate and current Either the audit plan or a separate audit strategy document should: • include an assessment of risks that the audit service itself faces in delivering the plan and plans for controlling and mitigating the risks identified • include consideration of if, and how, internal audit will rely on the assurance provided by other assurance providers • include an assessment of the range of audit techniques that have been selected as the most effective for delivering the audit objectives • set out how the internal audit service will measure its performance, quality assure itself and seek continuous improvement	**Fully conforms** √ **Generally conforms** **Partially conforms** **Does not conform** ***Associated references*** **PSIAS:** **2010 Planning** **2020 Communication and Approval** **2030 Resource Management**	Yes – as part of the planning process Yes – as part of the planning process Yes – as part of the planning process Yes – range of work and link to risks outlined in plan Yes – all audit plans are approved by the relevant Audit Committee Yes – as part of the audit management process Yes – noted in plan that it will be subject to review and all changes are approved by the relevant Audit Committee Included in the IMTP Yes, in terms of external audit, counter-fraud, HIW and other regulatory and statutory providers Yes, included in individual internal audit scopes Yes, KPIs are reported and QAIP process undertaken by Director of Audit & Assurance

Remedial actions	*Target date*	*Responsibility*
Aspects of the risk based plan could be stated more effectively in the audit plan template	September 2019	Director of Audit & Assurance

Integration with other assurance providers

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

APPENDIX C

Quality Reviews 2018/19 – Exceptions and differences noted:

Independence, objectivity and competency (Q1 – 3)

No specific comments other than to note that external support was used to undertake 3 of the audits. In two cases the auditors had/have worked with us for some time while in one case the auditor was new to NWSSP and the NHS in Wales.

Engagement Planning (Q4 – 9)

Q5 – in a couple of instances, the scope had been changed either between draft and final or between final and the conclusion of the audit. In most cases the explanation was clear on the file and reasonable, however, in a couple of cases I needed to speak to the relevant HIA to understand the rationale. Also, in a small number of instances the brief on file was the 'draft' rather than the 'final' but there was evidence that the HB/Trust had agreed the scope.

Performing the engagement (Q10 – 11)

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

Supervision and review (Q12 – 13)

Q13 – Head of Internal Audit review was clear in all cases which was an improvement on previous years.
Q13 – there was one instance where a few 'steps' remained to be reviewed.
Q13 – there are small differences in the way each team uses the structure and steps to record evidence of work done and the findings e.g. the use of 'Current Issues' and 'Formulate Findings'. In addition, Teams have added additional schedules and matrixes where appropriate.

Reporting (Q14)

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

Completion (Q15 – 16)

Q15 – All teams now use the checklist to demonstrate that process and quality checks have been performed before the issue of the draft/final reports. In a few instances I think that files could have been signed-off as complete quicker than they were (after final report and the issue of a management feedback request).
Q16 – we have sought feedback for most reviews but only a couple had any evidence on file of the feedback. However, all reports do go through to Audit Committee which acts as a measure of the quality and relevance of our work and satisfaction surveys are included in each Head of Internal Audit and Annual Report.

Other Comments (Q17)

Specific comments on files are included on each individual checklist which has been sent to each HIA.

Overall Summary

Overall, the quality of audit files is good. The number of findings is consistent with the previous year. The key lesson going forward is to consistently demonstrate/evidence any changes between the draft and final reports.

There are small differences between the ways teams use TM steps and some have introduced their own schedules and matrixes. Going forward, we will set aside time to compare and contrast these documents to see if we adopt nationally or retain local discretion.

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

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Gwasanaethau Gofal Sylfaenol
Shared Services Partnership
Primary Care Services

Primary Care Services

Contractor Payments

(All Wales)

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

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Review reference:	NWSSP-1819-06
Report status:	Final
Fieldwork commencement:	16th October 2018
Draft report issued:	14th May 2019
Management response received:	16th May 2019
Final report issued:	16th May 2019
Auditors:	James Quance, Head of Internal Audit Donna Morgan, Principal Auditor Phil Lewis-Davies, Principal Auditor
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Julie Turner, Processing Lead (SE)
Sarah Jones, Professional and Processing Lead

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 2018/19 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 one issue that would be classified as a weakness in the system control/ design for contractor payments. This is identified in the management action plan as (D).

2.4 Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/ control for contractor payments. These are 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:

General Medical Services

- Policies and procedures were available to all staff via SharePoint. Three of the 60 SOPs had been modified and updated since the last audit (with no significant changes).

- We did not identify any issues from our sample testing of inclusions on the Medical Performers List.
- 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 Open Exeter.
- It was evident from our testing of a random sample of seniority payments 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 well established with no adverse issues arising.
- 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 rent/ water/ rates payments were found to be supported by appropriate documentation and there was evidence of appropriate checks being carried out by PCS staff prior to payment.
- Following a review of a random sample of BACS control sheets, we found that 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.
- We did not identify any issues from our sample testing of inclusions in respect of the Dental Performers List.

- Testing of a sample of dental contract payment schedules found that 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.

- We found that payments had been processed in a timely manner following notification of changes to a dentist's contract. Upon notification of the impending change from the Health Board, the Contracts Team signs and dates each change on the contract schedule. It was evident from a PCS Contracts and Payments perspective, that these had been processed and passed for payment in an efficient manner.

- Two issues were identified from our testing of a sample of travel and subsistence forms. Please refer to **Finding 1** below.

- 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 was examined to ensure that authorisations had been received from the Health Board for payment. The testing revealed no instances of payments being made without the appropriate Health Board authorisations being received.

General Ophthalmic Services

- It was evident that policies and procedures were established and available to all staff via SharePoint. Two of the SOPs had been updated since the last audit.

- A sample of inclusions on the Ophthalmic Performers Lists were tested. Evidence of a passport/ birth certificate for one of the new applicants was not on file for one of the contractors (who is a UK citizen). Please refer to **Finding 2** below for further details.

- 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.

- A sample of GOS 1[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 in respect of the completion of these forms.

- Whilst sample testing GOS 6 forms we found one optician that had visited a specific care home 27 times from 01/04/18 until 01/04/19. However the optician never visited more than two patients in any one visit; thus claiming the maximum total fees of £37.56 for each patient[2].

  One particular period of interest was from 4th October 2018 until 8th November 2018. During this timeframe, the optician visited the care home at least once a week, tending to a total of nine patients, but never more than two patients per visit. As a result, the optician was eligible to claim the maximum total fee (£37.56) for each patient. Although this practice is allowable under the rules, operating on this basis would not appear to be 'in the spirit' of the contract.

  During discussions with the Management Team within PCS, we were advised that this particular issue would not fall within their remit. The Team confirmed that they had referred the details of this finding to both the PPV (Post Payment Verification) and Counter Fraud teams for further investigation.

- 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. One SOP had been updated since the last audit.

- Testing of a sample of pharmacies on the Pharmaceutical Performers Lists (these included changes to ownership and new contracts) did not identify any issues.

[1] A GOS 2 form constitutes a patient's prescription. It is not an application for payment in the same manner as GOS 1, 3, 4, 5 and 6 forms.
[2] For domiciliary (GOS 6) visits at one specific residence, the fee that is applicable to the first two patients is £37.56. For any third and subsequent patients at that same residence, the fee drops to £9.40.

- A walkthrough of pharmacy accounts confirmed that the completion of PSU002 and PSU003 forms for all batches of prescriptions submitted were received, recorded and processed accurately.

- In respect of processing of prescriptions, we randomly selected Pharmacy accounts and tested 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. Detailed reworking of a sample of audit reviews across the year noted minor discrepancies on related audit batches which had subsequently been corrected.

  We also noted that, at present, PCS Contractor Services audit check 1% of the volume of items prescribed each month, which amounts to approximately 70,000 items. We were advised by the Professional Services Team Manager that the results of monthly testing have always been below this maximum acceptable error rate of 1%. We therefore considered that there may be an argument to test a lower volume each month; focussing on accuracy rather than volume. Please refer to **Finding 3** below for further details.

- 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.

- Monthly payments (FP47A(C) forms) to pharmacists were found to be complete and accurate for the sample tested.

- 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.

Follow Up

Our follow-up of the previously agreed recommendation arising from the 2017/18 audit confirmed that it has been addressed and actioned (see **Appendix B**).

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**	**2**	**1**	**3**

Finding 1 – *GDS Travel and Subsistence Claims (O)*	**Risk**
During testing of a random sample of ten travel and subsistence claims for General Dental Services we found the following: • For one claim, we found that the claim form had not been signed as examined/ checked by a member of the PCS Contracts Team. (However it had been signed by the Dean of the Dental School and had been authorised by a member of PCS staff for payment); • For another claim, we found that the claim had not been signed as verified by the Dental Tutor/ Administrator/ Secretary. (Please note that we evidenced staining on the form as if there had been a spillage, however we could not identify any evidence of a signature).	Unsubstantiated costs are incurred.
Recommendation 1	**Priority level**
Primary Care Services will ensure that they sign and date claim forms to confirm that the payment has been appropriately checked for payment. Primary Care Services staff will return any claim forms that have not been signed as verified by the Dental Tutor/ Administrator/ Secretary, prior to approving any claims.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**

Payment and Contract Management staff will be informed of these findings and reminded of the importance of ensuring all claims are approved and verified in accordance with internal operating procedures.	Nicola Phillips, Head of Engagement and Support Services 31st May 2019

Finding 2 – GOS - All Wales Performers List *(O)*	**Risk**
We randomly tested five contractors that had applied to be included on the All Wales Ophthalmic Performers List. Standard Operating Procedure: O/SOP/001 requires that: *'The following documents need to be received in order to proceed with the application…* • *For UK citizens born in the UK, birth certificate or passport'...* The All Wales Supplementary/ Ophthalmic Checklist questions "Is the practitioner a British citizen or an EEA national". For this applicant, this section of the checklist was ticked, and it was confirmed in writing that the applicant was from the UK. However evidence of a birth certificate or passport for the application was not retained on file. Accordingly we could not provide assurance that the appropriate identification check had been undertaken.	Inappropriate candidates are accepted onto the performers list and are appointed as dentists as a result of ineffective identification checks.
Recommendation 2	**Priority level**
Relevant identification documents will be retained on file; in line with current retention guidance for future reference.	**Medium**

Management Response 2	Responsible Officer/ Deadline
A full review of checklists (Inc. MPL and DBS) will be undertaken to ensure that information reviewed and retained during ALL verification processes is appropriately recorded and shared. A record retention review will be undertaken to ensure all documents are kept in accordance with Velindre's record retention arrangements	Nicola Phillips, Head of Engagement and Support Services. 31st July 2019

Finding 3 – Pharmacy/ Prescribing Services - Quality Audit *(D)*	Risk
At the time of audit, Primary Care Services Contractor Services audit check 1% of the volume of items prescribed each month, which is approximately 70,000 items. We were advised by the Professional Services Team Manager that the results of monthly testing have always been below the 1% maximum acceptable error rate . We therefore considered that there is an argument to test a lower volume each month, focussing on accuracy rather than volume. Validating and costing of prescriptions is a heavily system driven process and systemic issues would be identified from a lower volume sample, say 0.1% or 7000 items each month. Rogue one off errors of immaterial value would only be identified based on random sample selection with chance of non-identification increasing from 99.0% to 99.9%.	The focus of quality audits is on volume as opposed to accuracy.
Recommendation 3	**Priority level**
Primary Care Services staff should consider a review of its current quality audit requirements.	**Low**
Management Response 3	**Responsible Officer/ Deadline**

To provide NWSSP, Health Boards, Welsh Government and contractors with assurance, we want to be confident that our quality assurance accurately reflects total workload submitted to us. The use of a 1% sample size for determining prescription pricing accuracy is therefore based on providing more statistically significant results that we can be confident in. Whilst this sample size can be reviewed, at present, it provides confidence that our sample and quality assurance more significantly reflects (i.e. more truly reflects) out to the total volume of prescription items submitted each month, which can between 6-7 mil items. Arguably, it is still important to make sure that automated processing is also checked alongside manual processing. To lower the sample size would require an exercise that was able to confidently assure that testing provided a significant degree of confidence in the result. To do this may require analysis on error rates against processing method and be able to provide warnings if there is deviation. With appropriate review, it may be possible to lower the sample size and this work can be taken up separately as part of the continual PCS improvement programme but is not a critical priority.	Nicola Phillips, Head of Engagement and Support Services 31st August 2019

Follow-up of Previously Agreed Recommendations arising from 2017/18 report

Rep. Ref	Recommendation	Responsibility and timescale	Action/Status	Updated responsibility and timescale
Medium Priority				
1	*2017/18 GOS Audit (Prev Rec 1)* 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.	Sandra Preece, All Wales Contracts Manager Initial deadline to inform all staff of requirements = June 2018. Follow up review deadline = April 2019	Actioned	N/A

Glossary of Terms

BACS – Formerly known as Bankers' Automated Clearing Services, BACS is an electronic system used to make payments directly from one bank account to another.

Compass – The Dental Contract Management System.

FP47A(C) – The summary payment forms for pharmaceutical services.

GDS – General Dental Services.

GMS – General Medical Services.

GOS – General Ophthalmic Services.

GOS 1 – This form relates to NHS funded sight tests.

GOS 3 – This form relates to NHS funded glasses and lenses.

GOS 4 – This form relates to NHS funded repairs and replacements.

GOS 5 – This form relates to privately funded sight tests.

GOS 6 – This form relates to NHS domiciliary visits to patients.

Open Exeter – Provides access to GP financial information.

PCS – Primary Care Services.

PD1 Reports – Provides statistical data relating to prescriptions dispensed in Wales aggregated by dispensing contractor type for each Local Health Board.

PSU002 – The Active Chemist Prescription Batch Report.

PSU003 – The Active Dispensing Doctor Prescription Batch Report.

QOF – Quality Outcomes Framework.

Sharepoint – The Health Board's document management system.

SLA – Service Level Agreement.

SOP – Standard Operating Procedure.

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.

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.

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Review reference:	NWSSP-1819-11
Report status:	Final
Fieldwork commencement:	13th March 2019
Fieldwork completion:	15th April 2019
Draft report issued:	29th April 2019
Management response received:	23rd May 2019
Final report issued:	24th May 2019
Auditor/s:	James Quance, Head of Internal Audit Martyn Lewis, IT Audit Manager
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Committee	Velindre NHS Audit Committee for NWSSP

ACKNOWLEDGEMENT

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

Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer.

1. Introduction and Background

The review of the arrangements in place for ensuring compliance with the General data Protection regulations (GDPR) within NHS Wales Shared Services Partnership (NWSSP) was completed in line with the 2018/19 Internal Audit Plan.

The General Data Protection Regulation (GDPR) was adopted on 27 April 2016. It took effect from 25 May 2018 and was immediately enforceable as law in all member states of the European Union (EU).

The primary objectives of the new legal framework are to institute citizens' rights in controlling their personal data and to simplify the regulatory environment through a unified regulation within the EU. Many principles of the GDPR are broadly the same as the existing Data Protection Act (DPA). One of the most significant changes is the increased penalties. Under the new regulations, penalties will reach an upper limit of €20m or 4% of annual turnover, whichever is higher.

In October 2017, Stratia Consulting was commissioned by Velindre NHS Trust on behalf of NHS Wales, to carry out external cyber security assessments for its organisations. The review included an assessment against the GDPR requirements included in the IASME standard. The IASME Governance standard is based on international best practice, is risk-based and includes aspects such as physical security, staff awareness, and data backup. The IASME governance self-assessment includes the Cyber Essentials assessment within it as well as an assessment against the requirements of the GDPR.

For each organisation, a cyber-security assessment report and security improvement plan (SIP) was produced, including for NWSSP. Additionally, an overarching security assessment and SIP for NHS Wales as a whole was produced.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of internal controls in operation. Weaknesses were then brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

This review seeks to establish how these GDPR arrangements have been embedded within the organisation and will seek to provide assurance that the arrangements at the operational level are extant and thus that the organisation is enabling compliance with GDPR in relation to:

- appropriate action is being taken to ensure that management and staff are aware of the GDPR and the impact it is likely to have;

- local governance controls and measures have been implemented to enable compliance with the GDPR; and
- a register of information assets is maintained and identifies the source, responsibility and sharing arrangements for each asset.

3. Associated Risks

The risks considered in the review are as follows:

I. insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation;

II. controls not operating resulting in non-compliance with GDPR; and

III. reputational damage and/or financial loss.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with GDPR is **Substantial** Assurance

RATING	INDICATOR	DEFINITION
Substantial		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.

We found that NWSSP has completed a significant amount of work to achieve compliance with the GDPR/ the Data Protection Act 2018.

Extensive guidance documentation, training and support has been developed, following an implementation plan developed using ICO guidance.

An Information Governance Steering Group (IGSG) is in operation and meets quarterly, and Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) are in place to manage information governance locally.

A centrally held Information Asset Register (IAR) is in place, and a standardised and consistent process and template has been developed for the recording and submission of local information assets.

The Asset register was found to be well designed and compliant with key GPDR requirements, though detailed review did highlight a number of areas with incomplete information for some assets.

Whilst the Information Asset process will always be a moving target to some extent with the register requiring consistent updating and review where information assets change, it is recommended that a centrally managed review exercise is undertaken at least annually in order to ensure a baseline standard is in place.

This, in addition to the ongoing work of IAOs and IAAs, should help ensure a consistent and standardised approach is in place and that the register is as up-to-date as possible.

The audit did not identify any findings that we would consider to be high priority during our audit fieldwork.

5. Assurance Summary

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

Assurance Summary					
1	Central Actions				✓
2	Local Governance				✓

Assurance Summary					
3	Information Asset Registers			✓	

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

Design of Systems/Controls

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

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system/control for GDPR

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Two **Medium priority** issues were identified which require management's attention and provide scope for improvements to be made. These concerned:

1) Review Asset Register Returns

Each NSSSP department is required to complete an Information Asset return in relation to the information they are responsible for. It is the responsibility of the department's Information Asset Owner and/or Administrator to ensure that all assets have been recorded and that records are accurate and kept up-to-date.

However, there was no centrally managed exercise to review the accuracy of the Information Asset Register undertaken on a regular basis to ensure a consistent and standardised approach is in place and ensure the register is up-to-date.

2) Departmental Asset Registers

Review of departmental asset registers highlighted a number of assets (approximately 45% for the departments noted below) with incomplete information which require review and updating. These were found in particular on the Procurement Services, Employment Services and Health Courier Services registers.

One **Low priority** issue was identified which requires management's attention and provides scope for improvements to be made.

3) Information Governance training reporting

It was noted that there was previously monthly reporting in place detailing levels of staff compliance with Information Governance training. This has not been produced since July 2018.

Good Practice

We identified the following areas of good practice:

- a GDPR implementation plan based on the ICO's 12 Step Plan for GDPR was created and used in monitoring the progress of GDPR activities;
- GDPR related risks are recorded and managed on the IG risk register. Controls and mitigations have been identified and documented;
- an Information Governance Steering Group (IGSG) is in operation and meets quarterly. It role includes the responsibility of ensuring "*compliance with any existing legislation and forthcoming changes to statutory law, including implementation and changes to consider under the General Data Protection Regulation (GDPR)";*
- Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) have been nominated for departments. IAOs are the Directors for each service area and the IAAs are the members of the Information Governance Steering Group (IGSG);
- the Information Governance Manager has developed guidance documents and undertaken appropriate awareness raising actions in preparation for GDPR;
- all staff are required to complete an online Information Governance electronic e-learning training package that has been updated with GDPR / Data Protection Act 2018 requirements;
- GDPR has been communicated to staff via a variety of channels including intranet updates, the IG intranet page, email updates and the NWSSP monthly e-newsletter;
- GDPR posters the have been developed and distributed across the departments;
- the Stratia report regarding GDPR was reviewed and all relevant actions incorporated into the work plan for GDPR;

- privacy notices have been developed and published to inform staff and the general public/ patients how their information will be used and stored;
- there is a centrally held IAR in place for GDPR with a process for all departments to submit their asset information;
- training on completion of information asset registers was provided to the Information Asset Owners as part of a IAO training package; and
- breach reporting has been updated as per GDPR requirements and includes a scoring system for the categorisation of information security breaches, and examples of how it should be used.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding 1 Review of Information Asset Data	Risk
Each NSSSP department is required to complete an Information Asset return in relation to the information they are responsible for. It is the responsibility of the departments Information Asset Owner and/or Administrator to ensure that all assets have been recorded and that records are accurate and kept up-to-date. However there was no centrally managed exercise to review the accuracy of the Information Asset Register undertaken on a regular basis to ensure a consistent and standardised approach is in place and ensure the register is up-to-date. This recommendation was discussed with the Information Governance Manager during the audit and the first review was underway at the time of this report.	Controls not operating resulting in non-compliance with GDPR.
Recommendation 1	**Priority level**
Management should ensure a regular, at least annual, process is introduced to ensure Information Asset Owners review and ensure that their asset data is accurate and up-to-date.	**Medium**

Management Response 1	Responsible Officer/ Deadline
An annual process is now in place. An email was sent on the 14th March 2019 requesting that all IAAs review their departmental returns and confirm whether there were changes or they were happy with the content.	Complete

Finding 2 Departmental Asset Registers	Risk
Review of Information Asset Registers highlighted that although the records for the core assets were complete, there were a number of areas where the information for some of the assets was not fully completed. • Procurement Services – missing data for 41% of the assets including data classification, the legal basis for processing, information on privacy notices and who information is shared with. • Employment Services – missing data on the legal basis for processing and how information is stored for 56%of the assets. • Health Courier Services – 56% of the assets are missing data on whether privacy notices apply to processing activities. Without the registers being complete NWSSP does not have complete visibility and assurance over the risks associated with its data processing activities.	Controls not operating resulting in non-compliance with GDPR.
Recommendation 2	**Priority level**
Each department Information Asset Owner/ Administrator should ensure the Asset Register is updated. Local registers should be checked for completeness as part of the regular review process.	**Medium**

Management Response 2	Responsible Officer/ Deadline
As part of the annual review process, IAA / IAOs are asked to review their registers to ensure the information is updated / accurate. Where there are any identified gaps or omitted information, the Information Governance Manager will liaise with nominated IAAs to ensure that this information is updated.	Information Governance Manager October 2019

Finding 3 Data Breaches	Risk
It was noted that there was previously monthly reporting in place detailing levels of staff compliance with Information Governance training. This has not been produced since July 2018. All staff are required to complete an online Information Governance electronic e-learning training package that has been updated with GDPR / Data Protection Act 2018 requirements. In addition, the ICO requires that an Information Governance training course is completed by all staff identified as "high risk" working with identifiable information within NWSSP who will receive bi-annual, Information Governance face to face training to ensure staff are aware of the confidentiality of the data the organisation holds and their responsibilities for securing it.	Lack of assurance staff are receiving IG/ GDPR training.
Recommendation 3	**Priority level**
Information Governance training reporting should be produced on a monthly basis to provide assurance to NWSSP around compliance with training requirements.	**Low**

Management Response 3	Responsible Officer/ Deadline
ESR eLearning Monthly reporting is now complete**. Electronic training reports have now been received to the end of March 2019 (and April 2019) and this is expected to continue**. All reports that are completed in respect of Information Governance compliance/training/breach reporting and other associated activity are fully up to date and are readily available for all committees that it is required for including Velindre IG&IMT, Information Governance Peer Working Group and the NWSSP Information Governance Steering Group. **The lack of Information Governance training reporting was down to an issue with a lack of resource within Workforce and OD. This was down to key personnel who produced the reports from the Electronic Staff Record that left for other employment within NHS Wales.	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, 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.

Confidentiality

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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.

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Procurement Services – Purchase to Pay

Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance

Previous review rating: **Reasonable Assurance**

CONTENTS

Review Reference:	NWSSP-1819-13
Report Status:	Final
Fieldwork completion:	2 May 2019
Debrief meeting:	1 April 2019 & 16 May 2019
Audit management sign-off:	9 May 2019
Draft report issued:	v1 9 May 2019 v2 28 May 2019
Management response agreed :	25 June 2019
Final report issued:	26 June 2019
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:	James Quance, Head of Internal Audit Sophie Corbett, Audit Manager Matthew Smith, Senior Auditor

	Cara Vernon, Auditor James Purdue, Financial Management Graduate Trainee
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 purchase to pay (P2P) process operated by the NHS Wales Shared Services Partnership (NWSSP) Procurement Services has been completed in line with the 2018/19 Internal Audit Plan.

The relevant lead for the assignment was Mark Roscrow – Director (Procurement Services).

The purchase to pay function incorporates:

- Local Procurement Teams: local procurement within Health Boards & Trusts
- Central Sourcing: all-Wales procurement
- Accounts Payable: invoice processing & payment
- eEnablement: Oracle system (including catalogue) management

The audit sought to provide assurance to the NWSSP and the aforementioned Health Boards/Trusts that risks material to the achievement of system objectives were managed appropriately.

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 the purchase to pay process.

The objectives reviewed were:

- Oracle catalogues are promptly and accurately updated;
- there is adequate control over the creation and amendment of creditor master-file data;
- all invoices are supported by a purchase order in line with the No PO No Pay policy;
- non-purchase order/manual invoices are authorised for payment prior to processing;
- systems ensured 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 Public Sector Payment Policy (PSPP);

- mechanisms are in place to ensure that duplicate payments are avoided or detected; and
- recommendations arising from the previous internal audit (report NWSSP-1718-11 refers) have been implemented.

1.3 Associated Risks

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

i. inaccurate information in the Oracle catalogue resulting in erroneous purchase orders and invoices being placed on hold;
ii. payments are made to the wrong supplier or for the wrong amount;
iii. payments are made without due authority;
iv. duplicate payments are not prevented or detected;
v. late payments resulting in breach of Public Sector Payment Policy;
vi. fraud; and
vii. previous internal audit recommendations have not been implemented.

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 Purchase to Pay 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.

Whilst we are able to report reasonable assurance overall, instances were identified where non-compliance with agreed policies/procedures is not being internally challenged. Consequently, these controls are not operating as intended. Compliance with the No PO No Pay Policy is a key example of this - our testing identified invoices that have been paid without a purchase order and do not fall within the agreed exceptions list. See page 8 for further details.

2.2 Assurance Summary Table

Assurance Summary					
1	Oracle Catalogues are promptly and accurately updated				✓
2	Creation and Amendment of Creditor Master-file Data			✓	
3	Invoices are Supported by Purchase Orders		✓		
4	Authorisation of Non-purchase Order Invoices				✓
5	Payments in Accordance with Agreed Prices				✓
6	Invoices on Hold / Compliance with PSPP			✓	
7	Duplicate Payments				✓
8	Previous Recommendations		✓		

** 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 Purchase to Pay. These are identified in Appendix A as (D).

2.4 Operation of System / Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Purchase to Pay. 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**	**4**	**0**	**4**

One further finding was identified which is outside of the direct control of NWSSP Accounts Payable and cannot be achieved without the agreement and cooperation of customer organisations. This is identified on page 11 of the report and has been reported to management to take forward with customer organisations.

3. SUMMARY OF AUDIT FINDINGS

Good Practice

The following examples of good practice were identified:

- Additions and amendments to the Oracle catalogue are promptly and accurately processed by eEnablement.
- Requests for additions/amendments to the supplier masterfile are promptly processed.
- Participation in a priority payment programme (Oxygen Finance) where small rebates are received from suppliers in return for payment ahead of agreed terms. The value of rebates taken during the period April 2018 – February 2019[1] was £296,316.
- 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, prevention and identification of duplicate invoices, call handling, invoices on hold and Oxygen Finance priority payment programme.

[1] Excluding May & December 2018 – no data available

We identified four **Medium Priority** findings:

1. No PO No Pay Policy

The all-Wales No PO No Pay policy was implemented on the 1st June 2018. With effect from 1st September 2018, following a three month transition period, invoices without a PO that are not on the agreed all-Wales exceptions list should be placed on a No PO No Pay hold in Oracle and payment withheld until the supplier provides a purchase order number.

An all-Wales exceptions list has been agreed by customer organisations via the Finance Academy P2P Group, for instances where a purchase order is not necessary or appropriate. Responsibility for deciding whether or not an invoice requires a purchase order seems to rest with Accounts Payable. The exceptions list is not aligned to specific suppliers or subjective codes and in some areas is too ambiguous, so there is scope misuse or error. We are aware that there is an ongoing exercise as part of the Finance Academy P2P Group to try and address this.

Accounts Payable have processed 1,784,008 invoices during the period April 2018 – March 2019. 44% of these were processed without a purchase order. As exceptions are not categorised as such within Oracle, it is not possible to estimate the expected ratio of PO and non-PO invoices in order to assess compliance with the No PO No Pay Policy.

The policy sets out a two stage escalation process for non-compliance:

- First reminder highlighting the requirements of the policy
- Final reminder for any subsequent breaches, notifying that payment will be withheld until a PO number is provided.

A report of invoices on a No PO No Pay hold is generated every Monday and an email sent to each supplier requesting PO numbers for their invoices currently on hold. The same email is sent every week for as long as the invoice(s) continue to be on the report.

This process differs to that set out within the No PO No Pay Policy. However, it is more efficient to administer and potentially more effective as it involves ongoing correspondence with the supplier until a PO number is received.

Sample testing of non-PO invoices was undertaken to establish whether they had been placed on a No PO No Pay hold and a PO number received

from the supplier. Six of the 15 invoices reviewed had not been matched to a PO or placed on a No PO No Pay hold. Failing to place these invoices on hold has resulted in them being paid without being matched to a PO and the suppliers have not been sent a no PO no pay email reminding them of the requirements of the policy.

2. Supplier Maintenance Process

Two issues from the 2017/18 internal audit have not been addressed – full details are provided at Appendix A. These related to:

- Improving the User Guide for New Supplier Set Up & Supplier Amendments; and
- Weakness in the control in place for identifying and conducting independent sample checks of amendments to bank details in Oracle.

3. Additions & Amendments to the Supplier Masterfile

Sample testing of 25 additions/amendments to the Oracle supplier masterfile identified three issues relating to:

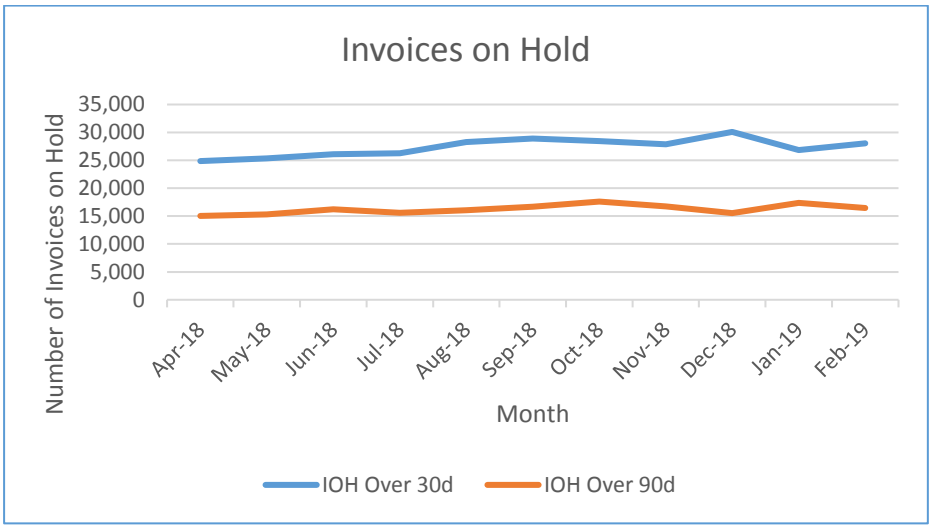
- the authorisation of one-off payment request forms;
- supporting evidence to confirm bank details provided on new supplier/amendment forms; and
- evidence of independent checking of additions/amendments to the masterfile.

We also identified an example of a control within the Supplier Maintenance Team which may not be necessary. This has previously been highlighted to management and the decision taken to retain the control. However, compliance is still not being enforced so the control is neither efficient nor effective.

We also note the risk around setting individuals up as suppliers on the Oracle system. In many cases the only supporting documentation available was handwritten bank details on a form that isn't received directly from the payee. Whilst this is permitted within the User Guide for New Supplier Set Up & Supplier Amendments, it carries a high risk of fraud or error. There is currently no requirement for suppliers (companies or individuals) to provide evidence of their bank details, for example a redacted bank statement or pay-in book.

4. Invoices on Hold

As at 28th February 2019 there were 28,000 invoices on hold for more than 30 days, with 58% on hold for more than 90 days and 21% predating 31st March 2018. The volume of invoices on hold has gradually increased during the period April 2018 – February 2019 by 13% (holds over 30 days) and 9% (holds over 90 days):



The process for reviewing invoices on hold was discussed with the Head of Accounts Payable, an AP Regional Manager and an AP Supervisor. We noted that:

- The investigation of invoice holds is complex as it requires the involvement of NWSSP Central Sourcing, NWSSP Local Procurement Teams, NWSSP Accounts Payable and the purchasing organisation.
- Central Sourcing operate by category (e.g. medical & clinical, non-medical), Local Procurement Teams operate by organisation and Accounts Payable operate by organisation and supplier. This means that that the invoice on hold reports have to be split on a different basis for Central Sourcing, Local Procurement and Accounts Payable.
- It is likely that several different people will be liaising with the same supplier to resolve invoice holds.
- Responsibilities for investigating invoice holds are not formally defined, which could signify a lack of ownership and accountability for ensuring that holds are pursued until cleared.
- The root cause of invoice holds is not identified or recorded so it is not possible to ascertain whether there are any systemic issues that require further investigation and correction.

- Positive PSPP performance suggests that new invoices on hold are being prioritised for investigation so that they can be cleared and paid within 30 days to achieve PSPP compliance, over invoices on hold for more than 30 days as they have already failed PSPP.

The Head of Accounts Payable advised that the Process Improvement Team has recently established a task and finish group responsible for reviewing and improving the existing invoice on hold process. The group includes representation from Central Sourcing, Local Procurement Teams and Accounts Payable.

Findings Outside of the Direct Control of NWSSP

In addition, the following finding has been reported to management as it is outside of the direct control of NWSSP Accounts Payable and cannot be addressed without the agreement and cooperation of customer organisations:

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 there is inconsistent use of this function across customer organisations. Consequently, PSPP performance is not comparable.

Finding 1: No PO No Pay Policy *(D+O)*	**Risk**
The all-Wales No PO No Pay policy was implemented on the 1st June 2018. With effect from 1st September 2018, following a three month transition period, invoices without a PO that are not on the agreed all-Wales exceptions list should be placed on a No PO No Pay hold in Oracle and payment withheld until the supplier provides a purchase order number. An all-Wales exceptions list has been agreed by customer organisations via the Finance Academy P2P Group, for instances where a purchase order is not necessary or appropriate. Responsibility for deciding whether or not an invoice requires a purchase order seems to rest with Accounts Payable. The exceptions list is not aligned to specific suppliers or subjective codes and in some areas is too ambiguous, so there is scope misuse or error. We are aware that there is an ongoing exercise as part of the Finance Academy P2P Group to try and address this. Accounts Payable have processed 1,784,008 invoices during the period April 2018 – March 2019. 44% of these were processed without a purchase order. In the absence of a definitive list of PO exceptions it is not clear which invoices do or do not require a PO, so compliance cannot be reliably measured. The policy sets out a two stage escalation process for non-compliance: • First reminder highlighting the requirements of the policy • Final reminder for any subsequent breaches, notifying that payment will be withheld until a PO number is provided.	Non-compliance with the No PO No Pay Policy.

A report of invoices on a No PO No Pay hold is generated every Monday and an email sent to each supplier requesting PO numbers for their invoices currently on hold. The same email is sent every week for as long as the invoice(s) continue to be on the report. This process differs to that set out within the No PO No Pay Policy. However, it is more efficient to administer and potentially more effective as it involves ongoing correspondence with the supplier until a PO number is received. Sample testing of non-PO invoices was undertaken to establish whether they had been placed on a No PO No Pay hold and a PO number received from the supplier. Six of the 15 invoices reviewed had not been matched to a PO or placed on a No PO No Pay hold. Failing to place these invoice on hold has resulted in them being paid without being matched to a PO and the suppliers have not been sent a no PO no pay email reminding them of the requirements of the policy.	
Recommendation 1	**Priority level**
As the No PO No Pay Policy will shortly have been in place for a year, an operational review should be undertaken in order to look at whether customer organisations and NWSSP are fully meeting their responsibilities under the policy. For example, responsibility for determining whether an invoice falls under the all-Wales exception list should be reviewed and consideration given as to whether the onus should sit with the customer organisation, as owner of the invoice and accountable for ensuring that their staff comply with the No PO No Pay Policy. In the meantime, management should:	**Medium**

• consider whether to enforce the current requirements of the No PO No Pay Policy, or alternatively update the policy to reflect the process in operation within Accounts Payable for writing to suppliers to request PO numbers; and • ensure that non-PO invoices that are not covered by the agreed exceptions list are placed on a No PO No Pay hold to ensure that the supplier is contacted to provide a PO number.	
Management Response 1	**Responsible Officer/ Deadline**
No PO No Pay Policy – Operational Review – Agreed this will need to be confirmed with the Chair of the All Wales P2P Forum, currently this is Pete Hopwood, Director of Finance, Powys Health Board. **Policy to be updated to reflect current process** - Agreed **No PO Invoices** – Agreed - Any invoice received that does not contain a PO and is not on the current exempt schedule will be placed on the No PO No Pay hold	The Operational Review was agreed to by the All Wales P2P Forum on the 10th June. Agreed - Russell Ward – Head of AP will update the Policy and this will be considered as part of the review as outlined above – by the end of July 2019. Agreed - Russell Ward – Head of AP – Complete - this is a current requirement

Finding 2: Supplier Maintenance Process *(D)*	**Risk**
Two issues from the 2017/18 internal audit have not been addressed: a) The User Guide for New Supplier Set Up & Supplier Amendments does not clearly set out the step-by-step process for requesting, processing and checking additions/amendments to the supplier masterfile. Management agreed that the user guide would be reviewed and updated to this effect. However, this has not been completed. b) Weakness in the control in place for identifying and conducting independent sample checks of amendments to bank details in Oracle. We recommended that management explore alternative methods of identifying and reviewing amendments to bank details within the supplier masterfile. However, from discussion with the Supplier Maintenance Team and Head of eEnablement, we note that no progress has been made in this respect.	Poor quality requests for additions/amendments to the supplier masterfile increasing the risk of incorrect payments.
Recommendation 2	**Priority level**
The User Guide for New Supplier Set Up & Supplier Amendments 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.	**Medium**
Management should explore alternative methods of identifying and reviewing amendments to bank details within the supplier masterfile. 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.	

Management Response 2	Responsible Officer/ Deadline
User Guides – Agreed - Updated User Guides have been created and we are waiting for feedback from Internal Audit to ensure that Internal Audit concerns have been addressed. As soon as the Guides are circulated, the Supplier Maintenance Team will only accept the new forms. If anyone sends through 'old' forms they will be returned. **Bank amendments** – Agreed - If the request contains bank amendments, each request is independently checked by another member of the supplier maintenance team, which is an additional check from the requestors. In addition to these checks, when banks amendments are made, an email is generated by the system and sent to an email box that the supplier maintenance team do not have access to and is then independently verified by an AP Manager The supplier maintenance team will explore how a further check can be achieved, utilising reports if feasible and practical.	Agreed - Noel Williamson/Sue Lewis – completed – awaiting Internal Audit feedback before circulating Agreed - Noel Williamson/Sue Lewis 31 July 2019

Finding 3: Additions & Amendments to the Supplier Masterfile *(D + O)*	Risk
Sample testing of 25 additions/amendments to the Oracle supplier masterfile identified the following issues: • Our sample included 11 one-off payment request forms, which should be 'signed' (name typed) as generated/prepared and authorised by Accounts Payable. Only one complied with this. Three had not be signed as generated or authorised, the remaining seven had been signed as either generated or authorised (not both). We have previously questioned the benefit of this requirement with management, noting that a 'signed' form equates to a name typed on a form which adds no value to the process. • One supplier addition had no supporting evidence for bank details provided by Accounts Payable on the One-Off Payment Request Form (for payments to an individual). Consequently, the Supplier Maintenance Team did not verify the details provided on the form to supporting documentation prior to processing. • Two additions/amendments did not have evidence of independent checking within the Supplier Maintenance Team. We also note the risk around setting individuals up as suppliers on the Oracle system. In many cases the only supporting documentation available was handwritten bank details on a form that isn't received directly from the payee. This is permitted within the User Guide for New Supplier Set Up & Supplier Amendments, however it carries a high risk of fraud or error. There is currently no requirement for suppliers (companies or individuals) to provide evidence of their bank details, for example a redacted bank statement or pay-in book.	Poor quality requests for additions/amendments to the supplier masterfile increasing the risk of incorrect payments.

Recommendation 3	Priority level
In order to reduce the risk of fraud/error, evidence of bank details (e.g. redacted bank statement) should be required for any additions/amendments to bank details. Potential data protection implications should be discussed with the Information Governance Manager.	**Medium**
Review the requirement for authorisation of One-Off Payment Request Forms. If it is retained, any non-compliant requests for additions/amendments should be rejected.	
Management Response 3	**Responsible Officer/ Deadline**
Bank Amendments- Agreed - If the request contains bank amendments, each request is independently checked by another member of the supplier maintenance team, which is an additional check from the requestors. In addition to these checks, when banks amendments are made, an email is generated by the system and sent to an email box that the supplier maintenance team do not have access to and is then independently verified by an AP Manager The supplier maintenance team will discuss any potential data protection implications with the Information Governance manager. **One-off Payment Request Forms** – Agreed any non-compliant requests for additions/amendments will be rejected and returned. As mentioned above, new Guides have been development and will be circulated once feedback from Internal Audit have been received	Agreed - Noel Williamson - /Sue Lewis 31 July 2019 Agreed - Noel Williamson/Sue Lewis 31 July 2019

Finding 4: Invoices on Hold *(D)*	**Risk**
As at 28th February 2019 there were 28,000 invoices on hold for more than 30 days, with 58% on hold for more than 90 days and 21% older than 31st March 2018. The volume of invoices on hold has gradually increased during the period April 2018 – February 2019 by 13% (holds over 30 days) and 9% (holds over 90 days). The process for reviewing invoices on hold was discussed with the Head of Accounts Payable, an AP Regional Manager and an AP Supervisor. We noted that: • The investigation of invoice holds is complex as it requires the involvement of NWSSP Central Sourcing, NWSSP Local Procurement Teams, NWSSP Accounts Payable and the purchasing organisation. • Central Sourcing operate by category (e.g. medical & clinical, non-medical), Local Procurement Teams operate by organisation and Accounts Payable operate by organisation and supplier. This means that that the invoice on hold reports have to be split on a different basis for Central Sourcing, Local Procurement and Accounts Payable. • It is likely that several different people will be liaising with the same supplier to resolve invoice holds. • Responsibilities for investigating invoice holds are not formally defined, which could signify a lack of ownership and accountability for ensuring that holds are pursued until cleared. • The root cause of invoices holds is not identified or recorded so it is not possible to ascertain whether there are any systemic issues that require further investigation and correction. • Positive PSPP performance suggests that new invoices on hold are being prioritised for investigation so that they can be cleared and paid within 30 days to achieve PSPP compliance, over invoices on hold for more than 30 days as they have already failed PSPP.	Non-payment of invoices resulting in suppliers placing NHS organisations on stop, consequently impacting on service continuity.

The Head of Accounts Payable advised that the Process Improvement Team has recently established a task and finish group responsible for reviewing and improving the existing invoice on hold process. The group includes representation from Local Procurement Teams, Central Sourcing and Accounts Payable.	
Recommendation 4	**Priority level**
The feasibility of defining responsibilities for different hold types, suppliers and organisations should be explored with the aim of improving ownership and accountability for the investigation and resolution of invoice holds.	**Medium**
Invoice holds are currently analysed by customer and hold type for the purpose of the KPIs. This analysis should be extended to include suppliers to enable the identification of themes and trends. Key problem areas should then be investigated to establish the root cause of the invoice holds, and corrective action taken where necessary to prevent recurrence. This will require a collaborative approach between Central Sourcing, Local Procurement Teams, Accounts Payable and customer organisations, as well as involvement of the supplier where appropriate, depending on the hold type.	
Management Response 4	**Responsible Officer/ Deadline**
Invoices on hold (IOH) has been a problem ever since Oracle was implemented and there are numerous factors that influence this. Over the past 3-years there has been considerable effort from all parties to resolve PSPP failures which has resulted in two distinct processes. There is a proactive approach to resolve invoice holds or identify disputes where the invoice is under 30 days old to support PSPP, but when the invoice goes beyond the 30 days, the approach largely	Agreed – Responsibility lies jointly with Graham Davies, Interim Director of Procurement and Russell Ward – Head of Accounts

becomes a reactive approach, typically when the supplier is chasing payment. As a result, this has contributed to the high number of invoices on hold as stated above in this report. Whilst AP plays a pivotal role in supporting Front Line Procurement, Central Sourcing and Health Organisations to resolve these holds, AP is not the owner. **Defining responsibility** – Agreed – This is jointly owned by Front Line Procurement, Central Sourcing and Health Organisations. Whilst Accounts Payable does play a pivotal role in investigating and resolving Invoice holds, AP is not owner. **Themes and Trends** – Agreed – Supplier trends are jointly owned by Front Line Procurement and Central Sourcing. **Collaborative approach -** Agreed – This is jointly owned by Front Line Procurement, Central Sourcing, Health Organisations and Accounts Payable.	Payable and Health Organisations. Ongoing. Russell Ward – Head of Accounts Payable will secure confirmation from Health Organisations via each organisations P2P chair. By the end of September 2019.

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.

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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The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

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 300841

Sophie Corbett (Audit Manager) - 01792 860596

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NHS Wales Shared Services Partnership

Audit Committee

9 July 2019

Internal Audit Progress Report

CONTENTS Page

1. INTRODUCTION

The purpose of this report is to highlight progress of the 2019/20 Internal Audit Plan at 1 July 2019 to the Audit Committee, together with an overview of other activity undertaken since the previous meeting.

2. PROGRESS AGAINST THE 2019/20 INTERNAL AUDIT PLAN

Number of audits in plan	21
Of which:	
Number of audits at planning stage	9
Number of audits in progress	2

Progress in respect of each of the reviews in the 2019/20 Internal Audit Plan is summarised at Appendix A.

The outcomes of the 2018/19 Internal Audit Programme were reported in the 2018/19 Head of Internal Audit Annual Report and Opinion. All 2018/19 audits were completed with the exception of the review of IT virtualisation which is ongoing and will be reported within the 2019/20 Head of Internal Audit Annual Report and Opinion and is included in the total number of audits above.

3. ENGAGEMENT

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

- Information Governance Steering Group
- Finance Academy P2P Group
- Advising the Head of Procurement on the development of the Procurement Manual
- Advising Accounts Payable and Primary Care Services on document retention
- Audit scoping and debrief meetings
- Liaison meetings with senior management

4. RECOMMENDATION

The Audit Committee is invited to note the above.

2019/20 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)								Scheduled for Q3
General Dental Services (GDS)								Scheduled for Q3
General Ophthalmic Services (GOS)								Scheduled for Q3
General Pharmaceutical Services (including Prescribing)								Scheduled for Q3
Post Payment Verification (PPV)								Scheduled for Q4
EMPLOYMENT SERVICES								
Payroll Services		Planning						

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
PROCUREMENT SERVICES								
Purchase to Pay (P2P)		Planning						
AUDITS FOR NWSSP								
FINANCE & CORPORATE SERVICES								
IR35		Work in progress						
Health and Safety								Scheduled for Q3
Performance Reporting		Planning						
Budgetary Control & Financial Reporting								Scheduled for Q4
Salary Sacrifice								Scheduled for Q4
Strategic Planning		Planning						
PROCUREMENT SERVICES								
Procurement Directorate Review		Planning						
Stores		Planning						

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
WORKFORCE & ORGANISATION DEVELOPMENT								
Time Recording		Planning						
Staff Expenses								Scheduled for Q3
IT								
IT Systems – Virtualisation (continued from 2018/19)		Work in progress						
IT Systems 2019/20		Planning						
CAPITAL & ESTATES								
Property Management		Planning						
ADVISORY REVIEWS AND RISK AREAS TO BE MONITORED								
Contact Centres (advisory)								Scheduled for Q2
Primary Care Payments System								Monitoring
Service Change								Monitoring

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
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.

Assurance rating	Assessment rationale	Guide to Rating
	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.	Significant audit matters require management attention both in terms of materiality and number. 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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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	4.1
PREPARED BY	Peter Stephenson, Head of Finance and Business Development
PRESENTED BY	Peter Stephenson, Head of Finance and Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Annual Governance Statement 2018-19

PURPOSE

To present the final Annual Governance Statement (AGS) to the Committee, for **APPROVAL**.

1. BACKGROUND

The Annual Governance Statement is a mandatory requirement. It provides assurance that NWSSP has a generally sound system of internal control that supports the achievement of its policies, aims and objectives, and provides 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 University NHS Trust's annual report and accounts. The external auditor will report on inconsistencies between information in the Statement and their knowledge of the governance arrangements for NWSSP.

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

The final Annual Governance Statement for 2018-19 is presented at **Appendix 1**, for the Committee's **APPROVAL.**

2. PROCESS FOR APPROVAL

The document's journey in terms of engagement and consultation is set out below, for assurance:

Date	Action
28 March 2019	Senior Management Team (SMT) To review the draft AGS
9 April 2019	NWSSP Audit Committee Consider and agree if it is consistent with the Committee's view of NWSSP's Assurance Framework
25 April 2019	Senior Management Team (SMT) To review the draft AGS
16 May 2019	SSPC To approve the AGS prior to submission to Audit Committee
30 May 2019	Senior Management Team (SMT) To formally adopt the AGS
9 July 2019	Audit Committee Review AGS along with the final Head of Internal Audit Opinion and final version agreed.
July 2019	Arrange Welsh language translation
July 2019	Publicise on NWSSP website

3. GOVERNANCE & RISK

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

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

Section 4 of the SSPC Standing Orders states that:

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

4. RECOMMENDATION

The Audit Committee are asked to:

- **APPROVE** the Annual Governance Statement.

Annual Governance Statement 2018/2019

Version	Approved
1	SMT 28 February 2019 draft for information
2	Velindre Integrated Governance Group 8 April 2019
3	Audit Committee 9 April 2019
4	SSPC 23 May 2019 Final
5	Audit Committee 9 July 2019 (for Final Approval)

CONTENTS

ANNUAL GOVERNANCE STATEMENT 2018/2019

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).

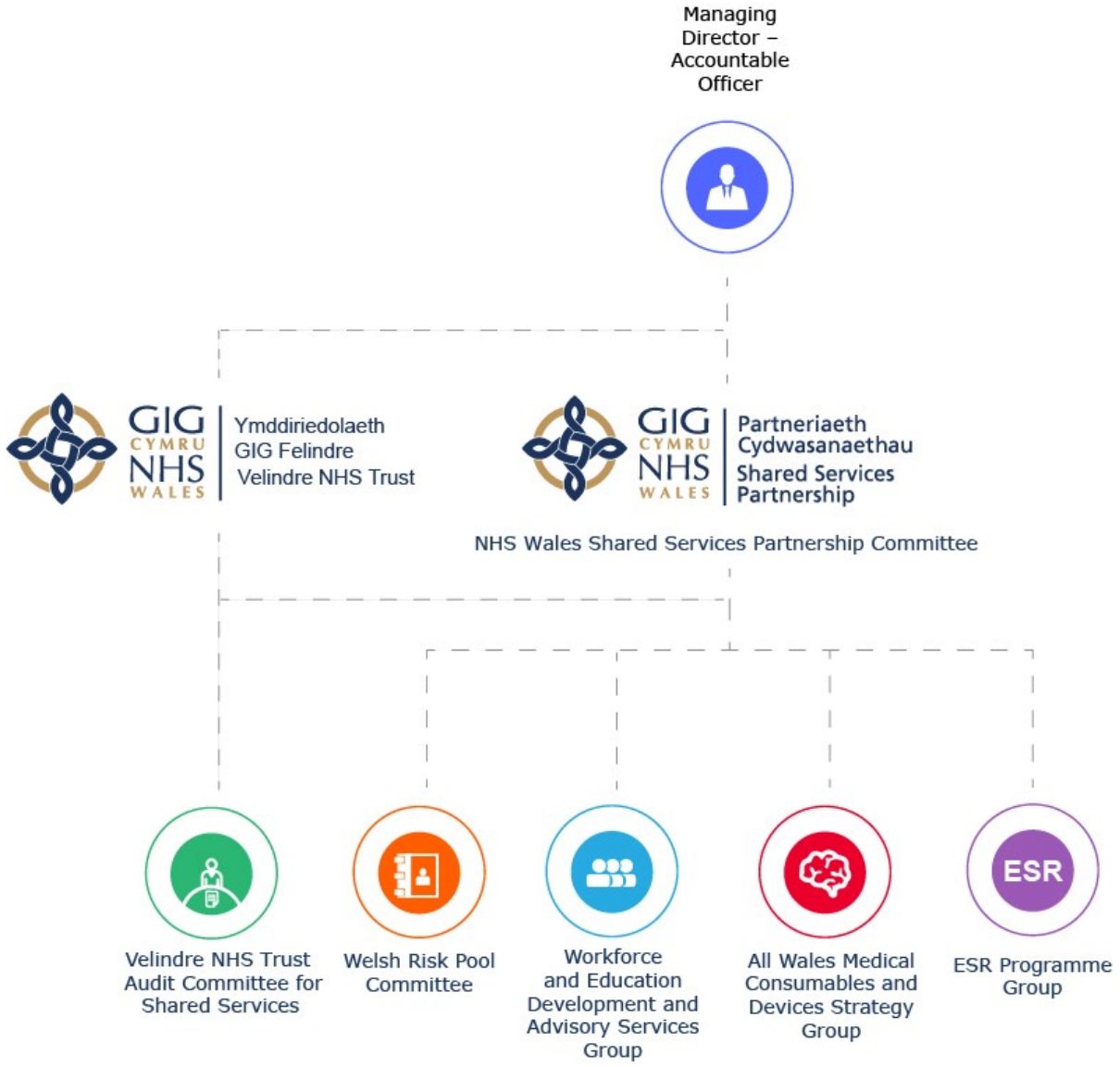
The Managing Director of Shared Services is accountable to the Shared Services Partnership Committee (Partnership Committee) in relation to those functions delegated to it. The Managing Director is also accountable to the Chief Executive of Velindre NHS Trust in respect of the hosting arrangements supporting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

The Workforce & Education Development and Advisory Services Group ceased to report to the Partnership Committee with effect from 1 October 2018 following the establishment of Health Improvement and Education Wales.

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 executive representative who acts on behalf of the respective Health Board or Trust.

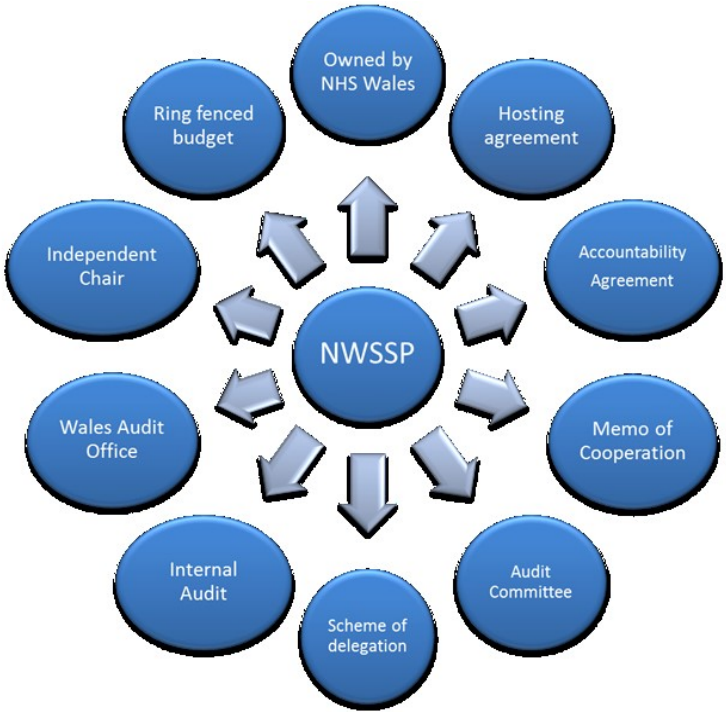
At a local level, Health Boards and NHS Trusts in Wales must agree Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out within the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, into 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, NHS Trusts and the newly formed Health Education and Improvement Wales (HEIW) 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 all NHS organisations in undertaking its functions, the responsibility for the exercise of Shared Services functions is a shared responsibility of all NHS bodies in Wales.

NWSSP's governance arrangements are summarised below.

Figure 2: Summary of Governance Arrangements



The 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 NWSSP; and
- Accountability Agreement between the Partnership Committee and the Managing Director of NWSSP.

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 2019 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 2018/2019

Name	**Position**	**Organisation**	**From – To**
Margaret Foster (Chair)	*Independent Member*	*NHS Wales Shared Services Partnership*	*Full Year*
Huw Thomas (Vice Chair)	*Interim Director of Finance*	*Hywel Dda UHB*	*Full Year*

Name	Position	Organisation	From – To
Neil Frow	*Managing Director of NWSSP*	*NHS Wales Shared Services Partnership*	*Full Year*
Hazel Robinson	*Director of Workforce & OD*	*Abertawe Bro Morgannwg UHB*	*Full Year*
Geraint Evans	*Director of Workforce and OD*	*Aneurin Bevan UHB*	*Full Year*
Christopher Lewis	*Acting Director of Finance*	*Cardiff and Vale UHB*	*Full Year*
Joanna Davies	*Director of Workforce & OD*	*Cwm Taf UHB*	*Full Year*
Eifion Williams	*Director of Finance*	*Powys THB*	*Full Year*
Phil Bushby	*Director of People & OD*	*Public Health Wales NHS Trust*	*Full Year*
Steve Ham	*Chief Executive*	*Velindre NHS Trust*	*Full Year*
Chris Turley	*Interim Director of Finance*	*Welsh Ambulance Services NHS Trust*	*Full Year*
Other Regular Attendees			
Denise Roberts	*Financial Accountant*	*Betsi Cadwaladr UHB*	*Full Year*
Dafydd Bebb	*Board Secretary*	*HEIW*	*Part-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 NWSSP as governance support.

Figure 4 – Attendance at the Meetings of the NHS Wales Shared Services Partnership Committee during 2018/2019

Organisation	21/06/ 2018	20/09/ 2018	15/11/ 2018	17/01/ 2019	14/03/ 2019
Abertawe Bro Morgannwg UHB	✓*	✓	✓	✓	*
Aneurin Bevan UHB	✓	✓	✓	✓	✓
Betsi Cadwaladr UHB	✓*	*	✓*	✓*	✓*
Cardiff and Vale UHB	✓	✓	✓	✓	✓
Cwm Taf UHB	✓	✓	*	✓	✓*
HEIW	*N/a*	*N/a*	*N/a*	✓*	✓*
Hywel Dda LHB	✓	✓	✓	✓*	✓
Powys Teaching Health Board	✓*	*	✓	✓	✓

Public Health Wales Trust	✓*	*	✓	✓	✓
Velindre NHS Trust	✓	✓	✓	*	✓
Welsh Ambulance Service Trust	✓	*	✓	*	✓
Welsh Government	✓	*	✓	*	✓

✓ 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

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

During 2018/2019, the Partnership Committee approved an annual forward plan of business, including:

- Regular assessment and review of:
    - Finance, Workforce and Performance information;

    - Corporate Risk Register;
    - Welsh Risk Pool;
    - Programme Management office updates.
- Annual review and/or approval of:
    - Integrated Medium Term Plan;
    - Annual Governance Statement;
    - Wales Audit Office Management Letter;
    - Annual Review;
    - Standing Orders and Standing Financial Instructions;
    - Health & Care Standards; and
    - Service Level Agreements.
- Deep Dives into:
    - Hire to Retire;
    - GP Specialty Registrar Trainees;
    - Legal & Risk Complex Case Team;
    - Specialist Estates Services.

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 July 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 2018/2019 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. (NB Phil Roberts replaced Professor Jane Hopkinson as an independent member, with effect from January 2019).

Figure 5 - Composition of the Velindre NHS Trust Audit Committee for NWSSP during 2018/19

In Attendance	April 2018	June 2018	July 2018	Oct 2018	Jan 2019	Total
Committee Members						
Martin Veale, Chair & Independent Member	✓	✓	✓	✓	✓	**5/5**
Ray Singh, Independent Member	✓	✓	✓	✓		**4/5**
Professor Jane Hopkinson, Independent Member (to October 2018)	✓	✓	✓	✓	N/a	**4/4**
Phil Roberts, Independent Member (from January 2019)	N/a	N/a	N/a	N/a	✓	**1/1**
Wales Audit Office						
Audit Team Representative	✓	✓	✓		✓	**4/5**
NWSSP Audit Service						
Director of Audit & Assurance	✓	✓		✓	✓	**4/5**
Head of Internal Audit	✓	✓	✓	✓	✓	**5/5**
Audit Manager	✓	✓	✓	✓	✓	**5/5**
Counter Fraud Services						
Local Counter Fraud Specialist	✓	✓	✓		✓	**4/5**
NWSSP						
Margaret Foster, Chair NWSSP	✓	✓	✓			**3/5**
Neil Frow, Managing Director	✓	✓	✓	✓	✓	**5/5**
Andy Butler, Director of Finance & Corporate Services	✓	✓	✓	✓	✓	**5/5**
Peter Stephenson, Head of Finance & Business Development	✓	✓	✓	✓	✓	**5/5**
Roxann Davies, Compliance Officer	✓	✓	✓	✓	✓	**5/5**
NWSSP Secretariat	✓	✓	✓	✓	✓	**5/5**
Velindre NHS Trust						
Mark Osland, Director of Finance			✓	✓	✓	**3/5**

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. The survey for 2018/19, undertaken during May 2019, had a 91% response rate (10 responses received) and identified the following:

- Over 90% of all responses were positive;
- All respondents felt that the Committee had been provided with sufficient authority and resource to perform its role effectively;
- All respondents considered that the Committee meets sufficiently frequently to deal with planned matters and that sufficient time is made available for questions and discussion;
- All respondents agreed that the atmosphere at Committee meetings is conducive to open and productive debate;
- All respondents agreed that the behaviour of members and attendees was courteous and professional; and
- All respondents agreed that the reports received by the Committee were timely and included the right format and content to enable the Committee to discharge its internal control and risk management responsibilities.

The results highlighted areas for consideration, which will form a Committee Effectiveness Action Plan for 2019-20, including 70% of respondents welcoming greater use of Committee paper software (e.g iBabs); the monitoring of implementation of actions arising and lessons learned in relation to Counter Fraud cases; and assessment of the quality and effectiveness of External Audit.

2.5 Sub Groups and Advisory Groups

The Partnership Committee is now supported by three, rather than four advisory groups. Following the establishment of Health Improvement & Education Wales on 1 October 2018, the Workforce Education and Development Services Advisory Group no longer reports to the Partnership Committee:

- **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 2018/2019

Name	Designation
Mr Neil Frow	Managing Director
Mr Andy Butler	Director of Finance and Corporate Services
Mr Gareth Hardacre	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 (until 30 September 2018)	*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 2019.

3.1 External Audit

During 2018/2019, NWSSP's external auditors were the Wales Audit Office (WAO). The Audit Committee has worked constructively with the WAO and the areas examined included:

- Position Statements (to every meeting);
- NWSSP Nationally Hosted NHS IT Systems Assurance Report 2017-18;
- Management Letter 2017/18; and
- WAO Assurance Arrangements 2019.

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

Quarterly returns providing assurance on any audit areas assessed as having "no assurance" or "limited assurance" were issued to Welsh Government in accordance with the instruction received from Dr Andrew Goodall, Chief Executive NHS Wales/Director General in July 2016. During 2018/19 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 Audit Committee to monitor progress against the agreed Counter Fraud Plan; including the following reports:

- Progress Update at each meeting
- Annual Report 2017-18
- Counter Fraud Work Plan 2018-19
- Counter Fraud Self Review Tool Submission 2017-18

During 2017/18, four new investigations into possible fraudulent or corrupt activity were instigated together with the five cases that were brought forward from 2016/17. Out of the four new cases, three 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 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 Director of Finance and Corporate Services annually.

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

In addition to this and in an attempt to promote an Anti-Fraud Culture within NWSSP, a quarterly newsletter is produced which is then available to all staff on the intranet and all successful prosecutions 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 2017-18 Internal Audit self-assessment;
- Tracking of Audit Recommendations;
- Corporate Risk Register;
- Directorate Assurance Maps; and
- Governance Matters report on single tender actions, declarations of interest, gifts and hospitality received and declined.

During 2018/19, 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 2018/19, 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.

Procurement Services maintains certification to a number of international and national standards including ISO 9001 Quality Management, ISO 27001 Information Security, OHSAS 18001 Occupational Health & Safety and Customer Service Excellence. Our Regional Stores are also accredited to the STS Code of Practice & Technical Standard for the Public Sector. During 2018/19 our ISO 9001 scope of certification was extended to include our Accounts Payable function in South Wales and Front Line Procurement teams at an additional four locations. In 2019/20 we will include our Accounts Payable function in North Wales. We will also be extending our Customer Service Excellence accreditation to include Health Courier Services. Work will also be completed to transition from OHSAS 18001 to ISO 45001 and comply with updates to the STS Code of Practice.

We continue to work towards the ISO27001 Information Security Management Standard (ISMS). We have developed on organisation wide cyber-security action plan that will be implemented prior to ISO 27001. We recently took part in a cyber–security audit as part of our work to achieve the Cyber Essentials Plus standard from the international NIST framework, our plan has been updated to reflect the recommendations. The standard aims to improve resilience and responsiveness to threats to information, preserving confidentiality, integrity and availability of information (CIA) by applying a risk management process. It deals with the need for prevention and all aspects of protocol including technical, physical and legal control.

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 2019-20 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. The register is divided into two sections as follows:

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

- Risks for Monitoring – this is for risks that have achieved their target score but which need to remain on the Corporate Risk Register due to their potential impact on the organisation as a whole. For these risks the focus is on monitoring both any changes in the nature of the risk (e.g. due to external environmental changes) and on ensuring that existing controls and actions remain effective (e.g. through assurance mapping).

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

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

In 2018/19 assurance maps were updated for each of the directorates to provide a view on how the key operational, or business-as-usual risks were being mitigated. An additional map was produced for the Wales Infected Blood Support Scheme and an overall map linked to the corporate objectives for NWSSP has also been documented. The new and updated assurance maps were presented to the Audit Committee in November 2018 and they will continue to be updated and reviewed by the Audit Committee annually.

During 2018/19 a Risk Appetite statement has also been documented and approved by the Audit Committee. This covers nine specific aspects of NWSSP activity with a separate appetite score for each. The operationalisation of the risk appetite is through the target scores in the corporate and directorate risk registers.

The annual internal audit of risk management was undertaken at the end of 2018/19 and 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 Risk Management was Substantial Assurance.

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 2019, there are two corporate risks categorised as having a "red" risk rating, relating to:

- Risk of a no-deal Brexit with a particular focus on the supply chain; and
- Plans for the replacement of the NHAIS system to allow payments to be made to GPs.

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 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. The implementation of the General Data Protection Regulations in May 2018 increased the responsibilities to ensure that the data that NWSSP collects, and its subsequent processing, is for compatible purposes, and it remains secure and confidential whilst in 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. The IGSG discusses quarterly issues such as GDPR and Data Protection Legislation, the Freedom of Information Act, Information Asset Ownership, Information Governance Breaches, Records Management, Training compliance, new guidance documentation and training materials, areas of concern and latest new information and law.

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

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

The Information Governance Manager attends various meetings including the 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.

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. During the year the Group has documented and approved a NHS Anti-Fraud Strategy for Wales.

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 opinion from this review was 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)

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 planning process for the 2019-2021 IMTP commenced with a stakeholder awayday in September 2018 and the completed IMTP was submitted to Welsh Government at the end of January 2019.

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 undertakes 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 overleaf:

Figure 9 – Self- Assessments Rating Against the Health and Care Standards 2018/2019

Theme	Executive Lead	2018/2019 Self-Assessment Rating	2017/2018 Self-Assessment Rating
Governance, Leadership and Accountability	Senior Management Team	4	4
Staying Healthy	Director of Workforce and Organisational Development	4	3
Safe Care	Director of Finance and Corporate Services Director of Specialist Estates	4	4
Effective Care	Senior Management Team	4	3
Dignified Care	Not applicable	Not applicable	Not applicable
Timely Care	Not applicable	Not applicable	Not applicable
Individual Care	Senior Management Team	4	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 4 as outlined below:

Figure 10 – NWSSP's Overall Self-Assessment Score Health and Care Standards 2018/2019

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 within Velindre University NHS Trust, we are required to adhere to their Equality and Diversity Policy, Strategic Equality Plan and Equality Objectives, which set out the Trust's commitment and legislative requirements to promoting inclusion.

Our Corporate Services Manager chairs the NHS Wales Equality Leadership Group, together with sitting on the All Wales Senior Offices Group for Equality. 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 our offering, including the Positive About Disabled People "Double Tick" symbol, "The Rainbow Mark" and we are working towards achieving a place on the Stonewall Cymru Workplace Index. Furthermore, 2018 saw NWSSP supporting NHS Wales

organisations with completion of their submission for all-Wales services, such as Procurement and Recruitment.

We have developed a process for undertaking Equality Integrated Impact Assessments (EQIIA), which we are hoping to integrate into our Project Management System software. The EQIIA considers the needs of the protected characteristics identified under the Equality Act 2010, the Public Sector Equality Duty in Wales and the Human Rights Act 1998, whilst recognising the potential impacts from key enablers such as Well-being of Future Generations (Wales) Act 2015 incorporating Environmental Sustainability, Modern Slavery Act 2015 incorporating Ethical Employment in Supply Chains Code of Practice (2017), and Welsh Language, Information Governance and Health and Safety.

Personal data in relation to equality and diversity is captured on the Electronic Staff Record (ESR) system and staff are responsible for updating their own personal records using the Electronic Staff Record Self-Service. This includes ethnicity; nationality, country of birth, religious belief, sexual orientation and Welsh language competencies. The "NHS Jobs" all Wales recruitment service, run by NWSSP adheres to all of the practices and principles in accordance with the Equality Act and quality checks the adverts and supporting information to ensure no discriminatory elements. NWSSP has a statutory and mandatory induction programme for all 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 was been included within the 2019 programme for new starters in the organisation.

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, the Welsh Language Measure (Wales) 2011 and the Welsh Language Standards [No7.] Regulations 2018.

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

These posts enable us to comply with our current obligations under the current Welsh Language Scheme and in meeting the requirements of the

Welsh Language Standards with the first deadline in May 2019. This has increased the demand for translation services in the following areas:

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

The preparation for the formal implementation of the standards is monitored through an action plan that is reviewed by the NWSSP SMT monthly. The arrangements for implementation were also the subject of an internal audit that reported in January 2019, and which provided reasonable assurance. 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.

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. We are now looking to offer our language services to other organisations and have already agreed to provide services to Public Health Wales, HEIW, and NWIS.

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'.

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.

During 2018-19, 25 complaints were received. 88% of the complaints received were responded to within the 30 working day target, which is an improved rate from 71% compliance during 2017/18, based on 14 complaints. Three responses were issued outside of the target, being responded to at 32, 34 and 46 working days respectively, where cases were particularly complex in nature. However, in all instances holding letters were issued and/or telephone calls were made to the complainants explaining that NWSSP were still in the process of investigating the matters raised and that they would be provided with a substantive response as soon as the investigation had been concluded.

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.

Figure 12 – Freedom of Information Requests 2018- 2019

There were 59 requests received within NWSSP during 2018/19, many of these were redirected to other bodies for response but those received were handled within the prescribed 20 day time limit for requests. This figure includes 26 requests that were either transferred out, or information provided to Velindre to complete a hosting body response.

FOI Breakdown
59 answered within the 20 day target
13 transferred out to another NHS body
13 provided a response for Velindre to complete a hosted organisation reply
0 responded to outside of the deadline
0 withdrawn

6.5 Data Security

In 2018/2019, 33 information governance breaches were reported within NWSSP; these included issues with mis-sending of email and records management. The majority of these were down to human error and education in these areas has been increased to ensure awareness of confidentiality and effective breach reporting when issues arise.

All breaches are recorded in the Datix risk management software, and investigated in accordance with the Information Governance and Confidentiality Breach Reporting protocols, which have been updated in year to reflect the implementation of GDPR. The protocols encourage staff to report those breaches that originate outside the organisation for recording purposes.

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

There was one Information Governance breach reported in 2018/19 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.

6.6 ISO14001 – Sustainability and Carbon Reduction Delivery Plan

As an organisation, we are committed to managing our environmental impact, lowering the organisation's carbon footprint and integrating the sustainable development principle into our day to day business. We successfully implemented ISO14001, our Environmental Management System in 2014, in accordance with Welsh Government requirements and have successfully maintained our certification to date through the operation of a Plan, Do, Check, Act cycle.

During August 2018, we successfully achieved transition to the updated ISO14001:2015 Standard, which puts greater emphasis on protection of the environment, continuous improvement through a risk process based approach and commitment to top-down leadership, whilst managing the needs and expectations of our interested parties. At this audit, no non-conformities and 3 opportunities for improvement were raised.

During February 2019, we successfully brought into scope of certification Westpoint Industrial Estate, Cardiff, which is where Health Courier Services, the wheels of the NHS in Wales, are based. At this audit, one minor non-conformity and 3 opportunities for improvement were raised.

Carbon Footprint

As part of our commitment to reduce our contribution to climate change, a target of 3% reduction in our carbon emissions (year on year, from a baseline of carbon footprint established in 2016-17), has been agreed and this is reflected within our Environmental and Sustainability Objectives. During 2018-19, we achieved our target and obtained an 11.32% reduction overall. We committed to reducing our carbon footprint by implementing various environmental initiatives and efficiencies at our sites within the scope of our ISO14001:2015 certification. Our *Sustainable Development Statement* explores this area in further detail. Performance highlights from 2018-19 were as follows:

Area	2016/17	2017/18	2018/19	Target	Target Achieved
Electricity CO2e	11% reduction	18% reduction	11.57% reduction	3% reduction	✓
Gas CO2e	13% increase	7% reduction	38.13% reduction	3% reduction	✓
Water M3	51% increase	9% reduction	6.72% increase	3% reduction	☒
Business Mileage Expenditure	6% reduction	15% reduction	New Baseline Established	15% reduction by 2021	✓
Business Mileage	7% reduction	11% reduction	New Baseline Established	15% reduction by 2021	✓
Waste CO2e	62% recycled/recovered	95% recycled/recovered	89% recycled/recovered	70% recycled/recovered	✓
Overall Carbon Footprint	**5.37% increase**	**3.78% reduction**	**11.32% Reduction**	**3% reduction**	✓

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.

In addition, much work has been undertaken in terms of the specific business continuity risks arising from a no-deal Brexit. Specific risk assessments have been undertaken and we have participated in and directed business continuity exercises to assess the effectiveness of our response to specific risks.

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. In 2018/19 work has been undertaken to document an overarching business continuity plan and supporting business impact assessment. This built on the local directorate plans that were already in place. Desktop exercises were undertaken in September 2018 to test NWSSP's resilience in a number of specific scenarios, and we also undertook a joint exercise with NWIS in October 2018 to consider our response in the event of a major cyber attack. Our resilience was also tested for real in April 2018 when travellers took over part of the Matrix House Car Park, and also through adverse weather conditions during the year.

Over and above this, 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 (which was updated in July 2018) 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.

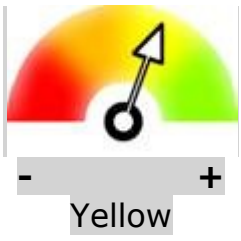
Each of the Committees have considered a range of reports relating to their areas of business during the last year, which have included a comprehensive range of internal audit and external audit reports and reports on professional standards from other regulatory bodies. The Committees have also considered 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 2018/2019 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		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.

Internal Audit review of Risk Management

Internal Audit undertook a review of Risk Management in 2018/19 to assess the effectiveness of the systems in place to manage and assure risks. This audit provides assurance to the Audit Committee 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 management framework 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 2018/19.

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.

Annual review of the SLAs ensures that they remain current and take account of service developments.

- **Reporting** – NWSSP has a broad range of financial and performance reports in place to ensure that the effectiveness of service provision and associated controls can be monitored and remedial action taken as and when required.

Through this structure NWSSP has maintained effective financial control which has been reviewed and accepted as appropriate by both the Internal and External Auditors.

CONCLUSION

This Governance Statement indicates that NWSSP has continued to make progress and mature as an organisation during 2018/19 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 2019/20:

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 2019/20.

Signed by:

Managing Director – NHS Wales Shared Services Partnership

Date: May 2019

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	4.2
PREPARED BY	Roxann Davies, Corporate Services
PRESENTED BY	Andy Butler, Director of Finance and Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Governance Matters

PURPOSE

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

1. 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 **28 March 2019 to 2 July 2019**. A summary of activity for the period is set out in **Appendix A**.

Description	No.
Invitation to competitive tender of value between £25,000 and the prevailing OJEU threshold (exclusive of VAT)	2
Single Quotation Actions	2
Single Tender Actions	1
Direct Call Off against National Framework Agreement	1
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)	0
Contract Extensions	0
File Note	0
Total	**7**

3. NWSSP PROCUREMENT SERVICES ALL WALES CONTRACTING ACTIVITY

During the period **9 March 2019 to 17 June 2019**, activity against **36** contracts have been completed. This includes **7** contracts at the briefing stage and **15** contracts at the ratification stage. In addition to this activity, extensions have been actioned against **14** contracts. A summary of activity for the period is set out in **Appendix B**.

4. STORES WRITE OFFS

The value of stores, at **30 June 2019**, amounted to **£2,766,750**. For the period **1 March 2019 to 30 June 2019**, a stock write off of **£2,253.23** has been actioned for out of date stock. This equates to **0.08%** of the total stock holding value in **June 2019**.

Stock Type	Bridgend Stores £	Denbigh Stores £	Cwmbran Stores £
Stock Value	1,452,349	744,596	569,804
Out of Date Stock	274.01	1,644.31	334.91
Total	**0.02%**	**0.22%**	**0.06%**

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.

5. GIFTS, HOSPITALITY & SPONSORSHIP

There have been **3** declarations made relating to gifts, hospitality and/or sponsorship, since the last Audit Committee meeting. A summary of the declarations made is set out in **Appendix C**.

6. WELSH GOVERNMENT QUARTERLY UPDATE

On a quarterly basis, we issue a letter to Dr Andrew Goodall at Welsh Government to confirm any Audit Reports which have achieved limited or no assurance. For Quarter 1 of 2019-20, we submitted a nil return.

7. RECOMMENDATIONS

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

APPENDIX A - NWSSP Contracting Activity Undertaken (28/03/2019 – 02/07/2019)

No.	Trust	Division	Procurement Ref No	Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required
1.	VEL	NWSSP-Employment Services	NWSSP-STA-508	01/04/2019	Single Tender Action	Provision of Primary Care National Advertising Platform	GP UK Support Services Ltd	£98,800.00	Sole supplier to provide this unique service	Endorsed – sole supplier to provide this service	No action required
2.	VEL	NWSSP-Supply Chain	NWSSP-ITT-40901	01/05/2019	Invitation to Tender	Provision of Roll Cages for the Transportation of Medical/Non Medical Consumables	Palletower GB Ltd	£99,000.00	Open invitation to tender – based on M.E.A.T	9 suppliers viewed the opportunity, 2 responses received	No action required
3.	VEL	NWSSP-HCW	NWSSP-DCO-39247	08/05/2019	Invitation to Tender	Tracking Devices Fleet Vehicles	Quartix Ltd	£99,000.00	Direct Award based on M.E.A.T	Compliant – 1 Issued 1 response received	No action required
4.	VEL	NWSSP-SES	NWSSP-SQA-497	08/05/2019	Single Quotation Action	NHS Technical engineering refresher & Development Training Course	Eastwood Park Training	£20,000.00	Compatibility with previous training received	Endorsed, as interim whilst formal Procurement undertaken	Formal Procurement to be undertaken
5.	VEL	NWSSP – Corporate & Finance	NWSSP-RFQ-41317	22/05/2019	Invitation to quote	Professional Support for Transforming Access to Medicines Work Specification	Grant Thornton	£25,000.00	3 Issued, 1 received based on M.E.A.T	Compliant – 2 suppliers viewed the opportunity, 1 responses received	No action required
6.	VEL	NWSSP – L&R	SSP-ITT-41489	27.05.2019	Invitation to Tender	Telephone Conference Service Provider	Kidatu Ltd	£70,000.00	Open invitation to tender – based on M.E.A.T	Compliant, 7 suppliers viewed the opportunity, 1 response received	No action required
7.	VEL	NWSSP-SMTL	NWSSP-SQA-521	25/05/2019	Single Quotation Action	ProReveal Protein Testing Kit	Peskett Solutions Ltd	£20,232.00	Sole supplier undertaking trials on AW basis in an independent environment	Endorsed –sole supplier to provide this service	No action required

APPENDIX B - All Wales Contracting Activity In Progress (09/03/2019 - 17/06/2019)

No.	Contract Title	Doc Type	Total Value	GD approval <£750K	WG approval >£500k	NF approval £750-£1M	Chair Approval £1M+
1.	Intermittent Pneumatic Compression contract includes the rental of machines for each Health Board and the purchase of consumables suitable for both foot and calf compression. The devices are one of the key methods by which patient DVT is prevented. This contract will supersede an existing contract, which is currently utilised by all Health Boards in Wales requiring the use of such devices.	ratification	£1,645,400	13/03/2019	18/03/2019	20/03/2019	20/03/2019
2.	Prep & Non-Prep Fruit & Veg Provision of fresh prepared and non-prepared fruit and vegetables to Betsi Cadwaladr, Powys, Hywel Dda University Health Boards.	ratification	£1,929,561	21/03/2019	12/04/2019	15/04/2019	23/04/2019
3.	Cleaning & Janitorial The provision of various cleaning & janitorial materials including catering chemicals, cleaning chemicals & janitorial products.	ratification	£2,808,772	21/03/2019	22/03/2019	01/04/2019	08/04/2019
4.	Hepatitis C Medicines use by All Wales hospital pharmacy departments and by patients within their own homes, as requested by the All Wales Drug Contracting Committee	ratification	£20,039,332	03/04/2019	15/04/2019	18/04/2019	23/04/2019
5.	POCT Anti Coagulation To supply Point of Care Testing Anti-Coagulation Testing Equipment, Test Strips, Associated Consumables and Training (Lot 1) and Anti-Coagulation Dosing Software (Lot 2) to meet requirements of DES.	ratification	£8,164,177	03/04/2019	20/05/2019	21/05/2019	22/05/2019
6.	Blood Glucose & Ketone Testing To supply professional point of care blood glucose and ketone testing equipment, tests, external quality assurance, audits and training throughout Wales by means of managed equipment service contract.	ratification	£3,494,216	05/04/2019	20/05/2019	21/05/2019	22/05/2019
7.	Opthalmic surgery consumables Ophthalmic Surgery involves some of the most complex interventional procedures that are carried out within NHS Hospitals. As the eye is an extremely fragile organ, it requires extreme care before, during and after any surgical procedures. The most common forms of Ophthalmic Surgery include Cataract Surgery, Glaucoma Surgery and Vitreo-Retinal Surgery. Cataract Surgery is recognised as one of the most common surgical procedures to be carried out within the NHS and involves the implanting of Intraocular Lenses (IOLs) in the patient's eye	ratification	£19,110,000	16/04/2019	08/05/2019	09/05/2019	10/05/2019
8.	Bespoke orthotics This contract will be the first ever All Wales contract for Bespoke Orthotics. The items are typically reserved for patients that suffer with abnormal or particularly acute conditions. Bespoke orthotic products (such as bespoke footwear, modular footwear, and bespoke ankle foot orthoses) are manufactured on an individual basis, catering to the specific needs of the patient.	ratification	£9,637,602	11/04/2019	15/05/2019	16/05/2019	29/05/2019
9.	Radiology Reporting The purpose of the contract is to continue to bridge the current national shortage of Consultant Radiologists within Heath Boards in Wales, which has resulted in a lack of capacity and unacceptable reporting times for some Radiology procedures	ratification	£24,600,000	24/04/2019	sent to WG 24/4*		
10.	Generic drugs - injection/infusions 3 The contract includes 110 lines across a range of therapy areas such as Chemotherapy, Arthritis, Heart Disease and Analgesics	ratification	£7,487,016	21/05/2019	12/06/2019		
11.	VEL - Intrepid HEIW The purpose of this contract is to provide a workforce management IT solution to manage the education, progression and training of the trainee junior doctor workforce.	ratification	£658,656	23/05/2019	sent to WG 23/5		
12.	AW Sterilisation & Decontamination Consumables To supply Sterilisation and Endoscopy decontamination consumables to NHS Wales	ratification	£14,000,000	23/05/2019	10/06/2019	sent to NF 10/6	
13.	Once for Wales The OFWCMS will be a web-based risk and compliance	ratification	2,624,046	30/05/2019	sent to WG		

	management interface solution enhancing reporting of quality, health, safety, environment, risk and compliance across the whole of NHS Wales.				30/5		
14.	NWIS - Microsoft Enterprise Agreement All Wales Microsoft Enterprise Licence Agreement	ratification	£36,617,247	04/06/2019	10/06/2019	sent to NF 10/6	
15.	Absorbents The contract is to cover absorbent swabs, dressing pads and cotton wool items that are widely used across health care activities. The products are simple in nature but vital for delivering day-to-day healthcare operations.	ratification	£1,274,957	04/06/2019	11/06/2019		
16.	AMHLD & CAMHS Collaborative National Framework for Adult Mental Health and Adult Learning Disability Hospitals And Collaborative National Framework for Child and Adolescent Mental Health Services (CAMHS) Low Secure and Acute Non-NHS Wales Hospital Services	extension (at risk)		30/05/2019	original approval applies	05/06/2019	05/06/2019
17.	Dressings (adhesive) and surgical tape The Dressings (Adhesive) & Surgical Tapes contract is historically related to the Wound Management contract but is comprised of items that are often considered as being simpler.	extension	£1,212,997	27/03/2019	original approval applies 01/06/16	09/04/2019	08/04/2019
18.	Fresh & prepared fruit veg & salad Provision of Fresh & Prepared Fruit, Vegetables & Salad	extension	£938,431	27/03/2019	original approval applies 17/9/14	03/04/2019	
19.	Biomass Supply of woodchip and Wood Pellet to Health Boards and Trusts Biomass fuel in the form of wood chip and wood pellets are used as a lower carbon alternative in place of gas or electricity for heating and hot water supply.	extension	£1,719,666	26/04/2019	original approval applies 30/9/13	01/05/2019	10/05/2019
20.	Biosimilars This contract is for Infliximab, Etanercept, and Rituximab, all medicines are purchased by hospital Pharmacy Departments. Infliximab is licensed to treat crohn's disease and rheumatoid arthritis. Etanercept is licensed for the treatment of adults with moderate to severe rheumatoid arthritis (RA), psoriatic arthritis, non-radiographic axial spondyloarthritis and plaque psoriasis. Rituximab is licenced for the treatment of non-Hodgkin's B-cell lymphomas, chronic lymphocytic leukemia, Wegener's granulomatosis, and microscopic polyangiitis. It is also licensed to treat rheumatoid arthritis in patients who have failed other biologic medications, such as Infliximab or Etanercept.	extension	£59,031,126	02/05/2019	original approval applies 8/5/17	08/05/2019	10/05/2019
21.	Adalimumab a Tumour Necrosis Factor Alpha (TNFα) Inhibitor; it is an anti-inflammatory and approved for the treatment of moderate to severe rheumatoid arthritis, active and progressive psoriatic arthritis, severe active ankylosing spondylitis, Crohn's disease, ulcerative colitis, hidradenitis suppurativa and uveitis	extension	£4,301,050	02/05/2019	original approval applies 23/11/2018	08/05/2019	10/05/2019
22.	Trastuzumab This contract is for Trastuzumab which is approved for the treatment of early-stage breast cancer that is **H**uman **E**pidermal growth factor **R**eceptor **2**-positive (**HER2**+). Trastuzumab is also approved, in combination with chemotherapy for the treatment of HER2+ metastatic cancer of the stomach or gastroesophageal junction in patients who have not received prior treatment for their metastatic disease. This contract is for the supply of Trastuzumab to hospitals and is also available for homecare.	extension	£13,210,408	02/05/2019	original approval applies 19/06/2018	08/05/2019	10/05/2019
23.	National Collaborative Framework For Younger Adults (18 - 64 years) in Mental Health and Learning Disabilities Care Homes & Care Homes with Nursing for NHS and Local Authorities in Wales. in collaboration with Welsh Local Authorities successfully concluded the procurement of a framework agreement for the provision of Services by independent providers to younger adults (18+) in mental health and learning disabilities care homes and care homes with nursing.	extension	£390,000,000	02/05/2019	original approval applies 28/9/16	23/05/2019	29/05/2019
24.	Suction Canisters & Liners the supply of suctions liners and canisters and included training and implementation of the system by the contract provider. Suction	extension	£1,048,321	13/05/2019	original approval	16/05/2019	22/05/2019

	systems in hospitals are used on patients to either clear a blockage or remove fluid during clinical operations. The suction canister is the container that fits onto a bracket on the wall behind each bed in every hospital. The liners are disposable and sit in the canister. The canisters and liners are available in a variety of sizes ranging from 1 litre – 3 litres and can be cascaded into others to give larger volumes. The liners can have a gelling agent inserted that solidifies the liquid for disposal purposes. The suction canisters and liners are also put on stands and trolleys for use in theatres.				applies 13/6/16		
25.	Supply of Wheelchairs, Associated Parts and Accessories supply of Wheelchairs, Associated Parts and Accessories to ALAS	extension	£8,518,000	23/05/2019	original approval applies 4/4/17	23/05/2019	29/05/2019
26.	ENT Consumables includes a variety of different consumables used to carry out inspection as part of a physical exam on the ear, nose or throat. These items include; Otoscopes and related consumables, Ear specula, Ear Wax Hooks, ENT Suction Handles, Jobson Horne Probes, Crocodile Forceps, Nasal specula, tongue depressors, etc.	extension	£1,559,493	29/05/2019	original approval applies	sent to NF 10/6	
27.	Breathing Filters, Masks & Accessories contract covers anaesthetic masks, a range of filters, catheter mounts and connectors. The contract provides a range of anaesthetic masks from multiple suppliers due to the variances in sizes from one supplier to another, and the differing sizes of patients' faces.	extension	£777,435	11/06/2019	original approval applies 29/11/16	sent to NF 11/6	n/a
28.	Generic drugs - injection/infusions 2 for purchase by All Wales hospital pharmacy departments, as requested by the All Wales Drug Contracting Committee. Includes 300 lines across a range of therapy areas such as Chemotherapy, Arthritis, Heart Disease and Analgesics	extension	£9,687,162	14/06/2019	original approval applies 02/05/2017	sent to NF 14/6	
29.	Patient identification wristband contract covers a range of patient identification wristbands used when patients are admitted into Hospital. The wristbands are specifically designed for use with dedicated printers and will display immediate and relevant information about the patient i.e. Date of Birth, Patients name, NHS Number, Hospital Number, 2D Barcode, First line of address, as per the NPSA Guidance.	extension	£1,518,264	Sent to NC 18/6			
30.	Absorbents The contract is to cover absorbent swabs, dressing pads and cotton wool items that are widely used across health care activities. The products are simple in nature but vital for delivering day-to-day healthcare operations.	briefing	£1,837,507	21/03/2019	05/04/2019	n/a	n/a
31.	Sevoflurane & Vaporisers Sevoflurane gas and vaporisers that are loaned from the Contractor. An option to purchase vaporisers is also included within the scope of the agreement. Sevoflurane is a rapid acting volatile liquid anaesthetic, used for the induction and maintenance of general anaesthesia. A specially calibrated vaporiser is used for its administration.	briefing	£2,202,984	11/04/2019	15/05/2019	n/a	n/a
32.	Erthropoietin Stimulating agents the supply of Erythropoietin Stimulating Agents (ESA) to hospitals and the supply and associated service to patients being treated within their own homes. Erythropoiesis is the process by which red blood cells are produced. It is stimulated by the decreased oxygen in circulation, which is detected by the kidneys, which then secrete the hormone erythropoietin. Erythropoietin Stimulating Agents (ESA) are structurally and biologically similar to naturally occurring protein erythropoietin. Clinicians prescribe ESAs to maintain haemoglobin at the lowest level that both minimises transfusions and best meets individual patient needs.	briefing	£5,460,820	11/04/2019	15/05/2019	n/a	n/a
33.	Contrast Media This contract is for all X-Ray Contrast Media purchased by all hospital Pharmacy Departments in Wales for use by radiology departments.	briefing	£5,577,768	21/05/2019	sent to WG 22/5	n/a	n/a

34.	Skin & Wound Closure contract includes Absorbable and Non Absorbable sutures (Braided and Monofilament), Mesh (Flat, Devices, Composite, and Biological) Skin Staplers, Skin Adhesives (Surgical and Minor), Mesh Fixation Devices (Absorbable and Non Absorbable) and Accessories.	briefing	£13,143,459	30/05/2019	12/06/2019	n/a	n/a
35.	Theatre Drapes Framework to cover disposable/non disposable theatre/surgical and incise drapes	briefing	£8,639,308	07/06/2019	sent to WG 7/6	n/a	n/a
36.	Bedding Linen & Textiles items included in this contract are non-disposable linen products laundered by the NHS Wales Laundries and supplied to Health Boards and Trusts for use primarily on wards and in some areas, Hospital Residences (if there any on site).	briefing	£1,638,668	11/06/2019	sent to WG 11/6	n/a	n/a

APPENDIX C – GIFTS, HOSPITALITY AND SPONSORSHIP DECLARATIONS (Quarter 1 of 2019-20)

No.	NWSSP Employee	Directorate	Type of Sponsorship	Date of Event	Donated by / Source of Hospitality	Description	Estimated or Approximate Value	Approved	Accepted (Yes/No)	Date of Acceptance or Approval
1.	Dave Hopkins Director of Primary Care Services	Primary Care Services	Hospitality	23/05/2019	Bridget McCabe, NI Medical	Attendance at Welsh Pharmacy Awards 2019 at The Vale Resort	£25	A Butler	Yes	03/05/2019
2.	Jonathan Simcock Framework Manager	Specialist Estates Services	Hospitality	07/06/2019	Know & Wells	Attendance at Constructing Excellence in Wales (CEW) 2019 Awards Dinner, Celtic Manner	£50	N Frow	Yes	03/06/2019
3.	Clifford Randall Senior Project Manager	Procurement Services	Hospitality	01/06/2019	SP Services (UK) Ltd	Attendance at 30th Anniversary Evening Function of SP Services	£60	A Butler	Yes	10/06/2019

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	4.3
PREPARED BY	Roxann Davies, Corporate Services
PRESENTED BY	Roxann Davies, Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Update on the Implementation of Audit Recommendations

PURPOSE

This report provides an update to the Audit Committee on the progress of tracking audit recommendations within NWSSP. In this report, the base position has been taken from the previous report presented to the Audit Committee. Therefore, please note that this report does not include figures and assurance ratings for the audit reports listed on the present Audit Committee agenda.

1. INTRODUCTION

NWSSP records audit recommendations raised by Internal Audit, Wales Audit Office and other external bodies, as appropriate. It is essential that stakeholder confidence is upheld and maintained; an important way in which to enhance assurance and confidence is to monitor and implement audit recommendations in an effective and efficient way. It is important to note that during 2018, the Audit Tracker achieved **Substantial Assurance**, following an Internal Audit.

2. CURRENT POSITION

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

There are **34** reports covered in this review; **7** reports have achieved **Substantial** assurance; **18** reports have achieved **Reasonable** assurance, **0** reports have been awarded **Limited** assurance or **No Assurance;** and **9** reports were generated with **Assurance Not Applicable**. The reports include **171** recommendations for action.

The following reports were categorised as **Assurance Not Applicable**:

- **4** Internal Audit Advisory Reports

- **2** Wales Audit Office Reports
- **1** SGS UK Ltd ISO14001:2015 Audit Report
- **1** Information Commissioner's Office Training Audit Report
- **1** Physical Security Review Report

Table 1 - Summary of Audit Recommendations

Recommendations		Implemented	Not Yet Due	Revised Deadline	Overdue	Not NWSSP Action
Internal Audit	**113**	**106**	**5**	**0**	**0**	**2**
High	0	10	0	0	0	0
Medium	0	44	1	0	0	0
Low	0	52	4	0	0	2
External Audit	**30**	**26**	**2**	**0**	**2**	**0**
High	0	1	0	0	0	0
Medium	0	25	2	0	2	0
Low	0	0	0	0	0	0
Other Audit	**28**	**28**	**0**	**0**	**0**	**0**
High	0	4	0	0	0	0
Medium	0	19	0	0	0	0
Low	0	5	0	0	0	0
TOTALS:	**171**	**160**	**7**	**0**	**2**	**2**

3. REVISED DEADLINES FOR APPROVAL

There are **4** recommendations which have not been implemented within their target completion date. It should be noted that, of the 4 recommendations:

- **2** of the recommendations have been marked as **Overdue**, having previously requested approval from the Committee to revise the deadline from 31 March 2019 to 30 June 2019; and
- **2** of the recommendations remain outside of the scope of NWSSP's gift to implement.

***OVERDUE**: WAO Nationally Hosted NHS IT Systems Assurance Report 2017-18*

- *Central Team previously granted extension from 31/03/2019 to 30/06/2019*
- *Primary Care previously granted extension from 31/03/2019 to 30/06/2019*

***NOT NWSSP**: Welsh Infected Blood Support Service Internal Audit Report 2018-19*

- *2 recommendations previously granted extension from 31/03/2019 to 30/06/2019 and both actions awaiting response from Welsh Government.*

Full details of the recommendations are set out in **Appendix B**, for the attention of the Audit Committee.

4. RECOMMENDATIONS

The Audit Committee are asked to:

- **NOTE** the report findings and progress made to date; and
- **REVIEW** the overdue recommendations, as set out within **Appendix B**.

Internal Audit Reference	Reference	Directorate	Health Board/Trust	Report Title	Year	Assurance Rating	Recommendations	Implemented	Not Yet Due	Revised Deadline	Overdue	Not NWSSP Action
INTERNAL AUDIT REPORTS												
NWSSP-1718-02	CORP/17-18/1	Corporate Services	NWSSP	Information Governance GDPR	2017-18	Substantial	2	2	0	0	0	0
NWSSP-1718-03	CORP/17-18/2	Corporate Services	NWSSP	Non-Medical Education Training Budget	2017-18	Substantial	3	3	0	0	0	0
NWSSP-1718-12	CORP/17/-18/3	Corporate Services	NWSSP	Audit Tracker Review	2017-18	Substantial	2	2	0	0	0	0
NWSSP-1718-16	CORP/17-18/4	Corporate Services	NWSSP	Corporate Governance	2017-18	Substantial	2	2	0	0	0	0
NWSSP-1718-06	CORP/17-18/5	Corporate Services	NWSSP	Surgical Materials Testing Laboratory (SMTL)	2017-18	Reasonable	3	3	0	0	0	0
NWSSP-1718-09	CORP/17-18/6	Corporate Services	NWSSP	Performance Management	2017-18	Reasonable	3	3	0	0	0	0
NWSSP-1819-02	CORP/17-18/6	Corporate Services	NWSSP	BACS Bureau Review	2018-19	Advisory Report	4	4	0	0	0	0
NWSSP-1819-04	CORP/18-19/1	Corporate Services	NWSSP	Wales Infected Blood Support Scheme	2018-19	Reasonable	10	8	0	0	0	2
NWSSP-1819-10	CORP/18-19/2	Corporate Services	NWSSP	Welsh Language Standards	2018-19	Reasonable	3	3	0	0	0	0
NWSSP-1819-14	CORP/18-19/3	Corporate Services	NWSSP	Risk Management and Assurance	2018-19	Substantial	2	2	0	0	0	0
NWSSP-1819-07	CORP/18-19/4	Corporate Services	NWSSP	Business Continuity Planning	2018-19	Reasonable	3	3	0	0	0	0
						TOTAL	**37**	**35**	**0**	**0**	**0**	**2**
	EMP/16-17/2	Employment Services	All Wales	TRAC System	2016-17	Reasonable	3	3	0	0	0	0
NWSSP-1718-10	EMP/17-18/1	Employment Services	All Wales	Payroll Services	2017-18	Reasonable	6	6	0	0	0	0
						TOTAL	**9**	**9**	**0**	**0**	**0**	**0**
NWSSP-1718-12	PCS/17-18/1	Primary Care Services	All Wales	Contractor Payments	2017-18	Substantial	1	1	0	0	0	0
NWSSP-1819-15	PCS/18-19/1	Primary Care Services	All Wales	Patient Medical Records Store and Scan on Demand Service	2018-19	Reasonable	6	5	1	0	0	0
						TOTAL	**7**	**6**	**1**	**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	5	0	0	0	0
NWSSP-1718-01	PROC/17-18/2	Procurement Services	All Wales	WAO Audit RKC Associates Lessons Learned by NWSSP	2017-18	Advisory Report	2	2	0	0	0	0
NWSSP-1718-11	PROC/17-18/3	Procurement Services	All Wales	Accounts Payable	2017-18	Reasonable	6	6	0	0	0	0
NWSSP-1819-01	PROC/18-19/1	Procurement Services	All Wales	Health Courier Services	2018-19	Reasonable	7	7	0	0	0	0
NWSSP-1819-08	PROC/18-19/2	Procurement Services	All Wales	Cwmbran Stores	2018-19	Reasonable	2	2	0	0	0	0
						TOTAL	**36**	**36**	**0**	**0**	**0**	**0**
SSU SES 1819 01	SES/18-19/1	Specialist Estates Services	All Wales	Primary Care Rental Reimbursement Reviews	2018-19	Reasonable	7	7	0	0	0	0
						TOTAL	**7**	**7**	**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
NWSSP-1718-04	WORK/18-19/1	Workforce	All Wales	GP Specialty Training Registrars	2018-19	Reasonable	4	3	1	0	0	0
NWSSP-1819-09	WORK/18-19/2	Workforce	NWSSP	Annual Leave Management	2018-19	Reasonable	5	5	0	0	0	0
NWSSP-1819-05	WORK/18-19/3	Workforce	NWSSP	Recruitment and Retention	2018-19	Advisory Report	3	0	3	0	0	0
						TOTAL	**17**	**13**	**4**	**0**	**0**	**0**
WALES AUDIT OFFICE EXTERNAL AUDIT REPORTS												
	WAO/17/18/2	All Services	All Wales	WAO Nationally Hosted NHS IT Systems Assurance Report	2017-18	Not Applicable	27	23	2	0	2	0
	WAO/16-17/2	All Services	All Wales	WAO Management Letter	2016-17	Not Applicable	3	3	0	0	0	0
						TOTAL	**30**	**26**	**2**	**0**	**2**	**0**
OTHER AUDIT REPORTS												
	ICO/17-18	Corporate Services	NWSSP	Information Commissioner's Office (ICO) Training Audit	2017-18	Not Applicable	10	10	0	0	0	0
	ISO14001/18-19	Corporate Services	NWSSP	SGS UK Ltd Audit of ISO14001 Environmental Management System	2018-19	Not Applicable	0	0	0	0	0	0
	SECURITY/18-19	Corporate Services	NWSSP	Physical Security Review of NWSSP	2018-19	Not Applicable	18	18	0	0	0	0
						TOTAL	**28**	**28**	**0**	**0**	**0**	**0**
						TOTAL RECS	**171**	**160**	**7**	**0**	**2**	**2**

APPENDIX B – RECOMMENDATIONS FOR COMMITTEE'S ATTENTION

ID	Internal Audit Report Ref Rec No Reference NWSSP Service Report Title Report Year	Status	Issue Identified	Risk Rating	Recommendation	Responsibility for Action	Management Response	Original Deadline	Updated Deadline	Update On Progress Made
CENTRAL TEAM										
1	2018.11 WAO/17/18/2 Corporate Services - Central Team All Wales WAO Nationally Hosted NHS IT Systems Assurance Report 2017-18	OVERDUE	CTES has not completed and documented a gap analysis assessment of the Oracle FMS to the Information Security Management Standard (ISO 27001) to identify potential improvement areas. It is good security management practice to assess and baseline a comparison to the ISO 27001 standard. CTES should then formally consider and whether the Oracle service aims for a formal IS027001 accreditation.	Medium	Complete a gap analysis assessment to the Information Security Management Standard (ISO 27001) to identify potential improvement areas. CTES should then formally consider and decide whether the Oracle service aims for a formal IS027001 accreditation.	Said Shadi, Associate Programme Director, Central Team	Agreed	31/03/2019	30/06/2019 / Approved by Audit Committee 09/04/2019	Estimated completion date of 30/08/19 - Senior Programme Manager to attend course which has been rearranged for w/c 1 July 2019 - therefore, timescale for completion has been impacted. Raised with WAO in March. Oracle FMS services are managed and supported by our partners Version 1 Solutions Ltd who are ISO 27001 accredited. RD signposted KE to KK, Business Quality Manager, in order to assist with the gap analysis exercise, independent review for recommendations and opportunities for improvement.
PRIMARY CARE SERVICES										
2	2018.15 WAO/17/18/2 Primary Care Services All Wales WAO Nationally Hosted NHS IT Systems Assurance Report 2017-18	OVERDUE	At the time of our fieldwork in March 2018 Primary Care Services has commenced plans to approve the re-procurement for the SQL 2008 server support and maintenance. The SQL server 2008 support and maintenance contract over the Prescription Pricing system server set up expired at the end of February 2018.	Medium	Replace and re-procure the SQL server 2008 support and maintenance contract over the Prescription Pricing system server set up that expired in February 2018.	Neil Jenkins, PCS	Agreed	01/03/2019	30/06/2019 / 09/04/2019 / Approved by Audit Committee	The new server environment has been built and was handed over to us on 12 June. We are in the process of migrating systems onto the new environment and would expect to have this aspect complete by 30 June. We will then require a period of testing and a suitable change window of at least 2 days to cut over onto the new environment. This will need to be out of business hours so we will identify a weekend to complete this work. From past experience, a two-day window can be tight so we may delay until the August bank holiday weekend to allow some contingency. Therefore currently, the latest date for go live we envisage would be 27 August. We discounted the extension of warranty on the grounds of cost, given that (a) there is sufficient resilience in the existing environment; (b) the cost of replacing parts is minimal; and (c) parts are easily and quickly accessible.

APPENDIX B – RECOMMENDATIONS FOR COMMITTEE'S ATTENTION

CORPORATE SERVICES										
3	NWSSP-1819-118 CORP/18-19/1 Corporate Services NWSSP Wales Infected Blood Support Scheme 2018-19	NOT NWSSP ACTION	Beneficiaries will only become ineligible for payments on death. At the outset of the audit the Service Manager advised us that checks were not undertaken to confirm that the beneficiaries transferred from the legacy trusts were still alive (and therefore eligible for payments) at the time of transfer. WIBSS is therefore reliant on notification of death from the beneficiary's family, so there is a risk of overpayment if notification is not received. We acknowledge that the availability of bereavement and widows payments on death of a beneficiary reduces this risk. We were subsequently advised that checks against the Welsh Demographics Service (WDS) database had now been undertaken (during the audit) by the Velindre Cancer Centre Benefit Support Officer. Twenty-five beneficiaries could not be located on the WDS database as they are not registered at a GP Practice within NHS Wales. We understand that access to the National Demographics Service database to enable the checking of beneficiaries outside of Wales is being explored. Risk: Overpayment following the death of a beneficiary.	Low	Access to the NDS database should be arranged. Periodic checks of the WDS and NDS (if access is obtained), should be undertaken to verify the ongoing eligibility of beneficiaries. The Staff Procedure Guide should then be updated to reflect eligibility checking arrangements.	Mary Swiffen-Walker	Agreed	31/05/2019	30/06/2019 / Approved by Audit Committee 09/04/2019	This is on-going. It has been raised with Welsh Government and at the WIBSS Governance Group meeting on 5th June 2019. WG have agreed to raise this with their counterparts in Scotland, England and Northern Ireland, during the monthly 4 party teleconferences, to see if an arrangement can be made to check data for each other.
4	NWSSP-1819-1310 CORP/18-19/1 Corporate Services NWSSP Wales Infected Blood Support Scheme 2018-19	NOT NWSSP ACTION	The application form has a section which must be completed by the applicants' doctor/consultant to state why they are eligible to apply, and provide evidence in support of this. Application forms are then submitted directly to WIBSS by the doctor/consultant. There are currently no checks undertaken to verify the authenticity of the doctor/consultant confirming eligibility. It was determined that the applicant Doctors details are not currently verified against the General Medical Council (GMC) register and neither are any other checks undertaken to confirm that the Doctor details are genuine. It is therefore recommended that this process is introduced to further strengthen the authorisation process with the Staff Procedure Guide updated accordingly. Risk: Applications are not appropriately scrutinised which could result in approval of fraudulent application and financial loss.	Low	Management should consider the benefit and feasibility of verifying the authenticity (such as checking GMC registration or direct contact) of the doctor/consultant confirming eligibility for an applicant to join the scheme.	Mary Swiffen-Walker	Agreed. Will be built into Procedure Guidance Process.	30/06/2019	30/06/2019 / Approved by Audit Committee 09/04/2019	This has been raised with WG, to establish how we might do this. We are waiting for a response.

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	4.4
PREPARED BY	Peter Stephenson, Head of Finance and Business Development
PRESENTED BY	Peter Stephenson, Head of Finance and Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	NWSSP Corporate Risk Register – July 2019

PURPOSE

To provide the Audit Committee with an update as to the progress made against the organisation's Corporate Risk Register.

1. INTRODUCTION

The Corporate Register is presented at **Appendix 1** for information.

2. RISKS FOR ACTION

The ratings are summarised below in relation to the Risks for Action:

Current Risk Rating	July 2019
Red Risk	2
Amber Risk	5
Yellow Risk	4
Green Risk	0
Total	**11**

2.1 Red-rated Risks

Risk A1 - Demise of the Exeter Software System
Current Risk Score: Red 20

We are continuing the dialogue with Northern Ireland and further delays with the implementation of the Capita system in NHS England reduces the pressure.

Risk A2 – Impact of a No-Deal Brexit
Current Risk Score: Red 20

The risk relating to a no-deal Brexit has been revised to focus on a specific requirement to engage with clinicians in assessing non-stock requirements, where we are currently waiting from guidance from Welsh Government. The more general supply chain risk has been reclassified as a monitoring risk, as IP5 is now up and running and contains sufficient stock to cope if there was no deal on Brexit by the end of October.

2.2 Changes to Risk Profile

No new risks have been added to the Corporate Risk Register since the date of the last Committee meeting in April.

The following risks have been removed from the Risk Register since the last meeting of the Committee:

- Pay Award and Priority Service Reconfigurement – this had been a major potential issue for Employment Services but has now been resolved;
- Changes to Student Bursary Scheme – these have been successfully implemented;
- Workforce Capacity – additional resource has now been recruited;
- Accounts Payable – public sector payment policy performance has exceeded the required targets for a considerable length of time and this risk will now be managed at a directorate level:
- Establishment of HEIW – this has been successfully achieved;
- Welsh Risk Pool – the financial position is reported regularly to SSPC and SMT and this will be managed at directorate level;
- Bridgend Boundary Change – although there are a few loose ends to tie up, this risk has now been dealt with: and
- GDPR – recent internal audits have provided substantial assurance in this area and the risk is managed through the Information Governance Steering Group.

3. RISKS FOR MONITORING

There are two risks that have reached their target score and which are rated as follows:

Current Risk Rating	July 2019
Red Risk	0
Amber Risk	1
Yellow Risk	1
Green Risk	0
Total	**2**

4. ASSURANCE MAPPING

A finding from the recent internal audit review of risk management was that some of the forms of assurance used to provide comfort on business-as-usual risks was not as robust as suggested by the Assurance Maps. The recommendation from the auditors was that the quality of each form of assurance was regularly assessed. At present, an annual update of the Assurance Maps is taken to the Audit Committee and this is due for the meeting to be held on 22 October. I will therefore be contacting each Directorate ahead of this date to attend the Directorate SMT, or arrange a separate meeting, to enable a detailed review of both the content of the Assurance Maps and the quality of the assurance provided

5. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the Corporate Risk Register.

Corporate Risk Register

Ref	Risk Summary	Inherent Risk			Existing Controls & Mitigations	Current Risk			Further Action Required	Progress	Trend since last review	Target & Date
		Likelihood	Impact	Total Score		Likelihood	Impact	Total Score				
Risks for Action												
A1	Risks associated with the demise of the Exeter system coming to an end in 2015, with no replacement system designed for NHS Wales. The contract in NHS England has been outsourced to Capita. (Added Apr 2017) **Escalated Directorate Risk**	4	5	20	Establishment of NHS Wales Steering Group. High level option appraisal undertaken. Mapping exercise completed with Capita and PCS subject matter experts to identify gaps between NHSE and NHSW. Legal Counsel advice received.	4	5	20	Continue dialogue with Northern Ireland. (DH 31/07/2019)	Letter sent by NF to NI BSO confirming our wish to progress discussions. NI BSO are arranging a visit over the summer to facilitate this. **Risk Lead: Director of Primary Care Services**	→	30-Sep-19
A2	Failure to obtain clinical engagement in assessing non-stock requirements stemming from a no-deal Brexit (added Apr 2019) **Strategic Objective - Customers**	4	5	20	Storage facility in place (IP5)	3	5	15		Brexit deadline extended to 31 October 2019. Trying to get WG to identify key stakeholders to take this issue forward. **Risk Lead: Director of Procurement Services**	→	31-Dec-19
A3	Disruption to services and threats to staff due to unauthorised access to NWSSP sites. (Added May 2018) **Strategic Objective - Staff**	5	4	20	Manned Security at Matrix CCTV Locked Gates installed at Matrix. Security Review Undertaken (reported Dec 18) Increased Security Patrols at Matrix.	1	4	4	Review progress with findings from security review (PS 31/07/19) On-going discussion with Landlord at Matrix re installing our own barrier) (RD/ND 31/07/19) Police reviewing security at IP5 (MR 31/07/19)	Security Review undertaken and reported to SMT in Dec 2018. No major findings but all agreed actions will be followed up through audit tracker. **Risk Lead; Director Specialist Estates Services/Director of Finance and Corporate Services**	→	31-Jul-19
A4	NWSSP are unable to recruit and retain sufficient numbers and quality of staff for certain professional services (Procurement Services) resulting in a potential failure to meet desired performance targets and/or deliver service improvements. (Added April 2017) **Strategic Objective - Staff**	5	4	20	Staff Surveys & Exit Interviews Monitoring of turnover and sickness absence Workforce & OD Framework Work with Great With Talent to develop On-Boarder, Absence & Exit questionnaires (3, 6 and 12 months) Development of Clerical Bank Strengthened relationship with local universities Work-based degree opportunities in some professional services Use of Social Media Use of Recruitment Consultants Targeted Advertising - Trade Journals	4	3	12	Exit interviews to assess rationale for staff leaving employment - 31 Mar 2018 (HR) - on hold due to procurement tender exercise	Recruitment and retention remains a concern, particularly within professional posts primarily with the procurement services function. Recruitment has improved in other professional functions. Work is taking place with all services to have in pace agile recruitment and retention strategies to attempt to address these concerns, utilising available data and information. **Risk Lead: Director of Workforce and OD**	→	30-Sep-19
A5	NWSSP is unable to adequately demonstrate the value it is bringing to NHS Wales due to insufficiently developed reporting systems. (Added April 2017) **Strategic Objective - Value For Money**	4	4	16	Quarterly Performance Reports to Health Boards & Trusts Performance Reporting to SSPC & SMT SSPC Assurance reports Periodic Directorate Meetings with LHBs & Trusts Quarterly meetings with LHB and Trust Exec Teams Regular updates to Peer Groups (DOF's, DWODS, Board Secretaries) Customer Satisfaction Surveys Internal Audit Review (May 2018) Presentations from CEB Gartner (June 2018)	2	4	8	1. Introduce consistent approach in reporting and meetings for all directorates and all LHBs & Trusts (AP) 2. Review and refine performance framework (AP - 30/06/19) 3. Work proactively to support NHS Wales in delivering the actions outlined within the NHS Wales Chief Executives National Improvement Programme (NIP)	1. Completed 2. Ongoing - draft framework produced and due to be approved by SMT in July 2019 3. Regular updates provided to DoFs and other peer groups **Risk Lead: Director of Finance & Corporate Services**	→	31-Jul-19
A6	NWSSP's lack of capacity to develop our services to deliver further efficiency savings and introduce innovative solutions for NHS Wales and the broader public sector. (Added April 2017) **Strategic Objective - Service Development**	4	4	16	IMTP Horizon scanning days with SMT and SSPC to develop services Established new Programme Management Office (PMO) IT Strategy Regular reporting to SMT and SSPC	2	3	6	1. Implementation of project management software (AB) 2. Invest in Robotic Process Automation (AB)	1. Procurement pilot project completed - currently being rolled out in NWSSP 2. RPA pilot in progress - update to July SMT **Risk Lead: Director of Finance & Corporate Services**	→	31-Jul-19
A7	Lack of effective succession planning at a senior level will adversely impact the future and strategic direction of NWSSP due to the age profile of the SMT. (added April 2017) **Strategic Objective - Staff**	4	3	12	Workforce & OD Framework On-going development of existing staff to ensure a ready supply of staff to meet the maturing organisation's needs. Leadership Development Programmes	3	3	9	1. Develop a plan which includes likely key dates for each of the affected services and which prioritises succession planning based on proximity of risk (HR) 31 Dec 18 2. NHS Wales Leadership Programme - identify key staff with potential for future development and encourage them to undertake the leadership programme - (HR) 31 Dec 18 3. National Succession Strategy for NHS Wales - participate in the work of the national group and identify high performing staff who may be eligible for consideration to support succession planning requirements - (HR) 31 Dec 18	Recent appointments of senior staff have helped to address this risk - risk to be reviewed again to check whether still requires reporting at this level. **Risk Lead: Director of Workforce and OD**	→	31-Aug-19
A8	Operational performance is adversely affected through the use of some out-of-date software systems, lack of consistent IT support across NHS Wales resulting in interoperability issues and the limited capacity of NWIS to meet the demand for IT development to develop our services. (added April 2017) **Strategic Objective - Excellence**	4	5	20	Created a Business Systems and Informatics Department Service Level Agreement (SLA) in place with NWIS Significant additional capital funding obtained from Welsh Government in prior year for IT investment Development of draft IT strategy Quarterly Reporting of Performance to SMT	1	4	4	1. Finalise IT Strategy for NWSSP, to include an IT replacement strategy - complete 2. Consolidate Desktop support from one strategic partner - currently a mix of arrangements (NWIS & BCU) - 31 Mar 2019 (AB) 3.Finalise Cyber Security Action plan - complete 4. Develop an overarching Business Continuity plan for NWSSP incorporating operational, IT and building requirements and test the plan annually - complete	All actions on track and a consultant from the Wales Quality Centre is currently working with NWSSP to enhance BCP arrangements. 1. Completed 2. Ongoing 3. Completed 4. Completed - plan developed and tested in Sept. Internal audit of BCP arrangements undertaken - reasonable assurance. **Risk Lead: Director of Finance & Corporate Services**	→	31-Jul-19
A9	Suppliers, Staff or the general public committing fraud against NWSSP. (added April 2019) **Strategic Objective - Value For Money**	5	3	15	Counter Fraud Service Internal Audit WAO PPV National Fraud Initiative Counter Fraud Steering Group Policies & Procedures Fraud Awareness Training	3	3	9	1. Increase level of counter fraud resource (AB 30/6/19) 2. Implement actions from Fighting Fraud Strategy (PS 30/6/19) 3. Formally present Counter Fraud Work Plan to SMT (AB 31/05/19)	Discussion with Craig Greenstock on 2/4/19 to increase level of resource. Fighting Fraud Strategy approved by CFSG on 26/3/19 Craig provided update to June 2019 SMT. Met with WG 2/7/19 to discuss Ophthalmics review **Risk Lead: Director of Finance & Corporate Services**	→	31-Jul-19
A10	Risk of cyber attack exacerbated if NWSSP, or other NHS Wales organisations, run unsupported versions of software. (added Apr 2019) **Strategic Objective - Service Development**	5	5	25	Cyber Security Action Plan Stratia Consulting Review IGSG Information Governance training	2	5	10	Consider introduction of mandatory cyber security e-learn (AB 30/06/19) Follow up progress with Cyber Security Plan (AB 30/06/19) Complete actions from internal audit review of BCP (PS 30/06/19) Promote use of Self-Serve ESR (GH 30/06/19) Move all desktop devices to Windows 10 by the Windows 7 end of support.	Nick Lewis to present update to July 2019 formal SMT **Risk Lead: Director of Finance & Corporate Services**	→	30-Sep-19
A11	Failure to comply with Welsh Language requirements and capacity to meet the increased demand for Welsh translation services resullting from the implementation of the Welsh Language Standards leading to reputational damage for NWSSP. (added April 2017) **Strategic Objective - Staff**	3	4	12	Welsh Language Officer appointed Staff required to populate Welsh language skillset in ESR Welsh Language Translator appointed WL awareness is included within the face to face corporate induction training day Accredited WL training in place at several NWSSP sites WL monitoring report submitted to SMT External comms - WIAP project ensuring all web information is bilingual, graphic design, public events, etc	2	3	6	1. Undertake a Cost/benefits analysis to justify further investment in Welsh Language capacity - complete 2.Bilingual interface of TRAC recruitment software to be fully bilingual - complete 3. Investigate the potential for introducing a WL hub to provide support with translation for NHS Wales - complete 4. Undertake Internal Audit review of progress against Welsh Language Standards - complete. Reasonable Assurance.	Regular updates to SMT and additional resource recruited Jan 2019. Further recruitment exercise in May 2019 Reasonable Assurance from Internal Audit review. Undertaken joint recruitment with PHW and NWIS - 3 new translators appointed in June 2019 **Risk Lead: Director of Finance and Corporate Services**	↓	31-Aug-19

Risks for Monitoring

M1	1. The Learning@Wales server provided and supported by NWIS requires enhancements to ensure user capacity is aligned with forecasted usage and is fully supported and managed to ensure provision of service does not degrade further. Further enhancements are required to reporting capability as this is affecting the service provided and reputation of NWSSP. 2. The ESR e-learning server is currently provided by NWSSP, via a server located in Manchester. This server has little resilience and requires hosting within NWIS DMZ with a fully supported service management wrap. Over 70% of learning undertaken in NHSW at 07/2017 was via e-learning. There would be a significant impact on the compliance of the workforce if the server failed. (added April 2017) **Escalated Directorate Risk**	4	4	16	Additional support provided from NWIS to schedule reports out of hours to minimise impact on server disruption. Significant cleansing and formatting of reports by DWS Team before they are forwarded to organisations to enable them to manage compliance. NWSSP IT function have enabled a temporary solution via the Manchester server.	2	4	8	1. Escalation with NWIS for resolution. 2. Provision of fully supported server, hosted in NWIS, DMZ required.	Migration should have been fully complete by end of May 19 but there are some issues with NWIS. Needs to be completed by 6 August, otherwise we will incur a further fee of £3.5k. **Risk Lead: Director of Workforce and OD**	→	
M2	Threats to the supply of medical consumables, and potential employment issues, in the event of a no-deal Brexit. (Added Sept 2018) **Strategic Objective - Customers**	4	5	20	Regular discussions with UK and Welsh Governments Attend Ministerial Advisory Board Velindre Brexit Group IP5	1	5	5	Need to continue to monitor in light of extension to Brexit to 31 October	Acquisition of IP5 completed on 22 March . Pdetailed papers provided to SSPC (Mar 19) and Audit Committee (Apr 19) Project Team established under leadership of Mark Roscrow. **Risk Lead: Director of Procurement Services**	→	

Key to Impact and Likelihood Scores

		Impact				
		Insignificant	Minor	Moderate	Major	Catastrophic
		1	2	3	4	5
Likelihood						
5	Almost Certain	5	10	15	20	25
4	Likely	4	8	12	16	20
3	Possible	3	6	9	12	15
2	Unlikely	2	4	6	8	10
1	Rare	1	2	3	4	5

Critical	Urgent action by senior management to reduce risk
Significant	Management action within 6 months
Moderate	Monitoring of risks with reduction within 12 months
Low	No action required.

*	New Risk
↑	Escalated Risk
↓	Downgraded Risk
→	No Trend Change

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	4.5
PREPARED BY	Roxann Davies, Corporate Services
PRESENTED BY	Roxann Davies, Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Annual Health and Care Standards Self-Assessment 2018-19

PURPOSE

The purpose of this report is to provide the Audit Committee with an update as to the Annual Health and Care Standards Self-Assessment 2018-19 and progress agains the Action Plan for 2019-20.

1. BACKGROUND

The Standards for Health Service in Wales provide a framework for consistent standards of practice and delivery across NHS 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 Framework comprises seven main themes and sub criteria against which NHS bodies need to demonstrate compliance.

2. PROCESS

The process for undertaking the annual self-assessment is that Corporate Services undertake an evaluation against the Standards, which is presented to the SMT for discussion and consultation at Directorate level, where appropriate. Any feedback provided from Directorates is reviewed and incorporated into the Self-Assessment. The SMT were content to approve the Self-Assessment and Action Plan on 27 June 2019. Following completion of the Self-Assessment, an Action Plan to manage and monitor areas whereby we may develop and strengthen our compliance against the Standards is developed, linked to the wider well-being agenda and is presented at a future SMT meeting, for approval. Following on from this, the Self-Assessment and Action Plan is then presented to the Partnership Committee, Audit Committee and the Velindre University NHS Trust Board, for endorsement.

3. REVIEW OF RATINGS FOR 2018-19

Each theme is assessed and given an overall 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:

Health and Care Standards Self- Assessment Ratings			
Theme	**2018-19 Rating**	**2017/2018 Rating**	**2016/2017 Rating**
Governance, Leadership & Accountability	4	4	4
Staying Healthy	4 ↑	3	3
Safe Care	4	4	4
Effective Care	4 ↑	3	3
Dignified Care	Not applicable	Not applicable	
Timely Care	Not applicable	Not applicable	
Individual Care	4 ↑	3	3
Staff and Resources	4	4	4

The overall rating against the mandatory Governance, Leadership and Accountability module and the seven themes reflects NWSSP's overall compliance against the Health and Care Standards and has been rated as a **4,** as outlined below This rating is based on progress against the Action Plan for 2018-19 and the work undertaken to address staff-wellbeing across the organisation, in line with A Healthier Wales:

Overall Health and Care Standards Self-Assessment Rating 2018-19					
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				✓	

4. PROGRESS AGAINST 2018-19 ACTION PLAN

Presented at **Appendix 1** is a summary of progress made to date against the Action Plan for 2018, which will subsequently be amended to include improvements for 2019-20 and brought to a future Committee meeting.

5. RECOMMENDATION

The Audit Committee are asked to:

- **ENDORSE** the Health and Care Standards Self-Assessment 2018-19.

Appendix 1 – Progress against Action Plan

No.	Action	Standard	Responsibility	RAG Status/ Deadline	Progress / Actions Taken
1.	Improving the performance management framework and developing meaningful key performance indicators into our integrated reporting mechanisms (IMTP, Annual Review, Sustainable Development Statement)	Governance, Leadership and Accountability	Head of Finance Head of IMTP	Ongoing 30/09/2019	Ongoing work within Finance and Corporate Services re development of performance management and planning framework
2.	Influencing updates of the corporate policies and procedures suite held by Velindre University NHS Trust to align with the Corporate Health Standard (e.g. smoking, substance abuse, alcohol)	Governance, Leadership and Accountability	Workforce & OD Corporate Services	Completed	All workforce policies highlighted for review have been updated following consultation undertaken
3.	Working towards attaining the Corporate Health Standard, Bronze Award	Staff and Resources	Workforce & OD Corporate Services	Ongoing 30/09/2019	Tracker to demonstrate assurance levels against the Standard has been developed; seeking confirmation for the assessment process/date
4.	Review the profile of our diverse workforce and promote this through communications channels	Staff and Resources	Workforce & OD	Completed	To be included within our Sustainable Development Statement 2018-19/Annual Review
5.	Analysing the Staff Survey 2018 data in relation to key themes around staff health and well-being to develop a strategic picture	Governance, Leadership and Accountability	Workforce & OD Corporate Services	Completed	Completed within Service Area working groups; being monitored centrally by Learning and Development/Workforce Engagement Lead
6.	Developing a staff well-being forum to promote best practice and encourage events and initiatives to be shared locally, identifying colleagues who can act as Champions to lead on topics in which they are interested (e.g. cycling, running, gym exercise, choir, “buddies” to anyone wishing to cease smoking, etc)	Staff and Resources	Workforce & OD Corporate Services	Completed	Staff Health and Well-being Partnership has been established; standing item for SMT agenda is verbal update from the Chair; champions for each directorate sought; standing item on Communications Strategy Group; increased use of social media to raise awareness of initiatives
7.	Integration of health and well-being questions into the Trust-wide Travel Survey, which informs the Travel Plan Action Plan for the Active Travel Act 2013	Staying Healthy	Corporate Services	Ongoing 31/12/2019	To be renewed in line with the Velindre Trust-wide revision of the Travel Plan and Survey
8.	Strengthening our Equality Integrated Impact Assessment Process through development of supporting guidance, reviewing the set-up of the remote panel and hosting workshop sessions	Governance, Leadership and Accountability	Corporate Services	Partially Completed 31/12/2019	Development of new template and guidance to assist completion of assessment process; one-to-one sessions offered for staff undertaking these; work ongoing in relation to workshop sessions following outcome of integration into new PMO software
9.	Explore collaboration opportunities for delivering training courses on mindfulness, stress management and well-being and assessing funding streams available	Staying Healthy	Workforce & OD	Completed	Various well-being and mindfulness training sessions delivered in collaboration with Eilesha / Learning and Development; sharing of mindfulness app developed by Velindre
10.	Strengthening our Corporate Induction offering for new starters to the organisation for health and well-being	Staying Healthy	Workforce & OD Corporate Services	Completed	Corporate Induction Toolkit for new starters has been developed to support integration and awareness of health and well-being in the workplace
11.	Alignment of Workforce & Organisation Development with WEDS/HEIW going forward to influence better communications on All-Wales campaigns	Governance, Leadership and Accountability	Workforce & OD	Ongoing 31/10/2019	Ongoing – Workforce to assess progress made to date in this area, since establishment of HEIW
12.	Explore benchmarking exercise with NHS Wales organisations	Governance, Leadership and Accountability	Corporate Services	Ongoing 31/03/2020	All-Wales approach being developed through Deputy Board Secretaries Network and integrated reporting tool development workstreams to align governance and accountability arrangements
13.	Utilise anonymous case studies and examples across our workforce and involve staff who express an interest by capturing existing employee–led health and well-being activities into the evidence (e.g. charity runs, sports followed, voluntary work, etc)	Staff and Resources	Workforce & OD Corporate Services	Completed	Integration into staff intranet pages for health and well-being, social media, Rhannu internal communications. Standing item in the Communications Strategy Group

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	4.6
PREPARED BY	Roxann Davies, Corporate Services
PRESENTED BY	Roxann Davies, Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Audit Committee Annual Report 2018-19

PURPOSE

The NWSSP Audit Committee Annual Report 2018-19 is presented to the Committee, for **APPROVAL**.

1. INTRODUCTION

The sixth Annual Report of the NWSSP Audit Committee, for the reporting period 2018-19, highlights the activities and details the performance of the Committee. The primary role of the Annual Report is to review the establishment and maintenance of the effective systems of internal control and risk management. In achieving this aim, the Committee assesses the work undertaken by Internal Audit, External Audit and Local Counter Fraud Specialists, together with management in areas of governance, risk and control.

The Committee shall endeavour to continue to develop its functions and effectiveness and intends to seek further assurance, throughout 2019-20.

2. RECOMMENDATION

The Committee is asked to **APPROVE** the Annual Report.

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

Annual Report 2018-2019

1. FOREWORD

I am pleased to present the Annual Report of the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership. It outlines the coverage and results of the Committee's work for the year ending 31 March 2019.

During the year, I was supported by Independent Members, Judge Ray Singh and Professor Jane Hopkinson, who offer considerable knowledge and wide-ranging experience to the Committee. I would like to take this opportunity to put on record my sincere thanks for the significant contribution made by Professor Jane Hopkinson during her time with the Committee, as we welcome Mr Phil Roberts as an Independent Member from 1 April 2019.

I would like to express my thanks to all the Officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by Internal Audit at NWSSP, Local Counter Fraud Services and by the Wales Audit Office.

2018-19's meetings have been well attended, and there was constructive dialogue and challenge throughout. Indeed, a characteristic of the Committee's work and its related meetings has been the willingness of all parties to raise issues, acknowledge shortcomings and put forward positive suggestions to help bring about meaningful improvements to services, systems and day-to-day working practices. This approach is to be welcomed and is very much appreciated by the Committee.

I am keen to foster and promote a culture of continual improvement and, as a Committee, we continued to conduct a brief effectiveness review session at the end of each meeting and introduced topical service presentations to the agenda in order to strengthen and engage in a meaningful way with this process. The issuing of electronic Committee papers has contributed to effective sustainable development and has helped to reduce our environmental impact.

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of NWSSP, in order to achieve better value for money and high quality, sustainable outcomes for NHS Wales.

Mr Martin Veale JP
Chair of the Velindre University NHS Trust Audit Committee for NWSSP

2. INTRODUCTION

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

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

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 Role

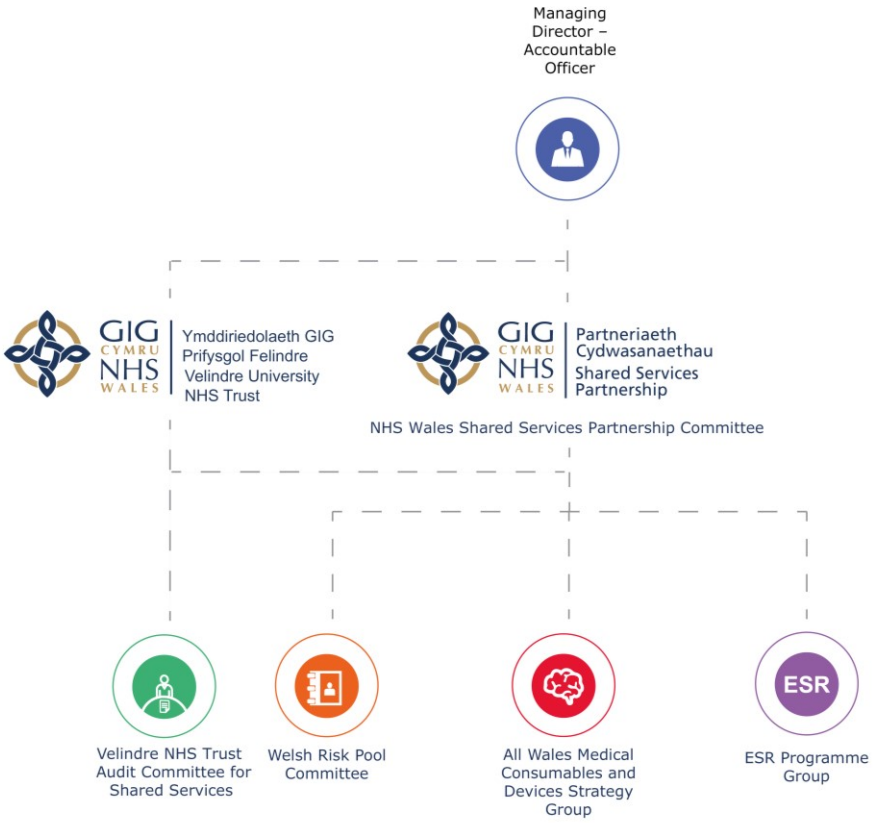
The Audit Committee advises and assures the Shared Services Partnership Committee (SSPC) on whether effective governance arrangements are in place through the design and operation of the SSPC Assurance Framework. This framework supports the SSPC in its decision-making and in discharging its accountabilities for securing the achievement of NWSSP's objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Organisation's system of internal control has been designed to identify the potential risks that could prevent NWSSP achieving its aims and objectives. It evaluates the likelihood of the risks being realised, considers the impact should they occur and seeks to manage them efficiently, effectively and economically. Where appropriate, the Committee will advise the SSPC (and Velindre University NHS Trust, where appropriate) and the Accountable Officer(s) on where and how the Assurance Framework may be strengthened and developed further.

The Committee's Terms of Reference are reviewed annually and are included within the Standing Orders for the SSPC and Velindre University NHS Trust.

Detail of the overall Assurance Framework is set out in **Figure 1** overleaf:

Figure 1: Overall Assurance Framework



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

3.2 Membership

Given the hosting and specific governance responsibilities of Velindre in relation to NWSSP, Velindre University NHS Trust's Audit Committee also acts as the Audit Committee for NWSSP. As such, the same three Independent Members sit on both Audit Committees.

3.3 Attendees

The Committee's work is informed by reports provided by the Wales Audit Office (WAO), Internal Audit, Local Counter Fraud Services and NWSSP personnel. Although they are not members of the Committee, auditors and other key personnel from both Velindre University NHS Trust and NWSSP are invited to attend each meeting of the Audit Committee. Invitations to attend the Committee meeting are also extended where appropriate to staff where reports relating to their specific area of responsibility are discussed by the Audit Committee.

3.4 Attendance at Audit Committee 2018-19

During the year, the Committee met on five occasions. All meetings were quorate and were well attended as shown in **Figure 2** below:

Figure 2: Meetings and Member Attendance 2018-19

In Attendance	April 2018	June 2018	July 2018	Oct 2018	Jan 2019	Total
Committee Members						
Martin Veale, Chair & Independent Member	✓	✓	✓	✓	✓	**5/5**
Ray Singh, Independent Member	✓	✓	✓	✓		**4/5**
Professor Jane Hopkinson, Independent Member (to October 2018)	✓	✓	✓	✓	N/a	**4/4**
Phil Roberts, Independent Member (from January 2019)	N/a	N/a	N/a	N/a	✓	**1/1**
Wales Audit Office						
Audit Team Representative	✓	✓	✓		✓	**4/5**
NWSSP Audit Service						
Director of Audit & Assurance	✓	✓		✓	✓	**4/5**
Head of Internal Audit	✓	✓	✓	✓	✓	**5/5**
Audit Manager	✓	✓	✓	✓	✓	**5/5**
Counter Fraud Services						
Local Counter Fraud Specialist	✓	✓	✓		✓	**4/5**
NWSSP						
Margaret Foster, Chair NWSSP	✓	✓	✓			**3/5**
Neil Frow, Managing Director	✓	✓	✓	✓	✓	**5/5**
Andy Butler, Director of Finance & Corporate Services	✓	✓	✓	✓	✓	**5/5**
Peter Stephenson, Head of Finance & Business Development	✓	✓	✓	✓	✓	**5/5**
Roxann Davies, Corporate Services Manager	✓	✓	✓	✓	✓	**5/5**
NWSSP Secretariat	✓	✓	✓	✓	✓	**5/5**
Velindre University NHS Trust						
Mark Osland, Director of Finance			✓	✓	✓	**3/5**

4. AUDIT COMMITTEE BUSINESS

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

The Audit Committee agenda broadly follows a standard format, comprising four key sections; External Audit, Internal Audit, Counter Fraud Services and 'Internal Control and Risk Management'. These are discussed further below.

4.1 External Audit (Wales Audit Office)

The Wales Audit Office (WAO) provides an Audit Position Statement at each meeting, summarising progress against its planned audit work. The following additional reports were presented during the year:

- WAO Nationally Hosted NHS IT Systems Assurance Report
- WAO Management Letter
- WAO Audit Assurance Arrangements 2019

WAO have stated that the findings of their work enabled them to place reliance on the services provided by NWSSP.

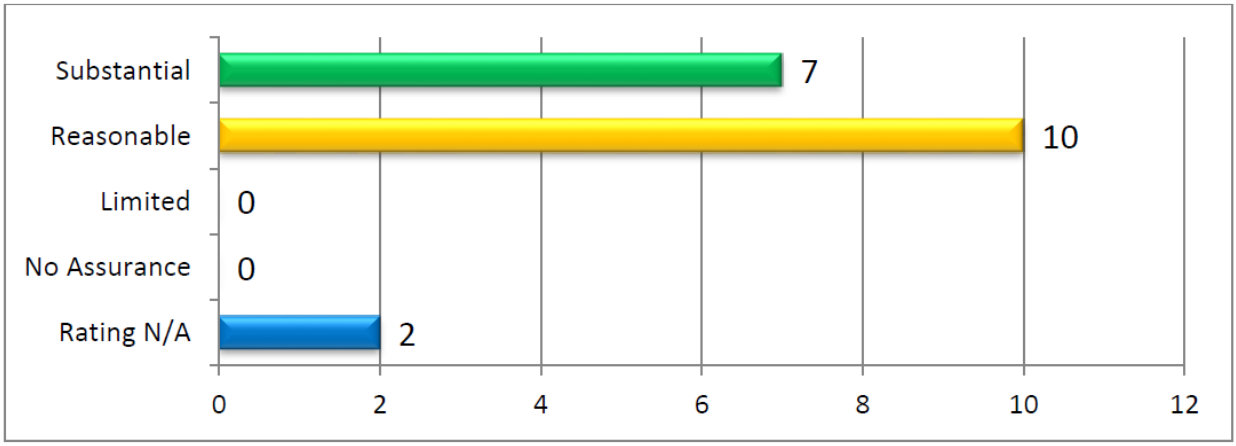
4.2 Internal Audit

Internal Audit have continued to support the organisation in the development and improvement of its governance framework by ensuring that the existing systems and processes of control are reviewed, weaknesses identified, and suggestions for improvement made.

19 Internal Audit reports were generated during 2018-19 and they achieved assurances as follows:

- **7** reports achieved Substantial assurance
- **10** reports achieved a Reasonable assurance
- **2** Advisory reports were generated (where assurance is not applicable)

Figure 3: Internal Audit Reports 2018-19 by Assurance Rating



During 2018-2019, the areas covered by Internal Audit's programme of work included:

- Internal Audit Position Statement at each meeting
- Head of Internal Audit Opinion and Annual Report
- External Quality Assessment for NHS Wales
- Quality Assurance and Improvement Programme Report
- Internal Audit Operational Plan
- 19 Internal Audit Reports, as detailed in **Appendix A**.

Head of Internal Audit Opinion and Annual Report

	The Shared Services Partnership 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.

Figure 4: Head of Internal Audit Opinion: Reasonable Assurance

4.3 Local Counter Fraud Services

The work of the Local Counter Fraud Services is undertaken to help reduce and maintain the incidence of fraud (and/or corruption) within NWSSP to an absolute minimum. Regular reports were received by the Committee to monitor progress against the agreed Counter Fraud Plan, including the following:

- Progress Update at each meeting
- Counter Fraud Annual Report 2017-18
- Counter Fraud Work Plan 2018-19
- Counter Fraud Self Review Tool Submission 2017-18
- Counter Fraud Press Release

As part of its work, there is a regular annual programme of raising fraud awareness, for which a number of days are allocated and included as part of a Counter Fraud Work-Plan which is approved annually by the Audit Committee.

In addition to this a quarterly newsletter is produced which is available to all staff on NWSSP's intranet; all successful prosecution cases are publicised in order to obtain the maximum deterrent effect.

4.4 Internal Control and Risk Management

In addition to the audit reports dealt with by the Committee during the reporting period, a wide range of internally generated governance

reports/papers were produced for consideration by the Audit Committee including:

***Annual Governance Statement*:** During 2018-19 the NWSSP produced its Annual Governance Statement which explains the processes and procedures in place to enable NWSSP to carry out its functions effectively. The Statement was produced following a review of NWSSP's governance arrangements undertaken by the NWSSP Senior Management Team and the Head of Finance and Business Development. The Statement brings together all disclosures relating to governance, risk and control for the organisation.

***Tracking of Audit Recommendations*:** The Committee has continued focus on the timely implementation of audit recommendations; with any changes submitted, being challenged and/or approved by the Committee. During April 2018, the audit tracking process was subject to a review by Internal Audit, for which **substantial assurance** was provided.

Audit Committee Effectiveness Survey: An anonymised Committee Effectiveness Survey was undertaken in May 2019, to obtain feedback from Committee members on performance and potential areas for development. The statements used in the survey were devised in accordance with the guidance outlined within the NHS Audit Committee Handbook and aligned with the statements used by Velindre University NHS Trust for its Effectiveness Survey.

The survey received a 91% response rate (10 responses) and identified the following:

- Over 90% of all responses received were positive;
- All respondents felt that the Committee had been provided with sufficient authority and resource to perform its role effectively;
- All respondents considered that the Committee meets sufficiently frequently to deal with planned matters and that sufficient time is made available for questions and discussion;
- All respondents agreed that the atmosphere at Committee meetings is conducive to open and productive debate;
- All respondents agreed that the behaviour of members and attendees was courteous and professional; and
- All respondents agreed that the reports received by the Committee were timely and included the right format and content to enable the Committee to discharge its internal control and risk management responsibilities.

A full list of the internal reports/papers considered by the Audit Committee in 2018-19 is attached at **Appendix B** for information.

The results highlighted areas for consideration, which will form a Committee Effectiveness Action Plan for 2019-20, including 70% of respondents welcoming greater use of Committee paper software (e.g. iBabs); the monitoring of implementation of actions arising and lessons learned in relation

to Counter Fraud cases; and assessment of the quality and effectiveness of External Audit.

4.5 Private Meeting with Auditors

In line with recognised good practice, a private meeting was held on 6 February 2019, between Audit Committee members, Internal Audit, External Audit and the Local Counter Fraud Specialist. This provided an opportunity for any matters of concern to be raised without the involvement of Executives. No issues of concern arose from the meeting. All auditors are also aware that they can directly approach the Chair at any time with any matters that concerns them.

5. REPORTING AND COMMUNICATION OF THE COMMITTEE'S WORK

The Committee reports a summary of the key issues discussed at each of its meetings to the SSPC and to Velindre University NHS Trust Board by way of a 'Highlight Report'. In addition, this Annual Report seeks to bring together details of the work carried out during the reporting period, to review and test NWSSP's Governance and Assurance Framework. The outcome of this work has helped to demonstrate the effectiveness of NWSSP's governance arrangements and underpins the assurance the Committee was able to provide to both the SSPC and Velindre University NHS Trust.

6. CONCLUSION AND FORWARD LOOK

The work of the Audit Committee in 2018-19 has been varied and wide-ranging. The Committee has sought to play its part in helping to develop and maintain a more effective assurance framework, and improvements have been evidenced by the findings of internal and external audit.

Looking forward, the Audit Committee has identified the following priorities for 2019/20:

- A higher standard of assurance, through strengthening existing governance processes, particularly in relation to corporate risk management and assurance mapping;
- A continued focus on the timely implementation of audit recommendations; and
- Better value for money and service improvement, through actions to improve the use of Committee software to issue papers electronically and reduce our environmental impact.

APPENDIX A

List of Internal Audits Undertaken and Assurance Ratings

Internal Audit Assignment	Assurance Rating 2018-19	Date Presented To Audit Committee
General Pharmaceutical Services (including Prescribing)	Substantial	09/07/2019
General Medical Services	Substantial	09/07/2019
General Ophthalmic Services	Substantial	09/07/2019
General Dental Services	Substantial	09/07/2019
Risk Management and Assurance	Substantial	09/04/2019
Actions undertaken in response to the NHS Protect Ophthalmic Loss Measurement Exercise Report	Substantial	09/04/2019
Information Governance and General Data (GDPR)	Substantial	09/07/2019
Employment Services – Payroll Services All Wales	Reasonable	05/06/2018
Procurement Services - Accounts Payable All Wales	Reasonable	09/07/2019
Business Continuity Planning	Reasonable	09/04/2019
Cwmbran Stores	Reasonable	22/01/2019
Patient Medical Records	Reasonable	22/01/2019
Welsh Language Standards	Reasonable	22/01/2019
Health Courier Services	Reasonable	23/10/2018
Welsh Infected Blood Support Scheme	Reasonable	22/01/2019
Annual Leave Management	Reasonable	22/01/2019
Primary Care Rental Reimbursement Reviews	Reasonable	22/01/2019
Recruitment and Retention	Advisory Report Assurance Not Applicable	09/04/2019
BACS Bureau	Advisory Report Assurance Not Applicable	23/10/2018
Substantial Assurance Rating	*7*	
Reasonable Assurance Rating	*10*	
Limited Assurance Rating	*0*	
No Assurance Rating	*0*	
Assurance Not Applicable	*2*	
Total	**19**	

APPENDIX B
Internally Generated Assurance Reports/Papers

Report/Paper	Every Meeting	Annually	As Appropriate
Tracking of Audit Recommendations	✓		
Governance Matters	✓		
Corporate Risk Register	✓		
Audit Committee Forward Plan	✓		
Health and Care Standards Self-Assessment and Action Plan		✓	
Annual Governance Statement		✓	
Audit Committee Effectiveness Survey, Results and Benchmarking Exercise Update		✓	
Audit Committee Annual Report		✓	
Audit Committee Terms of Reference		✓	
Review of the Shared Services Partnership Committee's Standing Orders (SSPC SOs)			✓
Integrated Medium Term Plan (IMTP)		✓	
Risk Appetite Statement		✓	
Assurance Mapping		✓	
Declarations of Interest Annual Report		✓	
Caldicott Principles Into Practice (CPIP) Annual Report and Improvement Plan		✓	
No Purchase Order (PO), No Pay Policy			✓
Transfer of Management of Redress			✓
Information Commissioner's Office (ICO) Training Audit and Action Plan			✓
Annual Review 2017-18		✓	
Workforce Education and Development Services (WEDS) Legacy Report		✓	
Report on how Procurement Services minimises obsolete warehouse stock			✓
Service Presentations received by the Committee 2018-19			
Integrated Medium Term Plan (IMTP)			✓
Cyber and Information Security			✓
General Data Protection Regulations (GDPR) Readiness			✓
Audit Committee Effectiveness and Benchmarking		✓	
Electronic Staff Record (ESR) Hire2Retire Programme			✓

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	4.6
PREPARED BY	Roxann Davies, Corporate Services
PRESENTED BY	Roxann Davies, Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Review of Audit Committee Terms of Reference

PURPOSE

The purpose of this report is to provide the Committee with proposed amendments to the Terms of Reference, for **APPROVAL**.

1. INTRODUCTION

NWSSP utilises Velindre University NHS Trust's Committee arrangements to assist in discharging its governance responsibilities. It is a requirement that the NWSSP annually review its Audit Committee Terms of Reference, to ensure they remain fit for purpose.

The attached document sets out the Terms of Reference for the Audit Committee, based on those of Velindre's Audit Committee and in accordance with model Standing Orders, reflecting the NHS Wales Audit Committee Handbook and current governance arrangements.

2. AMENDMENTS

Minor amendments are suggested to the Terms of Reference, in order to bring them up to date, to include references to Velindre as a University NHS Trust, amendments to the Shared Services Partnership Committee Standing Orders on 1 March 2019, changes to Committee Membership and the ensuring Committee papers are issued within 5 working days of the meeting.

3. RECOMMENDATION

The Committee is asked to **APPROVE** the amendments suggested to the NWSSP Audit Committee Terms of Reference.

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

Terms of Reference & Operating Arrangements

July 2019

1. BACKGROUND

1.1 In May 2012, all Health Boards and Trusts approved the Standing Orders for Shared Services Partnership Committee. Section 4.0.3 of the Standing Orders (as amended 1 March 2019) states:

"The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or ***utilise Velindre's Committee arrangements*** *to assist in discharging its governance responsibilities."*

These Terms of Reference set out the arrangements for utilising the Velindre University NHS Trust Audit Committee to support the discharge of those relevant functions in relation to NHS Wales Shared Services Partnership (NWSSP).

ORGANISATIONAL STRUCTURE

Velindre University NHS Trust has an interest in NWSSP on two levels:

a) The internal governance of NWSSP in relation to the host relationship; and
b) As a member of NWSSP Committee in relation to the running of national systems and services.

In 2012, it was agreed that the Velindre Audit Committee would be utilised to act on behalf of NWSSP Committee, that there would be a clear distinction between these two areas/functions and that they would be addressed separately under the Audit Committee arrangements. This 'functional split' allows for clear consideration of the issues relating specifically to the business of the nationally run systems and national services that are provided by NWSSP and avoids the boundaries between the governance considerations of the hosting relationship and the governance considerations of NWSSP being blurred. The functional split can be illustrated below:

(a) **Governance** **(Host Relationship)**	**(b)** **Nationally Run Systems & Services**
1 Velindre University NHS Trust **2 Audit Committee**	**Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership**

The governance and issues relating to the hosting of NWSSP dealt with in **(a)** will be incorporated into the standard business of the existing Velindre University NHS Trust Audit Committee, with a specific focus on alternating Trust Audit Committee business. The assurance for the business dealt with in **(a)** will be to the Velindre University NHS Trust Board. The Chair of NWSSP Audit Committee should receive copies of the meeting papers and will be invited to attend if there is anything on the agenda which has implications for the Shared Services Partnership Committee (SSPC).

Issues relating to NWSSP nationally run systems and services **(b)** will be fed into a separate Velindre University NHS Trust Audit Committee for NWSSP operating within its own work cycle. The assurance for the business dealt with in **(b)** will be to NWSSP Chair and the NWSSP Audit Committee, via the communication routes, detailed below.

The arrangements for **(a)** above, will not be considered further within these Terms of Reference, as it is for Velindre University NHS Trust Audit Committee to determine the relevant assurance required in relation to the host relationship.

This document goes on to outline the Terms of Reference for **(b)**, above.

2. INTRODUCTION

2.1 Velindre University NHS Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

2.2 In line with Standing Orders and NWSSP's scheme of delegation, the SSPC shall nominate, annually, a Committee to be known as the Velindre University NHS Trust Audit Committee for NWSSP. The detailed Terms of Reference and Operating Arrangements in respect of this Committee are set out below.

2.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference, as detailed in the NHS Wales Audit Committee Handbook, June 2012.

3 PURPOSE

3.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the SSPC and the Accountable Officer on whether effective arrangements are in place - through the design and operation of NWSSP's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the organisation's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Velindre University NHS Trust Board and SSPC as to where and how its system of assurance may be strengthened and developed further.

4 DELEGATED POWERS AND AUTHORITY

4.1 With regard to its role in providing advice to both Velindre University NHS Trust Board and the SSPC, the Audit Committee will comment specifically upon:

- The adequacy of NWSSP's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, designed to support the public disclosure statements that flow from the assurance processes (including the Annual Governance Statement) and providing reasonable assurance on:

  - NWSSP's ability to achieve its objectives;
  - Compliance with relevant regulatory requirements, standards, quality and service delivery requirements, other directions and requirements set by the Welsh Government and others;
  - The reliability, integrity, safety and security of the information collected and used by the organisation;
  - The efficiency, effectiveness and economic use of resources; and
  - The extent to which NWSSP safeguards and protects all of its assets, including its people.

- NWSSP's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- The planned activity and results of Internal Audit, External Audit and the Local Counter Fraud Specialist (including Strategies, Annual Work Plans and Annual Reports);
- The adequacy of executive and management's response to issues identified by audit, inspection and other assurance activity, via monitoring of NWSSP's Audit Action Plan;
- Proposals for accessing Internal Audit service (where appropriate);
- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and
- Any particular matter or issue upon which the SSPC or the Accountable Officer may seek advice.

4.2 The Audit Committee will support the SSPC with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit Statement, External Audit Opinion or other appropriate independent assurances), prior to endorsement by the SSPC;
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by NHS Protect.

4.3 In carrying out this work, the Audit Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

4.4 This will be evidenced through the Audit Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Audit Committee to review and form an opinion on:

- The ***comprehensiveness*** of assurances in meeting the SSPC and the Accountable Officer's assurance needs across the whole of the organisation's activities; and
- The ***reliability and integrity*** of these assurances.

4.5 To achieve this, the Audit Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There is an effective Counter Fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the SSPC and the Accountable Officer or through the effective completion of Audit Recommendations and the Audit Committee's review of the development and drafting of the Annual Governance Statement;
- The work carried out by key sources of external assurance, in particular, but not limited to the SSPC's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- The work carried out by the whole range of external review bodies is brought to the attention of the SSPC and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, together with the risks of failing to comply;
- The systems for financial reporting to the SSPC, including those of budgetary control, are effective; and
- The results of audit and assurance work specific to the organisation and the implications of the findings of wider audit and assurance activity relevant to the SSPC's operations, are appropriately considered and acted upon

to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Audit Committee will follow and implement the Audit Committee for Shared Services Annual Work Plan and will be evidenced through meeting papers, formal minutes, and highlight reports to the SSPC, Velindre Trust Board and annually, via the Annual Governance Statement, to the Velindre University NHS Trust's Chief Executive.

Authority

4.6 The Audit Committee is authorised by the SSPC to investigate or to have investigated any activity within its Terms of Reference. In doing so, the Audit Committee shall have the right to inspect any books, records or documents of NWSSP, relevant to the Audit Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to co-operate with any reasonable request made by the Audit Committee); and
- Any other Committee, Sub Committee or Group set up by the SSPC to assist it in the delivery of its functions.

4.7 The Audit Committee is authorised by the SSPC to obtain external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the SSPC's procurement, budgetary and other requirements.

Access

4.8 The Head of Internal Audit and the Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee at any time and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

4.9 The Audit Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist, without the presence of officials, on at least one occasion each year.

4.10 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

4.11 The Audit Committee may, subject to the approval of the SSPC, establish Sub Committees or Task and Finish Groups to carry out on its behalf specific aspects of Committee business. Currently, there is an established Welsh Risk Pool Committee which is a Sub Committee of the SSPC, however, there are no Sub Committees of the Audit Committee.

5 MEMBERSHIP

Members

5.1 A minimum of 3 members, comprising:

Chair	Independent member of the Board
Members	Two other independent members of the Velindre Trust Board. The Audit Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

5.2 In attendance:

NWSSP Managing Director, as Accountable Officer
NWSSP Chair
NWSSP Director of Finance & Corporate Services
NWSSP Director of Audit & Assurance
NWSSP Head of Internal Audit
NWSSP Audit Manager
NWSSP Head of Finance and Business Development
NWSSP Corporate Services Manager
Representative of Velindre University NHS Trust
Local Counter Fraud Specialist

		Representative of the Auditor General for Wales Other Executive Directors will attend as required by the Committee Chair
	By invitation	The Committee Chair may invite: - any other Partnership officials; and/or - any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter. The Velindre Chief Executive Officer should be invited to attend, where appropriate, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Secretariat

5.3	Secretary	As determined by the Accountable Officer

Member Appointments

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

5.4 Members shall be appointed to hold office for a period of four years. Members may be re-appointed, up to a maximum of their term of office. During this time a member may resign or be removed by the Velindre Trust Board.

5.5 Audit Committee members' Terms and Conditions of Appointment, (including any remuneration and reimbursement) are determined on appointment by the Minister for Health and Social Services.

Support to Audit Committee Members

5.6 The NWSSP Head of Finance and Business Development and NWSSP Corporate Services Manager, on behalf of the Audit Committee Chair, shall:

- Arrange the provision of advice and support to Audit Committee members on any aspect related to the conduct of their role
- Ensure that Committee agenda and supporting papers are issued 5 working days in advance of the meeting taking place; and
- Ensure the provision of a programme of organisational development for Audit Committee members as part of the Trust's overall Organisational Development programme developed by the Velindre Executive Director of Workforce & Organisational Development.

6 AUDIT COMMITTEE MEETINGS

Quorum

6.1 At least two members must be present to ensure the quorum of the Audit Committee, one of whom should be the Audit Committee Chair or Vice Chair.

Frequency of Meetings

6.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Audit Committee deems necessary, consistent with NWSSP's Annual Plan of Business. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Withdrawal of Individuals in Attendance

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

7 RELATIONSHIP & ACCOUNTABILITIES WITH THE TRUST BOARD & SSPC DELEGATED TO THE AUDIT COMMITTEE

7.1 Although the Velindre Trust Board, with the SSPC and its Sub Committees, including the Welsh Risk Pool Sub Committee, has delegated authority to the Audit Committee for the exercise of certain functions as set out within these Terms of Reference, it

retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The Audit Committee is directly accountable to the Velindre Trust Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Audit Committee, through its Chair and members, shall work closely with NWSSP and its other Sub Committees to provide advice and assurance to the SSPC by taking into account:

- Joint planning and co-ordination of the SSPC business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into NWSSP's overall risk and assurance arrangements. This will primarily be achieved through the discussions held at the SSPC, annually, at the end of the financial year.

7.4 The Audit Committee will consider the assurance provided through the work of the SSPC's other Committees and Sub Committees to meet its responsibilities for advising the SSPC on the adequacy of the organisation's overall system of assurance by receipt of their annual workplans.

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

8 REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Audit Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board, SSPC and the Accountable Officer on the Audit Committee's activities. This includes verbal updates on activity and the submission of committee minutes, and written highlight reports throughout the year;
- Bring to the Velindre University NHS Trust Board, SSPC and the Accountable Officer's specific attention any significant matters under consideration by the Audit Committee; and
- Ensure appropriate escalation arrangements are in place to alert the SSPC Chair, Managing Director (and Accountable

Officer) or Chairs of other relevant Committees, of any urgent/critical matters that may affect the operation and/or reputation of the organisation.

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

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

8.4 The NWSSP Head of Finance and Business Development and Corporate Services Manager, on behalf of the Partnership, shall oversee a process of regular and rigorous self-assessment and evaluation of the Audit Committee's performance and operation, including that of any Sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

9 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *(as per section on Committee meetings)*
- Notice of meetings
- Notifying the public of meetings
- Admission of the public, the press and other observers

10 REVIEW

10.1 These Terms of Reference and operating arrangements shall be reviewed annually by the Audit Committee with reference to the SSPC and Velindre Trust Board.

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	5.1
PREPARED BY	Peter Stephenson, Head of Finance and Business Development
PRESENTED BY	Peter Stephenson, Head of Finance and Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Fighting Fraud Strategy

PURPOSE

To present the Fighting Fraud Strategy to the Committee for assurance purposes.

1. BACKGROUND

The Counter Fraud Steering Group have produced a Strategy for NHS Wales to help counter the risk of fraud. This is supported by an action plan which sets out the strategic direction for all assurance providers across the NHS in Wales in the effort to counter fraud. The Strategy has been approved within Welsh Government and by the NHS Wales Directors of Finance Group.

The Fighting Fraud Strategy is presented at **Appendix 1.**

2. RECOMMENDATION

The Audit Committee are asked to:

- **NOTE** the Fighting Fraud Strategy.

NHS Wales

Fighting Fraud Strategy

CONTENTS

01 Foreword

I am pleased to introduce this Counter Fraud Strategy for NHS Wales. This Strategy will focus efforts on the fight against criminal fraud, bribery and corruption. The Welsh Government is clear that it will not tolerate economic crime against NHS Wales. These crimes are not victimless, because they steal funding that is intended to provide services to patients. Welsh Government supports action to protect these funds and to seek redress for all economic crimes committed against NHS Wales.

With a multi-dimensional approach through criminal prosecution, fraud prevention and awareness campaigns, we are determined to not only make economic crime much harder to commit, but also to increase recovery of funding stolen from NHS Wales. We will continue to build intelligence to gain a comprehensive picture of the evolving fraud risks and to develop creative, innovative and proportionate solutions to address them.

Development of a strategic, tactical and operational response across NHS Wales means that it will be better able to target weaknesses that fraudsters are exploiting. The more money that we are able to stop getting into the hands of criminals, the more resources are available for frontline services.

I am pleased to support this important work and am confident that this strategy will be a crucial step forward in fighting fraud in NHS Wales.

Finally, I would like to thank our highly motivated staff and stakeholders for their efforts in the continued fight against fraud, bribery and corruption within the NHS in Wales.

Dr Andrew Goodall CBE
Chief Executive, NHS Wales
June 2019

CONTENTS

02 Executive Summary

The prevalence and scale of economic crime, including all aspects of fraud, is an increasing concern for the UK. The aims of this Strategy are to prevent fraud from taking place in NHS Wales, and to increase the likelihood of detecting fraud with appropriate sanctions applied where appropriate. We will achieve this through:

- Using intelligence to understand the nature of fraud risks;
- Educating and engaging staff and stakeholders to raise awareness of the potential for fraud and the harm that it causes; and
- Pro-actively detecting and investigating frauds and securing appropriate sanctions.

Fraud against the NHS, which for the purpose of this document includes fraud, bribery, corruption and other relevant unlawful activity, affects all those who work within it and all those who rely upon it. Fraud steals valuable NHS resources, increases costs, reduces efficiency and undermines public confidence. NHS Wales and the Welsh Government are clear that fraud cannot be tolerated as it is unacceptable, and takes away vital resources intended for the provision of high quality patient care. Whilst controls to prevent fraud are in place, these must continually evolve over time to reflect learning, progress and an understanding of new potential risks and system weaknesses. As such, NHS Wales will focus its resources on prevention and detection activity, where these are likely to have the most impact.

Our approach includes the application of sanctions by means of criminal and disciplinary proceedings, in tandem with action to recover monies defrauded, via civil recovery or under the powers given by the Proceeds of Crime Act 2002. In the five years to 31 March 2019, 388 sanctions have been applied, and £2.3m of monies defrauded from NHS Wales reclaimed and returned to fund patient care.

The types of fraud that we particularly face includes:

- Procurement frauds;
- Contractors – inflated invoices/collusion in awarding of contracts;
- Dentists, GPs, Opticians, Pharmacists – claiming for treatments not provided to patients;
- Patients – falsely claiming exemption from NHS Charges;
- Staff – working while sick, timesheets and expenses, false qualifications;
- Grants to Voluntary Organisations; and
- Cyber Fraud.

The challenges that we face, in an environment where fraud risks are continually evolving, and where the level of fraud activity is believed to be increasing, are:

- There is a lack of comprehensive analysis of specific fraud risks which may result in counter fraud resources not being directed to the most appropriate areas; and
- Although each Health Board and Trust are required to appoint a Local Counter Fraud Specialist (LCFS), there is no benchmark for the level of resource that should be invested in counter fraud activity, resulting in significant variation in resourcing levels.

The scale and prevalence of economic crime, the wide variety of areas affected, and the challenges mentioned above, all point to the need for targeted and co-ordinated action to effectively tackle the problem.

03 Strategic Objectives

Our vision is to have an NHS in Wales, which is able to protect the resources needed for front-line patient care from fraud. To do this we need to have a co-ordinated approach:

- which educates and engages with staff and stakeholders to raise awareness of the potential for fraud and the harm that it causes;
- that uses intelligence to understand the nature of fraud risks; and
- pro-actively detects, investigates frauds and secures sanctions at all levels.

The key strategic objectives for NHS Wales over the mid-term are:

Inform and Involve

- continue to improve the approach to joint working
  - ➔ ensure that Counter Fraud Services are aligned and engaged with Audit & Assurance, the Post- Payment Verification Teams, and the Auditor General's auditors.
- reinforce the clear message that fraud will not be tolerated
  - ➔ continue to raise awareness with staff and stakeholders; and
  - ➔ ensure clear guidance on how to report suspicions.

Prevent and Deter

- identify the key fraud risks to NHS Wales:
  - ➔ undertake regular risk assessments;
  - ➔ work jointly with partners to make better use of data analytics;
  - ➔ in-depth analysis of relevant information; and
  - ➔ review existing sources of assurance.
- Maximise the benefits of partnership working
  - ➔ Sharing information and learning lessons with organisations such as the Auditor General, NHS Counter Fraud Authority, Health Inspectorate Wales, the Home Office, Cabinet Office and Welsh Government.
  - ➔ Continually reviewing and improving our system controls to address identified weaknesses.

Hold to Account

- ensure a consistent and comprehensive approach to counter fraud across the whole of NHS Wales:
  - ➔ develop a benchmark for LCFS resource in each organisation in NHS Wales;
  - ➔ require all NHS organisations to achieve a green rating against the Counter Fraud Standards; and
  - ➔ invest in and develop the Counter Fraud capacity across NHS Wales and develop a talent pipeline.
- improve the capacity for financial investigation work:
  - ➔ maintain a minimum resource of two financial investigators;
  - ➔ arrange additional training to reinforce cover arrangements and succession planning.

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04 Strategic Framework

Countering fraud requires a multi-faceted approach that is both proactive and reactive.

The various bodies involved in countering fraud within NHS Wales comply with broad principles to guide their work to minimise the incidence of fraud and to deal effectively with those who commit fraud against the NHS.

The overall requirement underpinning these principles is effective strategic governance, strong leadership and a demonstrable level of commitment to tackling fraud from senior management across NHS Wales. The key principles, which are the overarching areas scored by the NHS Counter Fraud Authority in the Counter Fraud Standards, are:

Inform and Involve – raising awareness with NHS Wales staff, stakeholders and members of the public in highlighting the fraud risks, the consequence of those risks to the NHS, and the measures taken against those found to have committed fraud;

Prevent and deter – providing solutions to mitigate identified fraud risks, undertaking proactive targeted work to detect possible fraudulent activity based on effective analysis of data, and discouraging individuals who may be tempted to commit fraud against the NHS;

Hold to Account – investigate allegations of fraud thoroughly and to the highest professional standards, and where appropriate seek the full range of civil, criminal and disciplinary sanctions and seek redress where possible; and

Strategic Governance – Fraud is constantly evolving and continuous re-evaluation and improvement is needed to ensure that our approach remains effective.

CONTENTS

NHS Wales Strategic Framework for Counter Fraud

CONTENTS

05 Resources

The primary approach to counter fraud services in NHS Wales is through the following:

Health Boards, Trusts and Special Health Authority

Local Counter Fraud Specialists

All Wales

Counter Fraud Service Wales

Specialist Support

NHS Counter Fraud Authority

- Welsh Government Directions on Counter Fraud require each Health Body to nominate qualified Local Counter Fraud Specialists, recognised and accredited by the Counter Fraud Professional Accreditation Board. There are currently 20 LCFS in Wales, all directly employed by NHS bodies. LCFS are the primary point of contact for all economic crime concerns within the health body they serve. They agree work plans with their respective organisations covering a balance of proactive (fraud awareness and detection) and reactive (fraud investigation) work, closely aligned to the delivery of the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

- The Counter Fraud Services Wales (CFSW) comprises seven experienced, accredited and trained investigators. The role of CFSW is to investigate large scale and complex economic crime and provide specialist operational guidance to the LCFS network. The CFSW are authorised to utilise restricted financial investigation powers under the Proceeds of Crime Act 2002, and currently have two fully trained investigators to undertake this work.

- The NHS Counter Fraud Authority (NHSCFA) is a special health authority providing services to NHS England. In accordance with a Section 83 Government of Wales Act 2006 arrangement, the NHSCFA provides specialist operational support services to NHS Wales. These include Forensic Computing and Specialist Dental services and the Welsh Government pay directly for these services via an annual SLA.

In addition to the above, the following functions also have a direct role in countering fraud:

- **Primary Care Services (PCS)** – The Post Payment Verification (PPV) team in PCS undertake checks within General Medical Services, General Ophthalmic Services and Community Pharmacy. Similar checks on Dental Services in NHS Wales are conducted via an agreement with NHS (England) Business Services Authority. The purpose of the checks is to provide assurance to the Health Boards that claims for payment made by primary care contractors are appropriate, and that the delivery of the service is as defined in the NHS service specification and relevant legislation. There is regular liaison and an Information Sharing Protocol with the CFSW and LCFS teams, with any potential fraud concerns referred for investigation.

- **Audit & Assurance** - all NHS bodies in Wales receive internal audit and assurance services delivered by the NWSSP Audit & Assurance Team. While they are not directly responsible for detecting fraud, their controls and assurance work can both highlight system weaknesses, and potential breaches of controls, which may indicate a higher propensity for fraud. In such circumstances, they work with the relevant LCFS to achieve a co-ordinated response. In addition, an Information Sharing Protocol between the LCFS and Audit & Assurance helps to reinforce the good relationship between the Counter Fraud and Internal Audit services;

- **Auditor General for Wales (Auditor General)** – all NHS bodies in Wales are subject to an external audit by the Auditor General. Whilst the work undertaken by the Auditor General's auditors is again not directly targeted at fraud, they too may uncover system weaknesses or actual indications of fraud. There is regular liaison between the Auditor General's auditors and CFSW to discuss possible fraud concerns;

- **National Fraud Initiative (NFI)** - The NFI was established by the Audit Commission in 1996 and matches data within and across public bodies every two years to identify anomalies that may be due to fraud. NFI is run in Wales by the Auditor General under statutory data matching powers. Since NFI started, it has found more than £35m in fraud and overpayments across the Welsh public sector and the latest biennial NFI exercise uncovered £5.4m, an increase of £1m from the previous exercise.

In addition to the specific measures highlighted above, it is incumbent on all NHS staff to be vigilant in identifying potential opportunities for, and/or actual occurrences of, fraud and to report any concerns to CFSW or the health body LCFS.

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06 Governance

The Counter Fraud Steering Group (CFSG) provides the prime governance and oversight for counter fraud arrangements in NHS Wales. The group is a subgroup of the all-Wales Directors of Finance Forum. The role of the CFSG is to provide strategic oversight and review of the counter fraud service provided to NHS Wales, and to make recommendations for change to Welsh Government and to the NHS Wales Directors of Finance Group for adoption.

The Group is chaired by the NWSSP Director of Finance and Corporate Services, with a current membership, which includes:

- Welsh Government representative
- NHS Wales Directors of Finance representative
- NHS Wales Audit Committee Chairs representative
- NWSSP Director of Audit & Assurance
- NWSSP Director of Primary Care Services
- NHS CFS Wales Operational Fraud Manager
- NHS Counter Fraud Authority representative
- NHS Wales LCFS representative
- NWSSP Head of Corporate Services
- NWSSP Legal & Risk Representative
- Auditor General representative (Observer)

Operationally, all local counter fraud services across Wales report to their Finance Directors and have their annual work plans approved and monitored by the Audit Committees in each organisation. These will typically meet four to five times a year and the respective LCFS for each organisation will attend the Committees and present their annual work plans, progress report and annual report to the appropriate meetings.

In addition, the CFS Wales Operational Fraud Manager presents updates on NHS Wales counter fraud activity, proactive work, potential risks, and accurate data on resources and sanctions via quarterly and annual reports and regularly updates the Health and Social Services Audit and Risk Committee of Welsh Government on fraud risks in NHS Wales.

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07 Quality Assurance

The quality of services is measured by compliance with the Fraud, Bribery and Corruption Standards (the standards), produced by the NHS Counter Fraud Authority, and adopted by NHS Wales. The standards are designed to ensure that counter fraud, bribery and corruption measures are implemented in accordance with the Minister for Health and Social Service directions, and the service level agreement between the Welsh Government and the NHS Counter Fraud Authority.

There are currently 23 standards, grouped under the following four key principles:

- **Inform and Involve** – assesses measures to raise fraud awareness, and to highlight the consequences of fraud;
- **Prevent and Deter** – assesses how an organisation discourages individuals from committing fraud, and ensuring that opportunities for fraud to occur are minimised;
- **Hold to Account** – assesses the arrangements to detect and investigate fraud, and how redress is sought through the appropriate application of sanctions; and
- **Strategic Governance** – assesses an organisation's strategic governance arrangements, to ensure that appropriate measures are embedded at all levels.

The quality assurance programme comprises two main processes: assurance and assessment. The assurance process primarily focuses on an annual self-review against the standards, which is undertaken by the organisation and the results submitted to the NHSCFA. The assessment process is then undertaken by the NHSCFA Quality and Compliance team.

The Self-Review Tool, supporting evidence and inspection process enables an independent assessment of the counter fraud resources and performance at the health body.

The annual assessments indicate that NHS Wales LCFS performance is generally positive, and confirm that any recommended improvements or enhancements are promptly addressed.

In addition, the work of the CFSW team is also subject to a cyclical governance assurance review, again conducted by the NHS CFA. This was last undertaken during 2017, and found that:

"In summary the CFS Wales conducts criminal investigations professionally and thoroughly. They comply with current legislation and NHS operational policies governing the conduct and management of criminal cases, including use of the FIRST case management system. The advice, guidance and support they provide to the wider counter fraud community in Wales is appreciated".

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08 Conclusion

NHS Wales and the Welsh Government is committed to sustaining and improving the health and wellbeing of the people of Wales. Maximising the use of resources is crucial to delivering on this commitment. We are therefore determined to combat NHS fraud wherever it arises and continue to adopt a co-ordinated approach to ensure that as far as possible healthcare funding is used for legitimate patient care.

To achieve this we need a shared vision and common sense of purpose i.e. of a Welsh Health Service where fraud is not allowed to flourish but which is mitigated and reduced through targeted interventions, supported by an anti-fraud culture in which all staff and stakeholders are engaged.

This strategy will help in engaging fully with all those who have a role in protecting services and resources and further raise the profile of the detrimental impact of fraud. The strategy will be supported by a detailed action plan that will be regularly monitored by the Counter Fraud Steering Group.

Contact Details

Office
NHS Counter Fraud Service Wales,
1st Floor,
Block B,
Mamhilad House,
Mamhilad Park Estate,
Pontypool
NP4 0YP

Email: NWSSP.Communications@wales.nhs.uk

Reporting Fraud

Report NHS fraud securely and confidentially by using the NHS Counter Fraud Authority's online reporting tool or by calling our free phone line on ***0800 028 40 60***.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Designed by NHS Wales Shared Services Partnership Communications

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COUNTER FRAUD & CORRUPTION

ANNUAL REPORT 2018/19

Craig Greenstock
Counter Fraud Manager
Cardiff and Vale University Health Board

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1. Management Summary

1.1 This Annual Report has been written in accordance with the provisions of the Welsh Assembly Government Directions on Fraud and Corruption, which requires Local Counter Fraud Specialists (LCFS) to provide a written report, at least annually, to the Health Body on any Counter Fraud work undertaken. The report content and style used complies with the model prescribed by NHS Counter Fraud Authority (formerly NHS Protect) and therefore is in the same format as those that have been submitted in previous years.

1.2 The Velindre University NHS Trust together with NHS Wales Shared Services Partnership (NWSSP) appointed as their nominated Lead LCFS, Craig Greenstock, Counter Fraud Manager at the Cardiff and Vale University Health Board, who completed his Counter Fraud Training in December 2000 and was accredited in March 2001.

1.3 During 2018/19, five (5) new investigations into possible fraudulent or corrupt activity were instigated together with the five (5) cases that were brought forward from 2017/18. Out of the five (5) new cases, four (4) of them involved alleged false claims that had been submitted to the NHS Student Awards Service.

1.4 Civil recovery of £22,697 has also been made for any monies fraudulently obtained that were identified during the course of the various investigations. Included as part of the civil recovery are claims, by the Velindre University NHS Trust, for all cost identified as a result of not only the fraud proven to have been committed, but also the LCFS' costs (e.g. court attendance, salary, travel expenses) in carrying out the individual criminal investigations.

1.5 If required, advice as to how to proceed is then sought on each individual case from NHS CFS (Wales) and once an investigation, into the allegations, has been concluded, legal opinion would also be taken from the Specialist Fraud Division - Crown Prosecution Service as to whether there was sufficient evidence to warrant and support a criminal prosecution.

1.6 Regular progress reports on the progress of cases have been made to the Trust's Audit Committee and where system weaknesses have been identified and recommendations made, these have been sent to the relevant Service Group and/or Directorate Managers.

1.7 The mix of cases investigated to date are summarised in **Appendix 2** and a full index of the cases reported/referred to the LCFS' are listed in **Appendix 3**.

1.8 Velindre University NHS Trust's policies and procedures (e.g. Human Resources, Finance etc) have been reviewed and commented upon in relation to the Counter Fraud Policy.

1.9 Close liaison and a good working relationship was established with the NHS Counter Fraud Service (Wales) following its establishment by Welsh Government and it becoming operational in October 2001, and this relationship continues to develop and strengthen.

2. Inform and Involve (Developing an Anti Fraud Culture)

2.1 The LCFS' have an on-going work programme with the NHS Counter Fraud Service (Wales) to develop a real Anti-Fraud Culture within the NHS.

Examples of work carried out to develop an Anti Fraud Culture include:

- Distribution of relevant Counter Fraud reports to the Trust's Senior Managers
- Submission of comments on draft Trust policies/protocols as appropriate relating to any Counter Fraud issues
- A number of fraud awareness presentations, five (5) in total, were given to over 50 NHS staff as part of planned Induction sessions in North Wales, Companies House in Cardiff and also Matrix House in Swansea. Sessions were also given to NWSSP Stores staff based in Bridgend and Cwmbran respectively. A number of other presentations are in the process of being arranged to take place in 2019/20.
- Analysis of staff feedback questionnaires is carried out following the fraud awareness sessions in order to gauge how much knowledge the attendees had of the counter fraud work that is being undertaken and also to assist in forming the content of future sessions.

Examples of work currently planned/being considered in developing an Anti-Fraud Culture:

- Additional fraud awareness presentations to other various staff groups as outlined in the NWSSP Counter Fraud Work-Plan for 2019/20.
- Developing the quarterly Counter Fraud Newsletter which currently provides NWSSP staff with real examples of fraud and the successful outcomes from such investigations.

2.2 In accordance with the Secretary of State Directions, as in **Appendix 1**, the LCFS' will:

- Proactively seek and report to NHS Counter Fraud Authority any opportunities where details of Counter Fraud work (involving action on prevention, detection, investigation, sanction or redress) can be used within presentations or publicity in order to deter Fraud and Corruption in the NHS.
- Report all allegations of fraud to NHS Counter Fraud Authority and develop a good working relationship to ensure that all information is available for presentations and/or publicity.
- Also share information with other LCFS' throughout Wales in order to build on good practice and identify areas where fraud may be prevented.

3. Prevent Fraud

3.1 The LCFS' will assist by providing information to and liaising with Velindre University NHS Trust Communication and Corporate Departments, if required, when reporting prosecution cases that may attract media attention to ensure that a consistent approach is taken and the message is sent out that fraud will not be tolerated within Velindre University NHS Trust.

The LCFS' regular liaise with Velindre University NHS Trust and NWSSP Senior Managers and other staff on all allegations of fraud received and it has been identified that this work by the LCFS' continues to have a positive impact in identifying and reporting any fraudulent activity.

The deterrence effect is difficult to measure, however, there are still a consistent number of referrals being made during 2018/19 and the majority have been from the NHS Student Awards Service. It is hoped from some of the planned awareness session that more NWSSP staff will be aware of the potential areas for fraud and, as a result of advice and further guidance from the nominated LCFS', will be more prepared to take action against any fraudsters by reporting the outcome of any subsequent investigation to the remaining staff.

The details of one particular NWSSP fraud related prosecution case did actually appear in both the National and Local press and was also disseminated to the managers involved and other staff via the quarterly Counter Fraud Newsletter and the Fraud Awareness presentations which have also been given to the various staff groups.

3.2 To be effective locally, publicity needs to have local relevance and it is important for the LCFS' to communicate local successes, particularly around Sanctions and Redress and so it is also important that outline details of all successful prosecutions continue to appear in Velindre University NHS Trust and NWSSP staff related publications.

3.3 The LCFS' will, in conjunction with NHS Counter Fraud Authority, NHS CFS (Wales) and NWSSP Corporate Department, consider publicity in any case of fraud, where a successful outcome is achieved as a result of action taken via any of the disciplinary, criminal and/or civil routes. This helps to reinforce the messages about action being taken to reduce fraud and will be carried out through the appropriate channels.

4. Deter Fraud

4.1 LCFS' will provide reports on systems weaknesses in each case where fraud is established to:

- NHS Counter Fraud Authority
- NWSSP Internal Audit
- Wales Audit Office (External Audit)

Examples where this has occurred are:

- Submission of new case notifications and intelligence information via NHS Counter Fraud Authority FIRST Case Management System.
- Providing regular reports and/or presentations to Velindre University NHS Trust, NWSSP Audit Committee and Senior Managers.
- Regular liaising with Internal and External Auditors with reference to investigations for assistance and previous reports held by them.
- Where, as a result of Counter Fraud work, any system weaknesses have been identified then the LCFS' have provided potential solutions and/or recommendations as part of closure reports to the relevant managers.

4.2 The LCFS' provide reports on policy weaknesses in each case where fraud is established to NHS Counter Fraud Authority, Velindre University NHS Trust and NWSSP's Finance Director.

4.3 Where policy and/or system weaknesses are identified, the LCFS' will notify the appropriate staff such as Velindre University NHS Trust's Finance Director, Director of Workforce & OD, Senior Managers, Internal and External Audit and/or NHS Counter Fraud Authority.

5. Hold to Account (Detection)

5.1 The LCFS' will take account of:

- Information from the Internal and External Audit functions regarding System Weaknesses (e.g. interpreter services and overseas/private patients).
- NHS Counter Fraud Authority Risk Management exercises in order to prioritise other areas of detection work.
- The LCFS' own enquiries and analysis of data, reports (including Whistle Blowing) and trends (e.g. sickness absence).
- National Fraud Initiative 2018/19 Data Matching Exercise

6. Hold to Account (Investigating Fraud)

6.1 The LCFS' will investigate cases in accordance with the Secretary of State Directions. All investigations have, therefore, been carried out in accordance with the directives outlined in **Appendix 1**.

The LCFS' will refer cases to NHS CFS (Wales) in accordance with the Welsh Assembly Government Directions and all cases have been reported using the NHS Counter Fraud Authority FIRST Case Management System. From January 2010, all NHS LCFS' have been required to electronically record all information regarding their investigations onto the NHS Counter Fraud Authority FIRST Case Management System, which is held within a restricted area within the NHS Counter Fraud Authority internet webpage.

6.2 Four (4) NWSSP cases were formally referred to NHS CFS (Wales) in 2018/19 via the FIRST Case Management System and there were also four (4) ongoing cases brought forward from 2017/18. Most referrals received are not necessarily and/or automatically reported on the NHS Counter Fraud Authority FIRST Case Management System, due to the fact that many are isolated instances and very low in terms of monetary value.

Each case is judged on the individual merits before proceeding with an investigation and in the majority of cases it has been found to best suited for the individual(s) to be dealt with under Velindre University NHS Trust's Disciplinary Policy rather than as part of a full scale criminal investigation and/or prosecution due to the small monetary amounts involved in the alleged fraud in addition to the cost of taking a case to court.

6.3 The LCFS' will and do provide NHS Counter Fraud Authority, Internal Audit and External Audit, NWSSP's Finance Director and Audit Committee, with regular update reports on significant movements with particular cases.

7. Hold to Account (Applying Sanctions and Seeking Redress)

7.1 The LCFS' will give consideration to the different sanctions available to them and have regard to the "Triple Track" approach to investigations, i.e. Criminal, Civil and Disciplinary action. To ensure that correct, prompt action is taken in each case, a close working relationship has been developed with NWSSP's Workforce and Human Resource Managers.

7.2 The LCFS' will supply NWSSP Accounts Receivable Department with information where fraud is established in order to enable them to recover the lost resources. A full file is maintained on each of the investigations carried out to provide information that will assist in the recovery of funds.

8. Annual Assessment Declaration

8.1 Since 2013/14 and following a review of the practice whereby NHS Counter Fraud Authority would determine how effective a Health Body's Counter Fraud arrangements were when compared to other NHS Bodies, a significant change was introduced into the way in which Health Bodies were to report and then be assessed.

8.2 This new process, based on a risk based approach, now requires each Health Body to undertake it's own Self Risk Tool **(Appendix 4**) based on a set of criteria and standards.

8.3 This SRT is then assessed, by NHS Counter Fraud Authority, against the individual standards as part of a three (3) year rolling programme with guidance, on the completion of the Self Risk Tool and the individual standards which have to met, being issued to all NHS bodies on an annual basis.

Appendix 1

WELSH ASSEMBLY GOVERNMENT DIRECTIONS

The following grid identifies the key requirements under Welsh Assembly Government Directions and outlines current activity within each section.

Paragraph	Instruction	Action by Health Board
2 (1)	Chief Executive and Director of Finance to Monitor and ensure compliance with these Directions and any other instructions on countering fraud and corruption against the NHS Action to be taken in accordance with the NHS Counter Fraud and Corruption Manual and in accordance with the Table annexed to the Directions	Regular meetings are held between the NWSSP Finance Director and the Nominated Lead LCFS. Where possible the Manual has been referred to for guidance and appropriate action taken. An updated Manual has previously been issued following a revision, by Welsh Government, after taking into account changes in legislation within the NHS in England.
2 (2)	Each health body shall facilitate, and co-operate with NHS Counter Fraud Authority's Quality Inspection work giving prompt access to staff, workplaces and relevant documentation	Good close working relationship has been established with NHS CFS (Wales). To date there has never been an issue over access to staff or workplaces. NHS Counter Fraud Authority Quality & Assurance Unit carried out a Focused Assessment in October 2016, with full co-operation, and their report was received and then accepted by NWSSP Hosted Body (i.e. Velindre University NHS Trust).
2 (3)	Endeavour to agree an SLA with NHS Counter Fraud Service (Wales).	The current SLA was signed in March 2010, but will be reviewed to incorporate any changes which may take place within the NHS in Wales.
3 (1)	Nomination of a suitable officer to act as LCFS. Notify NHS Counter Fraud Authority of replacement LCFS within three months of the need becoming apparent	The NWSSP Nominated Lead LCFS is Craig Greenstock.
3 (2)	A trained and accredited LCFS in post by 1 February 2002	The NWSSP's Nominated Lead LCFS was accredited in 2001 and is employed at another NHS Body, but undertakes the counter fraud work as part of a separate contracted-out service.

4 (a)	LCFS reports to Director of Finance	The Nominated Lead LCFS reports directly to the Finance Director, informs him of all cases as they are received and keeps him updated on any progress/closure.
4 (b)	LCFS provision of written report at least annually	The 2018/19 NWSSP CF Annual Report has specifically been produced at the request of the NWSSP General Manager and Finance Director. The information contained in the Annual Report will also be incorporated into the CF Annual Report which is then produced for the Hosted Body (i.e. Velindre University NHS Trust).
4 ©	Attendance at Audit Committee meetings Right of access to all Audit Committee members. Right of access to Chairman and Chief Executive	The NWSSP Nominated Lead LCFS or at least one of the Health Body's other LCFS' has attended all Audit Committee meetings that have taken place up to and including April 2019. The LCFS' have access to all Audit Committee members. The LCFS' have not required access during the year but are confident that, if required, right of access is available (as detailed in the health body's Counter Fraud Policy)
4 (d)	Undertake Pro-Active work to detect cases of Fraud and/or Corruption as specified by Chief Executive and Director of Finance, particularly where systems weaknesses have been identified	The LCFS' have made five (5) separate Fraud Awareness Presentations to over 50 staff as part of Coporate Induction planned sessions and also to other NWSSP staff based in the Bridgend and Cwmbran Stores respectively. The LCFS' also undertake Pro-Active Exercises and follow up all incidents of a potential fraudulent nature received via the NHS Counter Fraud Reporting Line, Velindre University NHS Trust's Whistle Blowing facilities and/or any Internal or External Audit reports.
4 (e)	Proactively seek and report opportunities for publicity to NHS Counter Fraud Authority (includes instances for inclusion in presentations) involving action to prevent, detect, investigate, impose sanctions and seek redress	One (1) particular successful fraud related case received significant media coverage in the National and Local press and has also been publicised across NWSSP and other Hosted Body sites via the quarterly Counter Fraud Newsletter.

4 (f)	Investigate cases of suspected fraud in accordance with division of work outlined, the LCFS will not investigate (unless there is prior agreement)	All cases investigated to date have followed the guidelines.
	LCFS will investigate where it is clear that they will be under £15k. Cases where it is clear they will be over £15,000 in value will be referred to NHS CFS (Wales).	Only cases less than £15,000 are investigated, and above £15,000 the cases are referred to, and investigated by/in liaison with, NHS CFS (Wales).
	There is evidence that fraud extends beyond the Health Body.	There have no related cases identified during the year which extended outside of the Health Body.
	GDS and/or prescription fraud are involved	There have been no alleged frauds reported that involved any altered documentation for prescribed drugs.
	There is evidence of corruption involving a public official	There have been no cases of alleged corruption reported during 2018/19.
	The LCFS' will provide assistance when required in investigation of cases involving their Health Body where the investigation falls within the remit of NHS Counter Fraud Authority.	There have been no matters reported that would have fallen within the remit of NHS Counter Fraud Authority.
4 (g)	Refer cases to NHS Counter Fraud Authority teams as appropriate	All cases appropriate to NHS CFS (Wales) have been referred.
4 (h)	Inform the appropriate NHS Counter Fraud Authority team of all cases of suspected fraud investigated by the Health Body.	Entries on the FIRST Case Management Systems, for intelligence purposes, have been completed for all cases of suspected fraud investigated during the year.
5	Co-operate with investigative work: Chief Executive and Director of Finance to ensure access is given as soon as possible and not later than 7 days from the request to the LCFS or NHS Counter Fraud Authority Operational Service staff to:	The LCFS' and NHS Counter Fraud Authority rights and responsibilities, as set out in the SLA, SFIs and the Counter Fraud Policy, have been fully complied with and both have received co-operation from all levels throughout the Health Body.

	Premises, records and data owned or controlled by the health body relevant to detection/investigation of fraud and corruption All staff who may have relevant information.	As above
6 (1)	LCFS to complete relevant forms when Director of Finance believes fraud or corruption to be present, so that NHS Counter Fraud Authority may supply advice on appropriate sanctions. LCFS and Director of Finance to consider further action in accordance with the NHS Fraud & Corruption Manual.	Investigations have complied with NHS Fraud & Corruption Manual and completed forms as appropriate.
6 (2)	Director of Finance to liaise with NHS CFS (Wales) concerning prosecutions prior to taking such action.	Investigations have complied with the NHS Fraud & Corruption Manual
6 (3)	Director of Finance to liaise with NHS CFS (Wales) prior to reaching a decision to refer cases to the police or other body for investigative action, if required.	Appropriate liaison took place in any cases to date where investigations have required referral to police or any other third party organisations (e.g. UK Borders Agency).
6 (4)	Non-disclosure of information, except for purposes of investigation or subsequent proceedings; no disclosure to anyone who may be implicated	There has been no disclosure of information to anyone who may be implicated in any of the investigations unless required under Police & Criminal Evidence Act.
6 (5)	LCFS to report details of any identified system weakness which would allow fraud or corruption to occur, to the internal auditors	The LCFS' liaise with Internal & External Auditors and provide information regarding system weaknesses. Managers are also informed of system weaknesses and advised accordingly.
6 (6)	LCFS to ensure investigations focus on obtaining information to ensure recovery of funds can take place. Director of Finance responsible for ensuring financial redress is sought where losses identified	A full file is maintained on each of the investigation carried out to provide information to assist the recovery of funds. Recovery of losses is considered in all cases and would be sought where appropriate.

Appendix 2

Further Information

1. Reporting lines

Trust Chief Executive (Velindre University NHS Trust)	Steve Ham Chief Executive's Office Corporate Headquarters Unit 2, Charnwood Court Parc Nantgarw, Nantgarw Nr.Cardiff. CF15 7QZ Email: Steve.Ham2@wales.nhs.uk
NWSSP Managing Director	Neil Frow NHS Wales Shared Services Partnership (NWSSP) 4-5 Charnwood Court Heol Billingsley Parc Nantgarw Cardiff CF15 7QZ Email: Neil.Frow@wales.nhs.uk
Executive Director of Finance (Velindre University NHS Trust)	Mark Osland Finance Director's Office Corporate Headquarters Unit 2, Charnwood Court Parc Nantgarw, Nantgarw Nr.Cardiff. CF15 7QZ Email: Mark.Osland@wales.nhs.uk
Director of Finance (NWSSP)	Andy Butler NHS Wales Shared Services Partnership (NWSSP) 4-5 Charnwood Court Heol Billingsley Parc Nantgarw Cardiff CF15 7QZ Email: Andy.Butler@wales.nhs.uk
Nominated Lead Local Counter Fraud Specialist	Craig Greenstock Counter Fraud Department 2nd Floor, Monmouth House University Hospital of Wales Heath Park Cardiff CF14 4XW Email: Craig.Greenstock@wales.nhs.uk

2. Mix of cases

Number of cases in 2018/19 including those brought forward from previous years:

Area (based on initial reported category)	Number of cases	Closed	Ongoing
Reimbursement of Costs (Student Awards)	8	6	2
False Sickness Absence	1	0	1
Miscellaneous (e.g. Theft of NHS Property)	1	0	1
Total	**10**	**6**	**4**

3. NHS Counter Fraud Authority Website

Information about NHS Counter Fraud Authority and the NHS Counter Fraud Strategy can be found at www.cfa.nhs.uk

Appendix 3

INDEX OF LCFS INVESTIGATIONS 2018/19

Ref. No	Subject	Status	
SSP14.05	Unauthorised Sale of NHS Property	Crown Court Hearing (Suspended Sentence) Civil Recovery (5k) still being made at £50 per month	Open - Balance o/s £2524.25
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. Defendant also ordered to repay £9,545 in compensation to the NHS within three (3) months and a further £13,713 to be paid to the Dept of Works and Pensions (DWP). The remaining sum of £68,165, owed to the DWP, is to remain on file for further consideration.	Closed in Qtr 2 - NHS payment received in full.
SSP16/04	False Claim for Costs	Magistrates Court Hearing - March 2017. Subject was fined £200 and ordered to pay compensation of £120 and £400 Costs - Awaiting outcome of internal University Fitness to Practice.	Closed in Qtr 2
SSP18.01	False Sickness Absence	Interview under caution in Feb 2018. Prosecution case submitted to CPS. Magistrates Court hearing on 24th July 2018. Referred to Crown Court and trial started in November 2018	To be closed. Subject was found guilty after a four (4) day Crown Court trial. Sentenced to 12 weeks in jail but this was suspended for 12 months. Also ordered to complete a total of 180 hours of unpaid work and must pay £8,216.71 compensation to the NHS in addition the sum of £2,500 in costs.
SSP18.04	False Claim for Costs	No evidence to support allegation. Unable to trace named individual.	Closed in Qtr 1
SSP18.05	False Claim for Costs	Interview under caution on 13/4/18 - Prosecution case file submitted to CPS	Closed in Qtr 3. CPS advised not in public interest to prosecute but civil recovery of £2,434 being made via instalments
SSP19.01	Unauthorised DBS Computer Access and possible GDPR issues	Various background and internal system checks made.	Closed in Qtr 3 with various Recommendations made to Management in relation to the systems, processes and internal controls being used regarding Data Protection and those employed to carry out DBS Checks.
SSP19.02	False Claim for Costs	Enquiries with childcare provider identified poor record keeping (attendance/payments).	Closed in Qtr 3. Poor record keeping by childcare provider. However, the subject didn't return to study and was then

			withdrawn from course.
SSP19.03	Alleged False Timesheets	Initial enquiries made and then referred to BCUHB (Denbigh Stores)	Closed in Qtr 3
SSP19.04	False Claim for Costs	Initial enquiries made and then IUC carried out on 14.1.19	Subject admitted to having received monies after providing “inaccurate” personal circumstances, but claimed only had done so following advice received which cannot be disputed. Subject seeking to agree repayment plan of £10,698.

Appendix 4

Summary of Risk against the Standards of NHS Bodies (Fraud, Corruption and Bribery) as at 31st March 2019

Area of Activity	Red/ Amber/Green level
Strategic Governance	Green
Inform and Involve	Green
Prevent and Deter	Green
Hold to Account	Green
Overall Level	Green

AREA OF ACTIVITY	DAYS USED
STRATEGIC GOVERNANCE	10
INFORM AND INVOLVE	8
PREVENT AND DETER	2
HOLD TO ACCOUNT	40
TOTAL DAYS USED	60

COST OF ANTI-FRAUD, BRIBERY AND CORRUPTION WORK	
PROACTIVE COSTS	£5.600
REACTIVE COSTS	£ 11,200
TOTAL COSTS	£ 16,800

Organisation Name

NHS Wales Shared Services Partnership (NWSSP)

Director of Finance

Andrew Butler

Date

13th May 2019

SRT Process Summary

Overall Score : **GREEN**

Submitted By : Mr Craig Greenstock

Submitted Date : 13/05/2019 08:59:21

1. Sections

1.1. **General**

1.2. **Strategic Governance**

1.3. **Inform and Involve**

1.4. **Prevent and Deter**

1.5. **Hold to Account**

General

Standard	Comments
Name of the organisation	VELINDRE NHS TRUST
Annual budget of the organisation *	£ 420 million to £ 600 million
Staff headcount at the organisation including contracted employees *	3,000 to 6,000
Organisation code	RQF
Organisation/provider type *	Care Trust
Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management *	Mr Mark Osland
Region *	WALES
Date of completion of this review	15/04/2019
Name and email of the Local Counter Fraud Specialist*	Craig Greenstock - craig.greenstock@wales.nhs.uk
Name of the counter fraud provider organisation (including in-house) *	Cardiff and Vale University Health Board
Name of the Chair of the Audit Committee	Martin Veale
Email of the Chair of Audit Committee	Martin.Veale@wales.nhs.uk
Strategic Governance, Inform and Involve and Prevent and Deter days used (Maximum 3 digits)*	48
Hold to Account days used (Maximum 3 digits)*	62
Total days used for counter fraud work	110
Number of referrals received during the most recent financial year	6
Number of cases opened during the most recent financial year	6
Number of cases closed during the most recent financial year	8
Number of cases open as at 31/03/2019	4
Amount of fraud losses identified during the most recent financial year	22697
Amount of fraud losses recovered during the most recent financial year	22697
Number of criminal sanctions applied during the year	1
Number of civil sanctions applied during the year	2
Number of disciplinary sanctions applied during the year	0
Cost of counter fraud staffing per financial year - Strategic Governance, Inform and Involve and Prevent and Deter*	£13,440.00
Cost of counter fraud staffing per financial year - Hold to Account	£17,360.00
Total costs for counter fraud work	£30,800.00

Strategic Governance

No	Standard	Rating	Comments

1.1	A member of the executive board or equivalent body is responsible for overseeing and providing strategic management and support for all counter fraud, bribery and corruption work within the organisation.	GREEN	The Trust's Finance Director has delegated responsibility for overseeing and providing all aspects of such work within the organisation. Evidence to support this is contained in various documentation such as the Trust's Annual Counter Fraud Report, regular Counter Fraud Progress Reports which are tabled at Audit Committee and Board meetings in conjunction with the Trust's Policies and Procedures which relate to and support the Counter Fraud work being undertaken.
1.2	The organisation's non-executive directors and board level senior management provide clear and demonstrable support and strategic direction for counter fraud, bribery and corruption work. Evidence of proactive management, control and evaluation of counter fraud, bribery and corruption work is present. If the NHSCFA has carried out a qualitative assessment, the non-executive directors and board level senior management ensure recommendations made are fully actioned.	GREEN	There is clear evidence to support this in the form of regular Counter Fraud Progress Reports tabled at Audit Committee meetings. In addition, there have been system and policy changes implemented as a result of recommendations which have been made following reports that were to be issued to Management in relation to system weakness that have also been identified during the course of the individual Counter Fraud investigations.
1.3	The organisation employs or contracts in one or more accredited, nominated LCFSs to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery and corruption to account.	GREEN	The Trust currently employs an Accredited Counter Fraud Specialist as part of an agreed Service Level Agreement to carry out the full range of Counter Fraud work on behalf of the Trust. This individual has, throughout the year, undertaken all relevant training including any required attendance at any Regional Forums held by NHS Counter Fraud Authority and/or NHS CFS (Wales).

1.4	The organisation has carried out risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee.	GREEN	There is clear evidence to support this in the form of regular Counter Fraud Progress Reports tabled at Audit Committee meetings. In addition, there have been system and policy changes implemented as a result of recommendations made following reports that were issued to Management in relation to system weakness that have been identified during the individual Counter Fraud investigations.
1.5	The organisation reports annually on how it has met the standards set by the NHSCFA and NHS CFS Wales in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.	GREEN	The Trust produces an Annual Counter Fraud Report which is then tabled at the relevant Audit Committee meeting. In addition and as part of the NHS Counter Fraud Authority's required process, the Trust also completes a Self Review Tool (SRT) detailing the level achieved when compared to the individual Standards on Fraud, Bribery and Corruption.
1.6	The organisation ensures that those carrying out counter fraud, bribery and corruption work have all the necessary tools and resources to enable them to carry out their role efficiently, effectively and promptly. This includes (but is not limited to) access to IT systems and access to secure storage.	GREEN	The LCFS has a dedicated office together with separate room to undertake interviews under caution together with additional secure storage facilities which enables all records including confidential material to be securely stored in a lockable location. In addition, the LCFS has access to all staff groups within the Trust including but not limited to Trust Board Members, Audit Committee Chair, Independent Members, Clinicians and Senior Executives which also includes the full support of the Finance Director.

1.7	The organisation ensures that there are effective lines of communication between those responsible for counter fraud, bribery and corruption work and other key staff groups and managers within the organisation, including (but not limited to) audit, risk, finance, communications and human resources. There is evidence of positive outcomes as a result of this liaison.	GREEN	Evidence in this area includes joint working arrangements that have been established together with UK Borders, Central Criminal Investigation Unit (Fraud and Error Service) in addition to signed working protocols between the LCFS and NWSSP Recruitment together with the Trust's Workforce Department plus agreed liaison and working practices established with NWSSP Internal Audit.

Inform and Involve

No	Standard	Rating	Comments
2.1	The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption. This should cover the NHSCFA's Fraud and Corruption Reporting Line and online fraud reporting tool, and the role of the accredited counter fraud specialist. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.	AMBER	Evidence supports the LCFS in that some Fraud Awareness Sessions have taken place during the financial year across the various staff groups . These sessions are tailored to meet the needs of the specific staff groups across the Trust. Individual exit questionnaires are also completed as feedback on the session. In addition, a quarterly newsletter is produced to include details of work undertaken and successful case outcomes. As part of measuring the effectiveness of fraud awareness, an online e-learning package has been developed, the results of which are then used to determine any NHS bodies where fraud awareness may be lacking and/or is required. However, due to sickness absence, a number of planned awareness sessions had to be curtailed
2.2	The organisation has a counter fraud, bribery and corruption policy that follows the NHSCFA's strategic guidance, publicises the NHSCFA's Fraud and Corruption Reporting Line and online reporting tool, and has been approved by the executive body or senior management team. The policy is reviewed, evaluated and updated as required, and levels of staff awareness are measured.	GREEN	The Trust recently reviewed it's Policy which was then approved by the Trust Board, placed on the Trust's website and disseminated to staff via the Trust's intranet.

2.3	The organisation liaises with other organisations and agencies (including local police, local authorities, regulatory and professional bodies) to assist in countering fraud, bribery and corruption. All liaison complies with relevant legislation, such as the Data Protection Act 1998 - General Data Protection Regulation (GDPR), and with relevant organisational policies. The organisation can demonstrate improved investigative and operational effectiveness as a result of the liaison.	GREEN	Evidence includes e-mails, meeting notes, case files and progress sheets with the LCFS having liaised with key stakeholders both internally and externally. These links include, but are not limited to the Police, UK Borders, NHS CFS Wales, NWSSP Payroll Services, Local Authorities, Wales Audit Office and NWSSP Internal Audit.
2.4	The organisation has a fully implemented code of conduct that includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the code of conduct are regularly tested.	GREEN	The Trust has a Standards of Behaviour Policy which incorporates Declarations of Interest, Gifts, Hospitality and Sponsorship. This Policy outlines the roles and responsibilities for staff and monitoring of actions. A report is also produced for the Audit Committee, who then receive regular reports on Declarations of Interest, Gifts and Hospitality to ensure compliance.

Prevent and Deter

No	Standard	Rating	Comments
3.1	The organisation reviews new and existing relevant policies and procedures, using audit reports, investigation closure reports and guidance from the NHSCFA and NHS CFS Wales, to ensure that appropriate counter fraud, bribery and corruption measures are included. This includes (but is not limited to) policies and procedures in human resources, standing orders, standing financial instructions and other finance and operational policies. The organisation evaluates the success of the measures in reducing fraud, bribery and corruption, where risks have been identified.	GREEN	All Trust Policies and /or Procedures which are to be reviewed and that have any reference to Fraud, Bribery and/or Corruption require "sign off" by the LCFS as part of the review process. Once approved such documents are then disseminated across the Trust and also placed on the Intranet and Internet websites.

3.2	The organisation uses relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including proactive exercises, to address them. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, evidence of primary care work, information on outliers, recommendations in investigation reports and information from payroll. The findings are acted upon promptly.	GREEN	As part of the joint working arrangement with NWSSP Internal Audit, an agreed reporting format of any suspicion of fraud has been agreed and documented. In addition, any system weaknesses are included within the individual Internal Audit reports that are tabled at Audit Committee meetings. In addition, any Fraud Warning Notices are disseminated to key stakeholders to inform NHS staff and also take the relevant action.
3.3	The organisation issues, implements and complies with all appropriate fraud, bribery and corruption intelligence bulletins, prevention guidance and alerts issued by the NHSCFA or NHS CFS Wales. In addition, the organisation issues local counter fraud, bribery and corruption warnings and alerts to all relevant staff following guidance in the NHSCFA Intelligence Alerts, Bulletins and Local Warnings Guidance. The organisation has an established system of follow up reviews to ensure that it remains vigilant and that all appropriate action has been taken.	GREEN	The Trust is pro-active in it's approach to identifying and addressing any system weaknesses. These are then reported on and any recommendations made are implemented to ensure mitigation of any weaknesses that have been identified. The LCFS would also use FIRST to record any fraud related system weaknesses on behalf of the Trust. In addition, any Fraud Warning Notices are disseminated to key stakeholders to inform NHS staff and also take the relevant action.
3.4	The organisation ensures that all new staff are subject to the appropriate level of pre-employment checks, as recommended by NHS Employers, before commencing employment within the organisation. Assurance is sought from any employment agencies used that the staff they provide have been subject to adequate vetting checks, in line with guidance from NHS CFS Wales, NHS Employers and the Home Office.	GREEN	In conjunction with NWSSP Recruitment Department, evidence will show that anomalies with the pre-employment checks (e.g. adverse DBS, false qualification certificates etc) are referred to the LCFS for further investigation and that there are clear referral reporting lines established.

3.5	The organisation has proportionate processes in place for preventing, deterring and detecting fraud, bribery and corruption in procurement.	GREEN	The LCFS has a targeted approach to this work when delivering fraud awareness sessions. The Audit Committee has a standing agenda item in relation to Declarations of Interest to ensure that all Standing Financial Instructions are adhered to and the process is subject to regular review. The Trust also uses the NHS Shared Services Partnership (NWSSP) to undertake any procurement and/or tendering process which contains an automated checking service to ensure that appropriate checks and systems are in place that fully meet the requirement of this standard at each stage of the process.
3.6	The organisation has proportionate processes in place for preventing, deterring and detecting invoice fraud, bribery and corruption, including reconciliation, segregation of duties, processes for changing supplier bank details and checking of deliveries.	GREEN	The NWSSP are responsible for ensuring that appropriate procedures are in place throughout the NHS in Wales. Any potential alerts are then issued to key stakeholders including the Head of Procurement and the relevant Accounts Payable Managers to ensure that an effective segregation of duties exists.

Hold to Account

No	Standard	Rating	Comments

4.1	The organisation ensures that the case management system is used to record all reports of suspected fraud, bribery and corruption, to inform national intelligence. The case management system is also used to record all system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.	GREEN	FIRST is an information gathering, intelligence disseminating and case management toolkit provided by NHS CFA for the use of organisations to assist them with the management of referrals, intelligence and fraud enquiries. The system is used by Accredited Counter Fraud Specialists to ensure that compliance with the Criminal Procedure and Investigations Act 1996 (CPIA) is adhered to. FIRST is updated on a regular basis and within required timescales, recording all appropriate information as stipulated in the NHS CFA guidance issued.
4.2	The organisation uses a case management system to support and progress the investigation of fraud, bribery and corruption allegations, in line with NHSCFA guidance.	GREEN	Files are updated within the timescales. All appropriate information is recorded and cases identified for closure appropriately. The Operational Fraud Manager for NHS CFS Wales in conjunction with the Trust's Nominated Lead LCFS will review information on FIRST on a regular basis to ensure that all appropriate information is recorded timely and used to identify any investigations that require further action or files for closure. This ensures that, where there may have been a break in activity on a case the reason can be recorded to ensure compliance with due process and legislative requirements.

4.3	The organisation shows a commitment to pursuing, and/or supporting the NHSCFA and NHS CFS Wales in pursuing, the full range of available sanctions (criminal, civil, disciplinary and regulatory) against those found to have committed fraud, bribery or corruption in primary and secondary care sectors, as detailed in the NHSCFA guidance and following the advice of the Operational Fraud Manager in NHS CFS Wales.	GREEN	The LCFS has adhered to all legislative requirements and will conduct investigations, when required, in line with guidance. Appropriate advice is sought from NHS CFS Wales at the start of any investigation. All investigation files are reviewed as part of Focused Assessments and are compliant with appropriate procedures and originals kept on file. This has resulted in a range of sanctions (e.g. criminal, civil and disciplinary) and recoveries being achieved. Any findings from investigations are then used to inform policy/procedural changes and recommendations implemented. Any system weaknesses are discussed with NWSSP Internal Audit and as part of the Audit Committee process.
4.4	The organisation completes witness statements that follow best practice and comply with national guidelines.	GREEN	All witness statement will be found to be fully compliant with the relevant National File Standards and any guidance issued.
4.5	Interviews under caution are conducted in line with the National Occupational Standards (CJ201.2) and the Police and Criminal Evidence Act 1984.	GREEN	All interview under cautions will be found to be fully compliant with guidance issued, CJ201.2 and the Police And Criminal Evidence Act 1984 (PACE). The caution is explained appropriately and there is a clear understanding of conversation management and lines of questioning pursued in relation to any allegations made. The closure of the interview will also include a summary of the discussions held. This process has recently been re-enforced as part of individual sessions provided by NHS CFA trainers.

4.6	The organisation seeks to recover, and/or supports the NHSCFA and NHS CFS Wales in seeking to recover, NHS funds that have been lost or diverted through fraud, bribery and corruption, following an assessment of the likelihood and financial viability of the recovery. The organisation publicises cases that have led to successful recovery of NHS funds.	GREEN	The Trust has a Counter Fraud and Corruption Policy which has been reviewed. The document outlines the recovery processes to follow when seeking Redress. Recoveries are monitored by the Trust and further action taken if payments are missed. In addition, NHS CFS Wales would also assist, if required, in recovering any amounts of money on behalf of the Trust.

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

NHS Counter Fraud Service

NHS WALES SHARED SERVICES PARTNERSHIP COUNTER FRAUD WORK PLAN 2019 - 20

1 Background

1.1 This Work-Plan provides a basis to formulate local Counter Fraud arrangements. The tasks outlined should be considered and reviewed on an annual basis. This guidance recommends the resources necessary to undertake work effectively across the areas of action outlined in NHS Counter Fraud Policy and Procedures. These recommendations are based on an annual Quality Assurance Programme, comprising two main processes, assurance and assessment. Both of which are closely liked to the anti-fraud, corruption and bribery corruption standards set out on an annual basis by NHS Counter Fraud Authority

1.2 The Quality Assurance process includes an Annual Self- Review against the standards, which is conducted by the individual Health Body and submitted to NHS Counter Fraud Authority together with the organisation's Counter Fraud Annual Report. The Quality Assurance process is conducted by NHS Counter Fraud Authority's Quality and Compliance team in partnership with the Health Body.

1.3 This Work-Plan is applicable to all NHS Trust's, Health Boards and Hosted Bodies in Wales. The individual NHS Trust's and integrated Health Board's are responsible for planning, designing, developing and securing delivery of Primary, Community, Secondary Care services, and Specialist and Tertiary services for their areas, to meet identified local needs within the National Policy and Standards Framework as set out by the Cabinet Secretary for Health.

1.4 The reorganisation of NHS Wales came into effect on 1st October 2009 and as such NHS Counter Fraud Authority, formerly NHS Protect, maintains a commitment to supporting the new structure via this Work-Plan for the year 2019-20. Organisations are expected to formulate Work-Plans by taking a Risk Based Approach, and this guidance should be used to assist in providing a framework on which such arrangements can be developed. Future guidance will encourage organisations to formulate bespoke plans.

1.5 The Wales Audit Office, in relation to the tem-plated work-plan, previously made the following comments:

" - - - [the Template Work-plan] appears to be a comprehensive and demanding proactive programme of Counter Fraud work. If the plan is delivered to a high standard across the NHS in Wales, [it] will make a significant impact in the prevention of fraud in the NHS.

It may be worth reminding LCFS' of the importance of liaison with External Auditors when planning local Counter Fraud work in order to prevent duplication of effort. There are some elements of the Counter-Fraud Work-Plan which External Auditors may review on a risk basis as part of their own reviews of Governance Arrangements, e.g. Whistle-Blowing arrangements, Declaration of Interests; Gifts and Hospitality. External Auditors will certainly be seeking to gain assurance that Counter Fraud arrangements are robust, particularly in the light of NHS reorganisation in Wales."

The Wales Audit Office also recognised that effective delivery of the plan does represent a substantive programme of work.

1.6 The total number of suggested **pro-active and reactive days** to be allocated in 2019-20 for the NHS Wales Shared Services Partnership is **75 days**. This response has been allocated using data from previous years work and organisations in both Primary and Secondary Care Sectors.

1.7 When planning the resources for Counter Fraud work, it is important that the Health Body legislates for reactive time and this should be reflected in any contracting arrangements with Counter Fraud providers. Reactive work is highlighted in boxes throughout this Work Plan.

1.8 Pro-Active work (i.e. Strategic, Culture, Deterrence, Prevention and Detection) should not be absorbed by reactive activity or *vice versa* and to this end NHS Counter Fraud Authority strongly encourages Pro-Active work to be 'ring-fenced'. Effective Pro-Active work needs to be undertaken otherwise the Health Body may be at risk from Fraud and/or Corruption.

1.9 We appreciate that organisations can vary in size and they should use the following scale to adjust the number of days accordingly.

Number of staff	Number of Pro-Active Counter Fraud days
Less than 4,999	295
5,000 to 9,999	305
10,000 to 13,999	315
More than 14,000	325

1.10 It is important to note that, whilst this is a Work-Plan to ensure effective Counter Fraud arrangements, it is not a maximum requirement and both NHS Trusts and Health Boards are strongly urged to consider further local requirements that might result in the recommended resource levels being exceeded. This Work-Plan provides assistance when considering Counter Fraud arrangements, but it is important that bespoke plans are implemented for each organisation using a Risk Based approach (see section 2).

1.11 Organisations that fall below this guidance should be able to provide evidence as to why decisions on work planning have been taken and these should be provided to NHS Counter Fraud Authority and/or NHS CFS (Wales) upon request. It should be noted that the 75 days referred to above are specific to NWSSP and additional days are also undertaken within Velindre NHS Trust's own work-plan.

1.12 The Work-Plan is a framework on which to build robust Counter Fraud arrangements and is therefore analogous with the Annual Quality Assurance Programme and Self Risk Assessment that each NHS Trust and Health Board is then asked to submit at the end of the financial year.

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

2.1 Those who are locally based are best placed to identify and understand the Counter Fraud requirements for their organisation. The successful implementation of NHS Policy for Countering Fraud relies greatly on the success of the Local Counter Fraud Specialist (LCFS) role.

2.2 The Counter Fraud Work-Plan should be bespoke for the NHS organisation it is designed for. For example, utilising local Annual Staff Survey results will identify areas to concentrate on in terms of awareness work, whilst examination of referral data might reveal the need for increased work on prevention or highlight that greater awareness is needed in a particular area or staff group.

2.3 Meeting with key personnel within NWSSP is crucial to information gathering and, along with staff survey results, can assist in the formulation of planning and provide information on the most effective methods of communication. Responses may also indicate areas of perceived risk and this may also be supported by previous experiences which could highlight a need for Pro-Active preventative or detection work.

2.4 The LCFS should have effective liaison with the individual whom, within the NWSSP and/or Hosted Body, is responsible for managing risk. It is recommended that frauds that have occurred within the organisation and beyond be brought to this person's attention to ascertain the risk to the NWSSP and/or Hosted Body, from the same type of fraud. Once identified, the fraud can be proactively addressed.

2.5 Risks identified by the LCFS need to be placed onto the Risk Register to provide another level of assurance that the risk will be managed appropriately.

2.6 Whilst every effort should be made to identify local risks, it is also important that consideration is given to information provided from outside the organisation (for example, from NHS Counter Fraud Authority fraud alerts) and this too must be incorporated into risk-based planning in the same way that local information is.

2.7 Keeping accurate records of Counter Fraud work is crucial for successful work-planning as is utilising previous LCFS outcomes, Risk Register entries and Internal Audit Reports. The end of year Quality Assurance Programme and Self Risk Assessment also encourages accurate record keeping and accountability and these documents should also be used to identify strengths and weaknesses.

2.8 To assist organisations to take a risk-based approach to Counter Fraud work and work planning, NHS Counter Fraud Authority has issued a Risk Assessment tool to guide LCFS' to undertake a Risk Assessment of the Counter Fraud arrangements in place at their own organisation. This tool has also been designed to complement the Quality Assurance process, and provides organisations with a mechanism to review Counter Fraud arrangements prior to completing the end of year Quality Assurance Programme.

3 Focusing on outcomes and not merely activity

3.1 The Counter Fraud work that is completed at the organisation should have outcomes that are demonstrable, they might relate to successful investigations or progress being made in the proactive areas. For example, the staff survey supports progress being made in developing an Anti-Fraud Culture or that Fraud Proofing Policies has seen a cessation of referrals from that particular area. Clearly the NHS must get value for the money it spends on Counter Fraud work and in planning for the year ahead consideration needs to be given to obtaining evidence to demonstrate this is happening.

4 Work-Plan template

INFORM AND INVOLVE		
Number of allocated days for Inform and Involve 15	**Recommended task / objective**	**Outcome and Impact**
Identifying the risks and consequences of crime against the NHS, and raising awareness of these risks amongst NHS staff, stakeholders, and the public	Take part in the development of the Induction programme for all new NWSSP staff and deliver awareness presentations on Counter Fraud work to those staff.	
	LCFS is to provide all staff with their role and contact details and inform staff that such Counter Fraud presentations are available to all staff groups.	
	Review the induction pack to be distributed during NWSSP's induction process, including slides handouts, leaflets and CFS forms.	
	A programme of counter fraud awareness training to be delivered to staff at all levels within NWSSP (managerial staff, junior staff etc). The LCFS should aim to complete at least 8 presentations to staff groups. The aim of this is to ensure the Health Body is being proactive in raising fraud awareness and able to build a real anti-fraud culture. These should include presentations: • to the Audit Committee • at Staff Forums • at a Team Brief • at Management Forums • to Authorised Signatories • Counter Fraud displays as part of fraud awareness initiatives	
	Evaluate all presentations, collate results, and amend presentations as a result of feedback. Write up a report on the outcomes for the Director of Finance.	
	Review localised fraud leaflets, posters, and newsletters, to promote the anti-fraud work being undertaken within NWSSP. Distribute at appropriate locations.	

	Develop and maintain counter fraud information on NWSSP's intranet site. Having a Counter Fraud site will allow staff easy access to Counter Fraud related information. Items to include on the site are: • overview of the Counter Fraud initiative locally and nationally • Role of the LCFS • Counter Fraud Policy • Proven NHS fraud related cases • Presentation Slides • Link to NHS Counter Fraud Authority website • Link to any appropriate HR policies (including whistleblowing policy) • Counter Fraud articles • Contact details of the Lead LCFS • Feedback Form The LCFS should be able to maintain a record of the number of staff who may have visited the site.	
	Undertake and analyse one or more of the following methods to identify level of fraud awareness (**NB.** this list is not exhaustive): • staff survey (consider putting a link on the intranet) • focus groups • internet quizzes • number of hits on the Counter Fraud webpage	
	LCFS to meet with key personnel within NWSSP to discuss fraud matters including: • NWSSP Managing Director • Director of Finance and Corporate Services • Director- Employment Services • Director - Audit & Assurance • Director - Special Estates Services • Managing Solicitor/Director - Legal & Risk Services • Director - Primary Care Services • Director - Procurement Services • Director - Workforce & OD	
	Arrange for a pay-slip message to be utilised when required.	

	Undertake and/or participate in Local Fraud Awareness initiatives and events.	
	The NWSSP has an Anti-Fraud, bribery and corruption policy which has been approved by Velindre NHS Trust's Board. The policy is reviewed and updated as required.	
	Meet regularly with the Head of Internal Audit and in accordance with the agreed protocol to discuss potential system weaknesses identified during audits or investigations and highlight work being undertaken by the LCFS, e.g. National or local proactive work.	
	Regular liaison with other bodies and forums to keep updated of any local concerns and/or issues	

PREVENT and DETER		
Number of allocated days for Prevent and Deter 10	**Recommended task / objective**	**Outcome and Impact**
Discouraging those who may want to commit crimes against the NHS and ensure that such opportunities are minimised.	Meet with NWSSP's Communications staff to discuss: • NHS Counter Fraud Authority Communications & Business Development Unit (CBDU) • Publicity of Counter Fraud work • Advance Warning system • Utilise not only publicity at NWSSP but also local, regional and national cases that may be relevant.	
	Review the Communication Strategy so that the most effective ways to communicate with staff at NWSSP are utilised.	
	Intelligence bulletins and alerts issued by NHS Counter Fraud Authority and/or NHS CFS Wales are actioned and followed up to ensure that preventative measures applied have achieved their intended outcome.	

	Recommended task / objective	Outcome and Impact
	Review distribution of the annual Conflict of Interest statements and ascertain if this is sufficient to deter potential risks in this area. Are the sanctions for fraud clearly indicated on the declaration which is then required to be signed by staff?	
	Include a heading entry in the Risk Register to specifically record fraud as a risk to NWSSP. Periodically review NWSSP's Risk Register.	
	Liaise with NWSSP's Risk Management Group to establish a link between Risk and Counter Fraud work and a methodology for addressing this. The intelligence gathered should be used proactively to make Risk Assessments. Meet with managers to discuss risk areas and refer high risk areas or trends to NHS Counter Fraud Authority's Head of Risk.	
	Meet with NWSSP's Head of Corporate Services to discuss risk areas or other areas of concern	
	Establish a formal written protocol with Internal Audit for the dissemination of information for areas where control weaknesses may allow a potential fraud to remain undetected and where investigations have identified system weaknesses that may require a future Internal Audit review.	
	Fraud proof a selection of general policies, procedures and claim forms used throughout NWSSP where there is a potential risk of fraud occurring. *Policies/procedures/claim forms that could be considered for fraud proofing may include:* ➢ *Recruitment including the controls covering qualification, employment history checks and DBS checks* ➢ *Timesheets and associated procedures/policies* ➢ *Travel and associated expenses* ➢ *Security of confidential data held by NWSSP* ➢ *Recovery of overpayments/advances of pay* ➢ *Service contracts checking work completed prior to payment* ➢ *Asset verification checks (inventory and capital items)*	

	Recommended task / objective	Outcome and Impact
	➢ *Standards of Business Conduct and conflict of interest declarations* ➢ *Acceptance of gifts and hospitality* ➢ *Mobile phone policy and private phone calls* ➢ *Losses and Special Payment controls and monitoring* ➢ *Delegated ordering controls* ➢ *Authorising signatory controls* ➢ *Absence Reporting and Monitoring* *Checks to be undertaken with Internal Audit to avoid duplication of effort when looking at such documentation/policies and procedures.*	
	Use the Systems Weakness Reporting (SWR) form to inform NHS CFS (Wales) at the earliest opportunity of any system weaknesses identified during the course of investigations which have potential national implications.	

	Recommended task / objective	Outcome and Impact
	Undertake local Pro-Active Exercises at NWSSP as agreed with the Director of Finance and in conjunction with NWSSP Internal Audit Plan.	
	Provide NHS Counter Fraud Authority Central Intelligence Unit with information to support the intelligence function using the facilities provided. Information submitted may be about a person, organisation or methodology and should relate to fraud or corruption within the NHS.	

HOLD to ACCOUNT		
Number of allocated days for Hold to Account 45	**Recommended task / objective**	**Outcome and Impact**
Detecting and investigating crime, prosecuting those who have committed crimes and seeking redress as a result	Conduct investigations as required in line with Appendix 5 of the *NHS Counter Fraud and Corruption Manual*, which outlines relevant procedural investigative legislation. Interviews under caution are conducted in line with the Police and Criminal Evidence Act 1984 Witness statements follow best practice and comply with national guidelines.	
	Assist NHS Counter Fraud Authority with information as required for any regional or national fraud cases. Ensure comprehensive information to enable risk exercises to be carried out effectively is submitted in a timely manner.	
	The development (or revision) of a policy with NWSSP' Employment Services on the interaction of these parties and the application of parallel sanctions: civil, disciplinary and criminal, as outlined in the NHS policy document *Applying Appropriate Sanctions Consistently (December 2007)* should provide a framework to this work. Knowledge of this process should be delivered to and agreed by NWSSP Senior Managers in conjunction with Velindre NHS Trust and should be tested to ensure it is understood, this will assist in the message becoming embedded within the organisational culture.	
	That NWSSP shows a commitment in pursuing the full range of available sanctions and that these sanctions are applied consistently	

	That NWSSP seeks to recover any NHS monies which can be identified as having been lost and/or diverted through fraud, bribery and/or corruption.	
	That NWSSP publicises cases that have led to the successful recovery of any NHS funds which have been lost through fraud, corruption and/or bribery.	
	Identify and maintain a record of the actual proven amount of loss to NWSSP so that appropriate recovery procedures can be actioned. To ensure that NWSSP has a procedure in place to recover money.	

STRATEGIC GOVERNANCE		
Number of allocated days for Strategic Governance 5	**Recommended task / objective**	**Outcome and Impact**
Ensuring that anti crime measures are embedded at all levels across the organisation	Attendance at all LCFS meetings held by NHS CFS (Wales).	
	Completion and agreement of Work-Plan with Director of Finance.	
	Regular meetings/liaison with Director of Finance are held	
	That NWSSP reports annually on the anti fraud, bribery, and corruption work carried out and details corrective action if standards have not been met.	
	Takes active part in the collation and preparation of the hosted body's, Velindre NHS Trust, Quality Assurance programme and Self Risk Assessment Tool.	
	Preparation for and attendance at NWSSP Audit Committee meetings. (including providing regular progress reports)	
	Undertake additional related training as required by NHS CFS (Wales) and/or NHS Counter Fraud Authority. The NWSSP ensures that there are effective lines of communication and reporting between those responsible for anti-fraud, bribery, and corruption work, and key operational staff and management The NWSSP demonstrates proactive support and direction for the anti-fraud, bribery, and corruption work	

	The NWSSP has at least one or more qualified and accredited LCFS to undertake the full range of anti-fraud bribery and corruption work, and there are sufficient resources in place to allow this work to be fully supported.	
	Conduct a risk assessment on overall counter fraud bribery and corruption arrangements in place. Any identified risks are translated into NWSSP's work plan.	

Appendix 1

Number of Days agreed with NHS Wales Shared Services Partnership's Finance Director for the 2019/20 Financial Year is 75 days.

Agreed/signed by

Signature: **Date:**

ANDY BUTLER
Director of Finance & Corporate Services - NWSSP

Signature: **Date:**

CRAIG GREENSTOCK
Counter Fraud Manager - Cardiff and Vale University Health Board

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9th July 2019
AGENDA ITEM	
REPORT PREPARED BY	Craig Greenstock, Counter Fraud Manager
PRESENTED BY	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Counter Fraud Progress Report as at 30th June 2019

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 30th June 2019, 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 - 9th July 2019

Counter Fraud Progress Report
as at 30th June 2019

CRAIG GREENSTOCK
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

NHS WALES SHARED SERVICES PARTNERSHIP

AUDIT COMMITTEE 9th JULY 2019

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 30th June 2019.

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 30th June 2019, **20days 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 three (3) cases currently under investigation, one of which is an ongoing civil recovery due to a lengthy repayment period. A verbal update on the progress made in the other case will be given to the Audit Committee.

3. PROGRESS AND GENERAL ISSUES

3.1 Fraud Awareness Presentations

During the first quarter, a total of three (3) separate fraud awareness sessions have been held in conjunction with staff based within the various Divisions.

Of the sessions held to date, these included one (1) session to staff as part of an induction day and two (2) further sessions that were carried out in Companies House and Matrix House respectively.

APPENDIX 1

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2019/20

AREA OF WORK	NWSSP	Days to Date
General Requirements		
Production of Reports to Audit Committee	3	0.5
Attendance at Audit Committees	3	0.5
Planning/Preparation of Annual Report and Work Programme	5	5
Annual Activity		
Creating an Anti Fraud Culture	4	0
Presentations, Briefings, Newsletters etc.	14	4
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. Procurement)	8	5
National Fraud Initiative 2018/19	2	1
Investigation, Sanctions and Redress		
The investigation of any alleged instances of fraud	25	4
Ensure that Sanctions are applied to cases as appropriate	4	0
Seek redress, where fraud has been proven to have taken place	2	0
TOTAL NWSSP	**75**	**20**

APPENDIX 2

COUNTER FRAUD ASSIGNMENT SCHEDULE 2019/20

Case Ref	Subject	Status	Open/Closed
SSP14.05	Unauthorised Sale of NHS Property	Crown Court Hearing (Suspended Sentence) Civil Recovery (5k) still being made at £50 per month	Open - Balance o/s £2524.25
SSP19.04	False Claim for Costs	Initial enquiries made and then IUC carried out on 14.1.19	Subject admitted to having received monies after providing "inaccurate" personal circumstances, but claimed only had done so following advice received which cannot be disputed. Prosecution file submitted to CPS for a legal opinion. Payment plan to recover £10,698.
SSP20.01	Forged Letter	Initial enquiries made and matter was referred back to Swansea University to investigate in relation to the validity of the letter.	Closed - no fraud against NHS.
SSP20.02	False Claim for Costs	Initial enquiries made which identified that the claim had actually been made as a single person with no dependent children and not as a married person with dependent children as was the allegation received.	Closed - no fraud identified.
SSP20.03	False Claim for Costs	Alleged that the subject has claimed for grant/bursary but is also working for the NHS on an agency basis which she has then failed to declare	Ongoing enquiries and subject also suspended for academic reasons.

Counter Fraud - Lessons Learned Report

AUDIT COMMITTEE

DATE OF MEETING	9th July 2019
PREPARED BY	Craig Greenstock - Counter Fraud Manager
PRESENTED BY	Craig Greenstock - Counter Fraud Manager
EXECUTIVE SPONSOR	Andrew Butler - Director of Finance and Corporate Services

REPORT PURPOSE	For Noting, Approval and Discussion

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING:		
NAME OF COMMITTEE OR GROUP	**DATE**	**OUTCOME**
n/a	n/a	n/a
ACRONYMS	NHS - National Health Service LCFS - Local Counter Fraud Specialist NWSSP - NHS Wales Shared Services Partnership NFI - National Fraud Initiative DWP - Dept of Works & Pensions POCA - Proceeds of Crime HMRC - Her Majesty's Revenue and Customs LA - Local Authority CPS - Crown Prosecution Service IUC - Interview under Caution	

1. SITUATION/BACKGROUND

The purpose of this report is to provide the Audit Committee with an update of any lessons that have been learned from undertaking fraud investigations within the Health Body and also other NHS Bodies in Wales.

2. CONCLUSION

It is important that any organization ensures that where any fraud is identified and/or suspected to have taken place that not only is it thoroughly investigated and any monies recovered, but also that procedures and policies are reviewed and/or changed in addition to control systems being put in place to ensure that any future opportunities to commit fraud are reduced to zero.

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

The Committee is therefore asked to:

- **RECEIVE** and **DISCUSS** the “Lessons Learned” Report
- **NOTE** the progress made to date

NHS WALES SHARED SERVICES PARTNERSHIP

Audit Committee - 9th July 2019

Counter Fraud Report on Lessons Learned

CRAIG GREENSTOCK
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

NHS WALES SHARED SERVICES PARTNERSHIP

AUDIT COMMITTEE 9th JULY 2019

Counter Fraud Report on Lessons Learned

1. Introduction

2. Sharing Lessons Learned

Mission Statement

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

1. INTRODUCTION

There is a need to ensure that the Velindre University NHS Trust and its' hosted bodies, including NHS Wales Shared Services Partnership, have robust policies and procedures in place to ensure that fraud is deterred in order to protect public money and also to assure the individual Audit Committees that control systems and a clear audit trail is in place whereby should a fraud be suspected and/or identified, then it can be reported and investigated correctly and in accordance with the relevant guidelines.

A key part of this process is that should a fraud be identified and investigated, any subsequent findings are then reported to the Director of Finance, so that recommendations can be made to close any weaknesses and so that lessons can be learnt and best practice then shared across the Health Body. This learning should be measurable and any changes made must then be open to audit scrutiny.

Where required and to ensure that lessons learnt and good practice is shared across the Health Body, then there has to be an agreed approach so that it can clear identify that lessons have been identified, implemented and monitored through audit not only at management level, but also from a governance prospective to determine the robustness of any such arrangements.

2. LESSONS LEARNED

Each fraud investigation is different and has to be taken forward on it's own merits and whilst every case does require a closure report which is then signed off prior to closure, by NHS Counter Fraud Service (Wales), not every investigation requires an action plan.

In the case of Velindre University NHS Trust, there has been a varied range of referrals, but the majority of investigations, over the last five (5) years, have been in relation to false claims made for funding to NHS Student Finance in respect of bursaries, grants and loans for nurse training courses.

False Claims for Costs

Whilst there has been a reduction in the number of cases being reported over the last couple of years that resulted following a change in the claim process from paper based to on-line, there have still been further recent cases, referred to NHS Counter Fraud, whereby the claimant has then provided false and/or misleading information as to his/her personal circumstances and these would have been take into account when calculating the amount of the claim and what payments could be made to the claimant.

Overpayment of Salary

There has been a recent batch of such cases being referred to NHS Counter Fraud whereby the subject, despite moving to another NHS post, has then received salary payments as a result of non-completion, by his her Line Manager, of the required paperwork (e.g. termination form, reduction in hours etc). In one of the recent cases, this resulted in a significant overpayment that then led to a criminal prosecution and ongoing recovery of the money.

The main lessons to be learned from these types of cases are as follows:

- Managers to ensure that Staff Termination are completed in a timely fashion
- Managers to ensure that their Budget Reports are reviewed on a monthly basis to identify any significant budgeted expenditure to actual anomalies
- Managers to ensure that their Staff in Post Reports are reviewed on a monthly basis to identify any leavers and/or “Ghost” employees.

Working Elsewhere whilst claiming to be on Sickness Absence

The main lessons to be learned from such investigations are for Managers to ensure that should a member of staff report a sickness absence, then the required forms (Self Certification and Medical Certificates) are completed and submitted on a timely basis.

In addition to this and should an employee be on Long Term Sickness Absence, then the procedure for dealing with such issues is then closely followed.

As a result and should there be any suspected fraud (e.g. working elsewhere), then there would be a clear audit trail in the subject personal file together with documentation that has been signed, dated etc which could then be used as part of any subsequent investigation.

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MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	6.1
PREPARED BY	Roxann Davies, Compliance Officer
PRESENTED BY	Roxann Davies, Compliance Officer
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Audit Committee Forward Plan 2019-20

PURPOSE

To provide a summary of items expected to be presented at forthcoming Audit Committee meetings, scheduled for 2019-20.

Month	Standing Items	Audit Reports	Governance	Annual Items
Q3 2019/20 **22 October 2019** *Boardroom* *NWSSP HQ, Unit 4/5* *Charnwood Court, Heol* *Billingsley, Parc Nantgarw,* *Cardiff, CF15 7QZ*	Minutes & Matters Arising External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** As outlined in the Internal Audit Operational Plan	Governance Matters to include Annual Review of Stores Write-Off Figures Tracking of Audit Recommendations to include Annual Review of Audit Recommendations Not Yet Implemented Corporate Risk Register Cyber Security Presentation	Minutes & Matters Arising Review of Risk Management Protocol, Assurance Mapping, Appetite Statement and Board Assurance Framework NWSSP Annual Review Including Sustainable Development Statement
Q4 2019/20 **21 January 2020** *Boardroom* *NWSSP HQ, Unit 4/5* *Charnwood Court, Heol* *Billingsley, Parc Nantgarw,* *Cardiff, CF15 7QZ*	Minutes & Matters Arising External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**External Audit** Wales Audit Office Proposed Audit Work **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 Review of Standing Orders for the Shared Services Partnership Committee Draft Integrated Medium Term Plan (IMTP) Summary & Overview
Q1 2020/21 **TBC April 2020** *Boardroom* *NWSSP HQ, Unit 4/5* *Charnwood Court, Heol* *Billingsley, Parc Nantgarw,* *Cardiff, CF15 7QZ*	Minutes & Matters Arising External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** As outlined in the Internal Audit Operational Plan Head of Internal Audit Opinion Review of Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register	Audit Committee Effectiveness Survey Annual Governance Statement Counter Fraud Self-Review Submission Tool Counter Fraud Work Plan Counter Fraud Annual Report

				Counter Fraud Policy Review Integrated Medium Term Plan (IMTP) Review of Raising Concerns (Whistleblowing) Policy Head of Internal Audit Opinion and Annual Report
Q2 2020/21 **TBC July 2020** *Boardroom* *NWSSP HQ, Unit 4/5* *Charnwood Court, Heol* *Billingsley, Parc Nantgarw,* *Cardiff, CF15 7QZ*	Minutes & Matters Arising External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**External Audit** Wales Audit Office Nationally Hosted IT Systems Report Wales Audit Office Management Letter **Internal Audit** As outlined in the Internal Audit Operational Plan Quality Assurance & Improvement Programme	Governance Matters Tracking of Audit Recommendations Corporate Risk Register	Counter Fraud Self-Review Submission Tool Counter Fraud Work Plan Counter Fraud Annual Report Results of Audit Committee Effectiveness Survey Review of Audit Committee Terms of Reference Audit Committee Annual Report Health and Care Standards Self-Assessment and Action Plan Caldicott Principles Into Practice Annual Report

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit of Financial Statements Report – **Velindre University NHS Trust**

Audit year: 2018-19

Date issued: May 2019

Document reference: 1271A2019-20

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

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

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

The team who delivered the work comprised Ann-Marie Harkin, Gillian Gillett, Kath Watts and the Velindre University NHS Trust audit team.

Contents

The Auditor General intends to issue an unqualified audit report on your 2018-19 financial statements. There are some issues to report to you prior to the Board's approval of the financial statements.

Summary report

Appendices

Summary report

Introduction

1 The Auditor General is responsible for providing an opinion on whether the financial statements give a true and fair view of the financial position of Velindre University NHS Trust (the Trust) at 31 March 2019 and its income and expenditure for the year then ended.

2 We do not try to obtain absolute assurance that the financial statements are correctly stated, but adopt the concept of materiality. In planning and conducting the audit, we seek to identify material misstatements in your financial statements, namely, those that might result in a reader of the accounts being misled.

3 The quantitative levels at which we judge such misstatements to be material for the Trust are £5.3 million. Whether an item is judged to be material can also be affected by certain qualitative issues such as legal and regulatory requirements and political sensitivity.

4 International Standard on Auditing (ISA) 260 requires us to report certain matters arising from the audit of the financial statements to those charged with governance of a body in sufficient time to enable appropriate action.

5 This report sets out for consideration the matters arising from the audit of the financial statements of Velindre University NHS Trust, for 2018-19, that require reporting under ISA 260.

Status of the audit

6 We received the draft financial statements for the year ended 31 March 2019 on 26 April 2019, in line with the Welsh Government's agreed deadline and have now substantially completed the audit work.

7 We are reporting to you the more significant issues arising from the audit, which we believe you must consider prior to approval of the financial statements. The audit team has already discussed these issues with Director of Finance and his team.

Proposed audit report

8 It is the Auditor General's intention to issue an unqualified audit report on the financial statements once you have provided us with a Letter of Representation based on that set out in Appendix 1.

9 The proposed audit report is set out in Appendix 2.

Significant issues arising from the audit

Uncorrected misstatements

10 During our audit, one misstatement was identified in the financial statements, which remains uncorrected. We do not consider this to be material to our audit opinion:

- the inventory balance is understated by up to a maximum of £456,000 and creditors correspondingly understated as a result of goods received into the IP5 store at the end of March 2019 being receipted onto the Oracle financial system in April 2019. This misstatement has no impact on the Trust's retained surplus for the year but would if corrected impact on other statements and notes – notably the Statement of Cashflows, Notes 16.1, 20 and 30.

11 Whilst Auditing Standards require us to request that this is corrected, we accept management's view that given the relatively low values and the tight timescale for closure of the audit, there is little benefit in amending the financial statements.

Corrected misstatements

12 There are misstatements which have been corrected by management, but which we consider should be drawn to your attention due to their relevance to your responsibilities over the financial reporting process. They are set out with explanations in Appendix 3. The amendments to the financial statements are minor by nature and there is no impact on the Trust's reported surplus.

Other significant issues arising from the audit

13 In the course of the audit we consider a number of matters both qualitative and quantitative relating to the accounts and report any significant issues arising to you.

We have no significant concerns about the qualitative aspects of your accounting practices and financial reporting

14 We found the information provided in the draft financial statements to be relevant and reliable. We also concluded that your accounting policies and estimates are appropriate and financial statement disclosures unbiased, fair and clear.

15 The draft financial statements were prepared to a good standard and were supported by good quality working papers which were generally provided on a timely basis, helping us to complete the audit within the required deadline.

We did not encounter any significant difficulties during the audit

16 There were no significant difficulties during the audit. To facilitate the audit process, we agreed 'audit deliverables' with management and have had continued engagement throughout the accounts production and audit process, which has been very helpful.

There were no significant matters discussed and corresponded upon with management which we need to report to you

17 There were no significant matters discussed and corresponded upon with management which we need to report to you.

There are no other matters significant to the oversight of the financial reporting process that we need to report to you

18 The Trust is required to prepare and include in its Accountability Report an Annual Governance Statement which sets out the Trust's governance structures, systems of internal control and risk management and the effectiveness of these systems in operation during the year. We reviewed the Statement to consider its consistency with Manual for Accounts requirements and with other information known to us from our audit work. We identified a number of minor narrative and presentation adjustments, which have been reflected in the final Statement, and we will continue to work with management to further develop the Statement in future years.

19 We have not identified any other matters significant to the oversight of the financial reporting process which we need to report to you.

We did not identify any material weaknesses in your internal controls

20 We have considered internal controls that are relevant to the preparation of the financial statements in order to design appropriate audit procedures, but not for the purpose of expressing an opinion on the effectiveness of internal control. We have not identified any matters which are material to the accuracy and completeness of the financial statements.

There are not any other matters specifically required by auditing standards to be communicated to those charged with governance

21 There are no other matters (such as those relating to fraud, compliance with laws and regulations, or subsequent events) that we need to report to you.

Independence and objectivity

22 As part of the finalisation process, we are required to provide you with representations concerning our independence.

23 We have complied with ethical standards and in our professional judgment, we are independent and our objectivity is not compromised. There are no relationships between the Wales Audit Office and Velindre University NHS Trust that we consider to bear on our objectivity and independence.

Appendix 1

Final Letter of Representation

Auditor General for Wales

Wales Audit Office

24 Cathedral Road

Cardiff

CF11 9LJ

28 May 2019

Representations regarding the 2018-19 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Velindre University NHS Trust for the year ended 31 March 2019 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts' directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Velindre University NHS Trust will continue in operation.
- ensuring the regularity of any expenditure and other transactions incurred.
- the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- our knowledge of fraud or suspected fraud that we are aware of and that affects Velindre University NHS Trust and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- the identity of all related parties and all the related party relationships and transactions of which we are aware.
- our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

Significant assumptions used in making accounting estimates, including those measured at fair value, are reasonable.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

All contingent liabilities have been identified and properly assessed. Contingent liabilities are considered to be not material to the financial statements

The financial statements are free of material misstatements, including omissions. The effects of an uncorrected misstatement identified during the audit is immaterial to the financial statements taken as a whole. A summary of this item is set out below:

- the inventory balance is understated by £456,000 and creditors correspondingly understated as a result of goods received into the IP5 store at the end of March 2019 being receipted onto the Oracle system in April 2019.

Representations by those charged with governance

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for ensuring that the Trust maintains adequate accounting records.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Velindre University NHS Trust on 28 May 2019.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Chief Executive as Accountable Officer	Chair of Trust Board
28 May 2019	28 May 2019

Appendix 2

Proposed audit report of the Auditor General

The Certificate and independent auditor's report of the Auditor General for Wales to the National Assembly for Wales

Report on the audit of the financial statements

Opinion

I certify that I have audited the financial statements of Velindre University NHS Trust for the year ended 31 March 2019 under Section 61 of the Public Audit (Wales) Act 2004. These comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement and the Statement of Changes in Tax Payers Equity and related notes, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and HM Treasury's Financial Reporting Manual based on International Financial Reporting Standards (IFRSs).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Velindre University NHS Trust as at 31 March 2019 and of its surplus for the year then ended; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)). My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I am independent of the Trust in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Chief Executive has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Chief Executive is responsible for the other information in the annual report and accounts. The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the National Assembly for Wales and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Report on other requirements

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the information given in the Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and the Governance Statement has been prepared in accordance with Welsh Ministers' guidance;
- the information given in the Foreword and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and the Foreword and Accountability Report have been prepared in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, I have not identified material misstatements in the Foreword and Accountability Report or the Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- proper accounting records have not been kept;
- the financial statements are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed; or
- I have not received all the information and explanations I require for my audit.

Report

I have no observations to make on these financial statements

Responsibilities

Responsibilities of Directors and the Chief Executive

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities [set out on pages ... and ...], the Directors and the Chief Executive are responsible for the preparation of financial statements which give a true and fair view and for such internal control as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors and Chief Executive are responsible for assessing the trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Responsibilities for regularity

The Chief Executive is responsible for ensuring the regularity of financial transactions.

I am required to obtain sufficient evidence to give reasonable assurance that the expenditure and income have been applied to the purposes intended by the National Assembly for Wales and the financial transactions conform to the authorities which govern them.

Adrian Crompton
Auditor General for Wales
11 June 2019

24 Cathedral Road
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CF11 9LJ

Appendix 3

Summary of corrections made to the draft financial statements which should be drawn to the attention of those charged with governance

During our audit the following misstatements were identified which have been corrected by management. We consider they should be drawn to your attention due to their relevance to your responsibilities over the financial reporting process.

Exhibit 1 – summary of corrections made to the draft financial statements

Value of correction	Nature of correction	Reason for correction
£312,000	**Note 13 - Property, plant and equipment** Decrease transport equipment disposals other than by sale with a corresponding decrease in depreciation. No impact on surplus for the year.	Assets re-classified as held for sale in 2017-8 were included in the asset register but were sold in 2018-19.
£62,000 Revenue increased	**Note 23 – Provisions** Additional provision made by one health body. This also resulted in a corresponding increase in expenditure and income. No impact on surplus for the year.	Late amendment made by health body that was not reflected in the draft accounts submitted.
£500,000	**Note 23 – Provisions** Classification error between current and non-current clinical negligence and defence costs provisions. No impact on surplus for the year.	Audits of the underlying provisions at health bodies identified amendments where non-current provisions had been incorrectly classified as current provisions
£1,235,000	**Note 24.1 – Contingent liabilities** Decrease legal claims for alleged medical negligence with a corresponding decrease in amounts recovered under insurance arrangements. No impact on surplus for the year.	Audits of the underlying contingent liabilities at health bodies identified corrections needed to agree back to supporting systems.

Value of correction	Nature of correction	Reason for correction
£6,810,000	**Note 24.2 – Remote contingent liabilities** Increase remote contingent liabilities. No impact on surplus for the year.	Audits of the underlying remote contingent liabilities at health bodies identified corrections needed to agree back to supporting systems.
£5k	**Remuneration report – single total figure of remuneration** Increase other remuneration banding of medical director and salary banding for non-executive director.	Remuneration was incorrectly disclosed
Various	**Remuneration report – pension disclosures** Amendments made to cash equivalent transfer value (CETV) figures for all disclosed employees	Real increase in CETV not calculated in line with guidance.

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MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 July 2019
AGENDA ITEM	6.5
PREPARED BY	Tim Knifton, Information Governance Manager
RESPONSIBLE HEAD OF SERVICE	Peter Stephenson, Head of Finance and Business Development
TITLE OF REPORT	NWSSP Freedom of Information Act (2000) Annual Report for 2018/19
PURPOSE To provide the Audit Committee with an update as to the Freedom of Information Requests received during 2018/19, for information only.	

1. Introduction and Background

The Freedom of Information (FOI) Act 2000 provides a right to access official information and confers two statutory responsibilities on public authorities:

- The duty to confirm or deny whether the information requested exists; and if so,
- The duty to communicate the information, subject to a limited range of exemptions.

The Freedom of Information Act 2000 provides public access to information held by public authorities. The Act covers any recorded information that is held by a public authority including NHS organisations. Recorded information includes printed documents, computer files, letters, emails, photographs, and sound or video recordings.

The main principle behind FOI is that people have a right to know about the activities of public authorities, unless there is good reason for them not to. Under both legislations individuals have a right to request any recorded information held by a public authority. Any information it is thought may be held can be requested.

A request can be in a form of a question, rather than a request for specific documents, but questions do not have to be answered if this would mean creating new information of giving an opinion or judgment that is not already recorded. Some information may not be given because it is exempt, for example because it would unfairly reveal personal details about someone else.

The FOI legislation continues to be used widely and there has been a year on year increase in the number of requests received. In addition to the volume of requests increasing, the requests are now also becoming far more complex in

nature; the impact of this is that requests can take significantly longer to process.

2. Responsibilities

Management of the arrangements to comply with the Freedom of Information Act within NWSSP is the responsibility of the Director of Finance and Corporate Services with the day to-day management being the responsibility of the Head of Finance & Business Development and the Information Governance Manager to ensure that all legal requirements are met.

3. Response within statutory time limits

Public authorities must reply to Requests for Information under FOIA within **20 working days** to comply with statutory time limits.

Between April 2018 and March 2019, Corporate Services received a total of **59** Requests for Information. Of these, 14 were transferred out to the Health Boards and 13 were transferred to Velindre with information to provide a hosted organisation wide response.

Receipt of requests April 2018 to March 2019

Service	No of Requests	Percentage of Requests received
Corporate Services	8	13.6%
Employment Services	2	3.6%
Finance/WIBBS	2	3.6%
Health Boards/Trusts	4	6.8%
Informatics	3	5%
Legal & Risk Services	1	1.8%
Primary Care Services	19	32%
Procurement Services	12	20%
Procurement/Finance	1	1.8%
Workforce	6	10%
Workforce, Employment, Corporate and Finance	1	1.8%
Total	**59**	**100%**

Response times in days April 2018 to March 2019

Month	1-5	6-10	11-15	16-20	21+	Total
April 2019	2	1			-	3
May	4	2	1	2	-	9
June		1			-	1
July					-	0
August		2		1	-	3
September	2	1	1	2	-	6
October	3	3	1	3	-	10
November	6	6			-	12
December	1				-	1
Jan 2019	1	1		1	-	3

February	1		1	2	-	4
March	1	3	1	2	-	6
Total	**21**	**20**	**5**	**13**	**0**	**59**

The tables above show the number and percentage of requests received per department and the number and percentage responded to on time. Full details of the requests received for the entire 2018/19 financial year are attached in **Appendix A.**

4. Refusals, Exemptions, Internal Reviews and Information Commissioner's Office enquiries

The FOIA contains exemptions that allow public authorities to withhold information in certain cases. Should a customer be unhappy with the content of the response received, the exemption applied, or they are dissatisfied with the length of time it has taken to process, they can ask for an Internal Review of their request. Internal review requests should be responded to within 40 working days. The Corporate Services Team policy is to provide a response to Internal Review requests within 20 working days and where this is extended to the optimum amount of 40 working days the requestor is advised.

Should the requester remains dissatisfied with the Corporate Services response to their internal review request or their complaint they can approach the Information Commissioner's Office (ICO) to ask them to review the decision.

In the financial year, 2018/19 there was one (1) referral made to the Information Commissioner's Office (NWSSP ref: 49-18), December 2018. This is being handled by the Complaints officer for the organisation.

5. Disclosure Log

The definition of a disclosure log is a web page or a document that publishes a list of documents that an organisation has already released under the Freedom of Information Act 2000.

The rationale for disclosure logs is that if one person has expressed an interest in accessing particular documents then the same documents might be of interest to the wider community. Disclosure logs provide access to information for people who want to access the same documents as a previous applicant, and who would otherwise have needed to submit their own formal request for access, with the associated processes and timeframes.

Disclosure logs also provide an opportunity for an organisation to publish documents with associated supporting information, explaining issues of public interest in greater depth.

NWSSP has produced Disclosure Logs detailing requests back from 2015. These highlight the request received, the description of this and the date a response was given.

To date, NWSSP has not received any communication (queries or questions) in relation to a request that has been published in a disclosure log.

NHS Wales Shared Services Partnership (NWSSP)

CALDICOTT: PRINCIPLES INTO PRACTICE (C-PIP)

OUT-TURN REPORT 2018/19 &

IMPROVEMENT PLAN 2019/20

Version No. v0.1
Status: Draft

Author: Tim Knifton
Approver: IGSG/SMT

Date: 1/3/2019
Next Review Date: in line with new toolkit (2019)

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Change Control

Version	Handler	Details	Date
V0.1	Tim Knifton	Review and comparison of 2017/18 assessment	March 2019
	Tim Knifton	Draft of new assessment to reflect 2018/19 arrangements	March 2019

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EXECUTIVE SUMMARY

The objective of the NHS Wales Shared Services Partnership (NWSSP) Caldicott Out-Turn Report 2018/19 and the accompanying 2019/20 Improvement Plan is to demonstrate NWSSP has 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 2018/19** 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 (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 that addressed the General Data Protection Regulations (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.

Any shortfalls and areas that require improvements will be transferred and incorporated within the 2019/20 NWSSP Caldicott Improvement Plan.

The **Caldicott Out-Turn Report 2018/19** 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 2018/19 reporting period is **98%**, which is a 2% improvement on the previous year. Compliance in the development of an Information Asset Register (IAR) and appointing volunteers to the roles of Information Asset Administrator and Owner (IAA's/IAO's) has been reflected in this score.
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 2019/20** 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 two 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.

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 2018/19 Caldicott assessment, along with the key improvements that need to be considered.

1. NWSSP CALDICOTT OUT-TURN REPORT 2018/19

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 advising 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, the Audit Committee, Velindre IG and IM&T Committee and other specific, appropriate 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 from the NWSSP 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 the Medical Director, NHS Wales Informatics Service (NWIS), which is another part of the hosted service arrangement.

1.3 NWSSP C-PIP Self-Assessment 2018/19

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 be 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 2018/19, 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 **2018/19** reporting period NWSSP scored **98%** (scoring 64.5 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.

The improvement on the **2017/18 assessment (scored at 96%)** is due to the creation and establishment of a full Information Asset Register for the organisation, which satisfies this area that formed part of the General Data Protection Regulation readiness for the organisation.

1.5 C-PIP Score Comparison

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

- Fully compliant on **36**;
- Partially compliant on **2**; 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, Senior Information Risk Owner and Information Governance roles and responsibilities;
- An established culture of Information Governance Steering Group meetings that provide support and cascades 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);
- The preparation undertaken within Information Governance to comply with the rollout of the General Data Protection Regulations (GDPR) in May 2018;
- An effective Information Governance training regime for all NWSSP staff;
- The assurance of effective reporting arrangements;
- An Information Asset Register and Information Asset Administrators and Owners (IAAs/IAOs);
- 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 2019/20

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 2019/20 Improvement Plan** that are presented in **Appendix B**. These provide an in depth analysis of all the necessary standards and their subsequent management action points.

A summary of the two points that need to be addressed are:

- A fully tested organisational Business Continuity and Disaster Recovery plan must be developed and in place (these are in place but remain untested); 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. The Information Governance Manager is responsible for the completion of the assessment and this report based on the answers to the assessment questions. This is usually completed following a review of the previous assessment and monitoring any progress that 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.

However, it is important to note that there is a new toolkit in development by NHS Wales Informatics Service (NWIS) that will include a more developed and detailed assessment of Caldicott compliance. To add some context, the toolkit is being developed by an NWIS Task & Finish Group specifically revising and updating to reflect arrangements that NHS England has for its assessment processes.

Therefore, NWSSP will complete a new assessment for 2019/20 when this has been agreed and launched later in 2019 (date to be announced). This should ensure that the NWSSP is completing their assessments at the same time as other NHS Wales organisations.

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) and other appropriate forums as required.

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 2018/19

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 the Medical Director at NHS Wales Informatics Service (NWIS). The Medical Director is a senior member of staff and sits on the management board and/or equivalent of the hosted organisation under Velindre NHS Trust. Within the NWSSP, the 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) when required. 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 and information is cascaded to Velindre NHS 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 that was completed before the 25th May 2018 deadline. These have been and are continued (where appropriate) to be tabled at the IG Steering Group and the Senior Management Team. The Caldicott Guardian is aware of the work of the NWSSP Information Governance function as part of hosted arrangements.

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 for guidance.
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	There are appropriate mechanisms in place within NWSSP to ensure compliance with legislation and responsibilities defined under the General Data Protection Regulation (GDPR), the Caldicott Report and other associated legislation and codes of practice. Privacy Notices have been developed for Service Users and staff across the organisation.

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 Information Governance Manager has identified and scored risks relating to IG and a register exists for NWSSP that is reviewed and updated as required. Any risks categorised as being "red" are discussed at the SMT for consideration on whether the risks need to be captured on the overarching corporate risk register. Corporate risk features as a standing agenda item for both the 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 Information Governance Manager has a developed Confidentiality Breach Incident Reporting procedure in place that was approved by both 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/or 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 2018.
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. Thorough audits have been completed for the various repositories within NWSSP within 2016 and are underway in 2019.

Number	Assessment Standard	NWSSP Response	Score	Comments
M4	Does the organisation have an accurate and up to date Notification to the Information Commissioner under current Data Protection Legislation?	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.
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.

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 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 NWSSP has a complete Business Continuity Plan and Business Impact Assessment. The NWSSP are proposing to move away from local plans to a consistent corporate approach. However, each department does have (or will have) its own action cards for specific circumstances.

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 current Data Protection Legislation 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 for information for any request NOT involving patient data. This is the responsibility of the Information Governance Manager. Health Records requests in Mamhilad, Pontypool handle patient information and deceased record requests.
IP2	Do you tell patients and service users about the ways in which their information will, or may be used?	Compliant	2/2	A task and finish group developed a new "Your Information, Your rights" guidance document and posters that were based on previous information that was provided to patients and service users. This was updated to reflect the General Data Protection Regulation (GDPR) and the need to inform service users. A privacy notice (PN) already exists for NWSSP staff that was approved earlier in 2017. Further PNs were developed for areas such as Workforce, Payroll, Recruitment and Pensions before May 2018 and approved for use.

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 handout 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. There is also a "Training Network" that has been set up for all trainers within NWSSP.

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 2017 and the feedback received was positive with very minor recommendations to strengthen IG training. These actions have now been completed. 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 annually. 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 tailored and delivered as required, and training is offered every month. This is a rolling programme for all staff employed within the organisation. The recommendation is for staff to attend every 2 years.

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 2017 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. 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 1,600 employees since January 2016 (as at March 2019).

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 is continually scored at 90% or over for the whole of NWSSP. The compliance rate will never achieve 100% due to the configuration of some services within NWSSP (Health Courier Services for example) and the timing of new starters completing the toolkit. 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?	Compliant	2/2	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 is an area that continues to receive focus. All departments and divisions within NWSSP have completed an information asset register and are encouraged to continue to review this on an ongoing basis.

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.
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. Any transfers of data will be subject to scrutiny in the event of a no-deal Brexit.
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.

Number	Assessment Standard	NWSSP Response	Score	Comments
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.

Number	Assessment Standard	NWSSP Response	Score	Comments
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 over 90% of Shared Services' laptop and desktop estate. Whole disk encryption is applied to all these machines. Except for certain authorised individuals, a policy enforces the encryption of removal media on NWIS supported devices. The remainder 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.
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.

Number	Assessment Standard	NWSSP Response	Score	Comments
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.

NWSSP Caldicott Improvement Plan 2019/20

Assessment Standard		Management Action	Responsible Directorate	Objective Owner	Implementation Date	Progress (Traffic Light)	Comments	Cross Reference (H & C Stds & Other)
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	July 2019		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
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	July 2019		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