VELINDRE NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP

TUESDAY 5 JUNE 2018 / 1.30pm – 4.00pm

NWSSP HEADQUARTERS – CHARNWOOD COURT, NANTGARW

AGENDA

ITEM NO.	ITEM	DOCUMENT	PRESENTED BY
PART A			
PRESENTATIONS / BRIEFINGS			
0.1	Results of the Audit Committee Effectiveness Survey	Presentation	Roxann Davies
STANDARD BUSINESS			
1.1	Welcome and Opening Remarks	(Verbal)	Martin Veale
1.2	Apologies	(Verbal)	Martin Veale
1.3	Declarations of Interest	(Verbal)	Martin Veale
1.4	Minutes from meeting held on 24 April 2018		Martin Veale
1.5	Matters Arising		Martin Veale
ASSURANCE, RISK & GOVERNANCE			
2.1	Governance Matters		Andy Butler
2.2	Tracking of Audit Recommendations		Peter Stephenson
2.3	Review of NWSSP Risk Management Protocol		Peter Stephenson
2.4	Annual Governance Statement		Peter Stephenson
INTERNAL AUDIT			
3.1	Head Of Internal Audit Annual Report and Opinion 2017-18		James Quance

3.2	Internal Audit Review of Audit Tracker		Sophie Corbett
3.3	Corporate Governance Internal Audit Report		Sophie Corbett
3.4	Payroll Services Internal Audit Report		Sophie Corbett
3.5	Surgical Materials Testing Laboratory (SMTL) Internal Audit Report		Sophie Corbett
3.6	Performance Management Internal Audit Report		Sophie Corbett
3.7	Internal Audit Operational Plan 2018-19		James Quance
EXTERNAL AUDIT			
4.1	Wales Audit Office Position Statement		Gillian Gillett
COUNTER FRAUD			
5.1	Counter Fraud Draft Work Plan 2018-19		Andy Butler
NEW REPORTS			
6.1	No Purchase Order, No Pay Policy		Andy Butler
6.2	Transfer of Management of Redress		Andy Butler
ITEMS FOR INFORMATION			
7.1	Information Commissioner's Office Training Audit Action Plan		Andy Butler
7.2	Forward Plan		Roxann Davies
ANY OTHER BUSINESS (Prior Approval Only)			
8.1	Meeting Review		Martin Veale
DATE OF NEXT MEETING: Tuesday, 24 July 2018 from 14:00-16:00 NWSSP Boardroom HQ, Charnwood Court, Nantgarw			

Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
Tuesday 5 June 2018, 1.30pm-4.00pm, NWSSP HQ, Charnwood Court, Nantgarw

0	PRESENTATIONS
0.1	Results of Audit Committee Effectiveness Survey - Roxann Davies
1	STANDARD BUSINESS
1.1	Welcome & Opening Remarks - Chair
1.2	Apologies - Chair
1.3	Declarations of Interest - Chair
1.4	Minutes of Meeting Held on 24 April 2018 - Chair 1.4 Minutes of Meeting Held on 24 April 2018 (Part A)
1.5	Matters Arising - Chair 1.5 Matters Arising
2	ASSURANCE, RISK & GOVERNANCE
2.1	Governance Matters - Andy Butler 2.1 Governance Matters
2.2	Tracking of Audit Recommendations - Peter Stephenson 2.2 Tracking of Audit Recommendations 2.2 Appendix A - Summary of Latest Audit Reports 2.2 Appendix B - Overdue & Revised Deadline Recommendations
2.3	Review of NWSSP Risk Management Protocol - Peter Stephenson 2.3 Review of NWSSP Risk Management Protocol 2018 2.3 Appendix 1 - NWSSP Risk Management Protocol 2018
2.4	Annual Governance Statement - Peter Stephenson 2.4 Annual Governance Statement 2017-2018 2.4 Appendix 1 - Annual Governance Statement 2017-2018.docx
3	INTERNAL AUDIT
3.1	Head Of Internal Audit Annual Report and Opinion 2017-18 - James Quance 3.1 Head Of Internal Audit Annual Report and Opinion 2017-18
3.2	Internal Audit Review of Audit Tracker - Sophie Corbett 3.2 Internal Audit Review of Audit Tracker
3.3	Corporate Governance Internal Audit Report - Sophie Corbett 3.3 Corporate Governance Internal Audit Report
3.4	Payroll Services Internal Audit Report - Sophie Corbett 3.4 Payroll Services Internal Audit Report
3.5	Surgical Materials Testing Laboratory (SMTL) Internal Audit Report - Sophie Corbett 3.5 Surgical Materials Testing Laboratory (SMTL) Internal Audit Report
3.6	Performance Management Internal Audit Report - Sophie Corbett 3.6 Performance Management Internal Audit Report
3.7	Internal Audit Operational Plan 2018-19 - James Quance 3.7 Internal Audit Operational Plan 2018-19
4	EXTERNAL AUDIT
4.1	Wales Audit Office Position Statement - Gillian Gillett 4.1 WAO Position Statement 4.1 Appendix 1 - WAO Position Statement
5	COUNTER FRAUD
5.1	Counter Fraud Draft Work Plan 2018-19 - Andy Butler 5.1 Counter Fraud Draft Work Plan 5.1 Appendix 1 - Counter Fraud Draft Work Plan

6	NEW REPORTS
6.1	No Purchase Order, No Pay Policy- Andy Butler
	6.1 No PO, No Pay
	6.1 Appendix 1 - No PO No Pay Policy
6.2	Transfer of Management of Redress - Andy Butler
	6.2 Transfer of Management of Redress.doc
7	ITEMS FOR INFORMATION
7.1	Information Commissioner's Office Training Audit Action Plan - Peter Stephenson
	7.1 Information Commissioner's Office Training Audit Action Plan
7.2	Forward Plan – Roxann Davies
	7.2 Audit Committee Forward Plan
8	ANY OTHER BUSINESS (Prior Approval Only)
8.1	Meeting Review - Chair
9	DATE OF NEXT MEETING: 24 July 2018, 14:00-16:00, Boardroom at NWSSP HQ, Nantgarw

VELINDRE NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP

MINUTES OF MEETING HELD TUESDAY 24 APRIL 2018
14:00 – 16:00
BOARDROOM, NWSSP HQ, NANTGARW

ATTENDANCE	**DESIGNATION**	
INDEPENDENT MEMBERS:		
Martin Veale (MV)	Chair & Independent Member	
Jane Hopkinson (JH)	Independent Member	
Ray Singh	Independent Member	
ATTENDANCE	**DESIGNATION**	**ORGANISATION**
ATTENDEES:		
Margaret Foster (MF)	Chair	NWSSP
Neil Frow (NF)	Managing Director	NWSSP
Andy Butler (AB)	Director of Finance & Corporate Services	NWSSP
Peter Stephenson (PS)	Head of Finance & Business Development	NWSSP
Simon Cookson (SC)	Director of Audit & Assurance	NWSSP
Sophie Corbett (SC1)	Audit Manager	NWSSP
James Quance (JQ)	Head of Internal Audit	NWSSP
Roxann Davies (RD)	Compliance Officer	NWSSP
Maria Newbold	PA	NWSSP
Sarah Jones (SJ)	Local Counter Fraud Representative	Cardiff & Vale UHB
Gillian Gillett (GG)	Audit Representative	Wales Audit Office
ATTENDANCE	**DESIGNATION**	**ORGANISATION**
IN ATTENDANCE:		
Nicholas Lewis (NL) ***(Item 0.1 only)***	Application Designer	NWSSP
Tim Knifton (TK) ***(Items 0.1/0.2/6.2 only)***	Information Governance Manager	NWSSP
Dr Sarah Blackburn (SB) ***(Items 0.1/0.2/6.2/ 3.5 only)***	Independent Reviewer	Chartered Institute of Internal Auditors

Item		**Action**
PRESENTATIONS		
0.1	**Cyber Security Update (Presentation)** NL delivered an informative presentation regarding Cyber Security within NWSSP. RD agreed to circulate links to the Committee following NL's presentation.	**RD**

<table>
<tr><th>Item</th><th></th><th>Action</th></tr>
<tr><td>0.2</td><td>General Data Protection Regulation (GDPR) Readiness Update (Presentation)
TK delivered a helpful presentation to the Committee on the current position of NWSSP in relation to GDPR readiness.</td><td></td></tr>
<tr><td colspan="3">STANDARD BUSINESS</td></tr>
<tr><td>1.1</td><td>Welcome and Opening Remarks
The Chair welcomed all attendees to the April Audit Committee meeting.</td><td></td></tr>
<tr><td>1.2</td><td>Apologies

Apologies of absence were received from:

<table>
<tr><th>ATTENDANCE</th><th>DESIGNATION</th><th>ORGANISATION</th></tr>
<tr><td>Steve Ham</td><td>Chief Executive</td><td>Velindre NHS Trust</td></tr>
<tr><td>Mark Osland</td><td>Executive Director of Finance, Corporate Services</td><td>Velindre NHS Trust</td></tr>
<tr><td>Craig Greenstock</td><td>Local Counter Fraud Specialist</td><td>Cardiff and Vale UHB</td></tr>
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</td><td></td></tr>
<tr><td>1.3</td><td>Declarations of Interest

None identified.</td><td></td></tr>
<tr><td>1.4</td><td>Unconfirmed Minutes from meeting held on 6 February 2018

The minutes of the meeting held on 6 February 2018 were AGREED as a true and accurate record of the meeting.</td><td></td></tr>
<tr><td>1.5</td><td>Matters Arising from meeting held on 6 February 2018

The Chair highlighted the matters arising from the meeting held on 6 February 2018 and noted that in relation to the publishing of Committee papers, RD would arrange to upload these following the meeting. It was agreed that if there are items that are exempt from the public domain then the agenda should be split into two parts, Part A, which will be published and Part B, which will remain confidential.

All other matters arising had either been completed or were on the agenda.</td><td>RD</td></tr>
</table>

ASSURANCE, RISK & GOVERNANCE		
2.1	**DRAFT Annual Governance Statement** The draft Annual Governance Statement was presented to the Committee and it was noted that this was due to the fact that some of the year end figures are yet to be finalised. The final document will be presented to the Committee at the June meeting. The draft document has already been presented to SMT and SSPC. The statememt is generally positive with no major issues identified in the year and no internal audits undertaken that resulted in limited or no assurance. The findings of the EQA undertaken by the CIIA (see separate agenda item) were also included as a very positive assessment of the work of the internal auditors. The statement also reflects the positive changes made to the management of risks across NWSSP during 2017-18. It was noted that the Risk Management Protocol has recently been revised and PS will bring this to a future Committee meeting. The Chair requested that any comments regarding the draft Annual Governance Statement be sent to PS by 8 May 2018. Once finalised, it will be formally approved at the June Committee and will be published in July.	**PS** **ALL**
2.2	**Governance Matters** AB presented the report and noted that minor amendments have been made by to the appendices, in line with that discussed at February Committee. JH observed that the out of date stock figures reflected good progress made. AB noted that the cost for the provision of boxes for Supply Chain was queried and it was noted that one response had been received, and that the purchase was made from the National Procurement Framework, as we are required to do so.	
2.3	**Tracking of Audit Recommendations** PS presented the report and provided an update on the current position as to audit recommendations and noted that all Internal Audit reports to date had received reasonable or substantial assurance. It was noted that the overall picture is very positive with 209/222 recommendations having been implemented.	

	Internal Audit are currently undertaking a review of the NWSSP Audit Tracker and the associated process, and their findings will be presented at the June Committee meeting. At present there are no recommendations with outstanding deadlines, however a request was made to revise the deadline of five recommendations. Three are dependent on actions within Health Boards, and two are within the gift of NWSSP's implementation, but require additional time to complete. The Committee agreed the revised deadlines proposed. In relation to the Procurement recommendations, an update was provided by Mark Roscrow, Director of Procurement Services and he will confirm at the formal SMT meeting on 26 April 2018 that these have been implemented (since confirmed). The Chair agreed with the approach for NWSSP to differentiate when a recommendation is not within NWSSP's gift to implementation. However, it was agreed to continue to monitor these through to completion, via the Audit Tracker. The Chair highlighted that it would be useful for the Committee to receive an annual overview of all recommendations not yet implemented and RD agreed to add this to the Forward Plan.	**IA** **RD** **RD**
2.4	**Audit Committee Effectiveness Survey** RD stated that the Audit Committee Effectiveness Survey was due to be issued electronically at the end of April and confirmed with Committee the individuals who would be requested to complete it. The deadline for response was agreed as 11 May 2018. RD noted that we received a 100% response rate in 2017. This year we will also be able to benchmark the responses against Velindre NHS Trust as the majority of the questions are the same across both bodies.	**RD**
INTERNAL AUDIT		
3.1	**Internal Audit Progress Report** JQ reported that Internal Audit will present the Head of Internal Audit Opinion and an update on the work in progress at the June meeting. It was noted that the Internal Audit Report on Payroll was work in progress at the time the papers were issued and JQ confirmed that the fieldwork has now been concluded with no significant issues arising. JQ advised that the results from the body of work across the larger areas in NWSSP are looking very positive	

	and there is nothing to report that should cause any issues at present. JQ advised that the 2018/19 audit plan would be presented at the June Audit Committee Meeting, at the latest and the Chair requested that next year the 2019/20 plan be presented at the April meeting.	**IA**
3.2	**Internal Audit Report of Accounts Payable** SC1 presented the Internal Report on Accounts Payable. The report achieved Reasonable Assurance with three medium and three low priority findings. Four further findings were not included within the action plan as they are findings outside of the control of NWSSP. The Chair enquired as to the process for monitoring these issues and NF stated that there is an All Wales P2P meeting scheduled for 4 May 2018 where these actions would be taken, so that they can be highlighted to those parties concerned. The Chair advised that he was concerned to note the issue around the sharing of passwords; however, he continued that he was pleased to see that the issue had been resolved. JH requested an example of the issues that did not appear in the action plan and SC1 advised as to invoice approval workflow. NF added that the report should be seen in the context of approximately 4 million transactions per annum. SC1 enquired as to who the report would be distributed to and it was confirmed that it should be taken to all Audit Committees.	
3.3	**Internal Audit Report of Primary Care Services** JQ presented the Internal Audit Report on Primary Care Services and noted that an assessment against the four areas of PCS had been conducted and reported together. The report achieved Substantial assurance with one medium recommendation for Dental Services. The recommendation was accepted and it was confirmed that an additional check would be put in place to address this. JQ noted that planning for next year is currently underway and the Chair confirmed that he was happy with the report.	

3.4	**Internal Audit Report of Non-Medical Education Training Budget** SC1 presented the Internal Report on Non-Medical Education Training Budget. The report achieved Substantial Assurance with one medium and two low priority findings. The medium finding related to an overpayment to Bangor. AB advised that annually, NWSSP agree how much is to be paid for students going into the new year. There is a need to identify potential commissions, estimate the student count and monitor figures on a regular basis in order that the contracts can be adjusted. AB advised that there had been a change to the system this this year and it was noted that if students studied in Wales and chose not to have a bursary, they were eligible to have a loan. The students also had a 10-week period following commencement of their course where they could change their mind. Bangor did not recruit to the numbers we asked them to commission in March, which is incredibly rare. An overpayment was made to Bangor but the money has been repaid and the system has already been updated to prevent a re-occurrence of the issue. AB stated that it had been a good time to review NMET prior to the transfer of responsibilities to HEIW in October 2018; it was particularly pleasing that the responsibility would be transferred accompanied by a substantial assurance rating from Internal Audit.	
3.5	**Internal Audit External Quality Assessment** SC introduced Dr Sarah Blackburn from the Chartered Institute of Internal Auditors (CIIA), who undertook the recent External Quality Assessment (EQA) of Internal Audit. SB advised that an External Quality Assessment is required under International Internal Audit Standards and is to be undertaken every five years. SB confirmed that as part of her role within the CIIA, she was heavily involved with the setting of the Standards and acting on behalf of CIIA, was authorised to carry out these assessments. SB confirmed that SC and his team gained 100% compliance within their IA function, which was very unusual in her experience. There were a small number of recommendations made in order to assist with small efficiency gains. The Chair echoed the positive comments and noted that IA conformed in all 64 assessment criteria, which fell into the top	

	category and should be hugely commended. The Chair confirmed that he was very pleased with the report. AB queried if SB was aware of effective performance indicators for IA as he would like to see assessments move away from outcomes and outputs; instead looking at measuring impact on the organisation. The benefits of reviewing the timeliness in which internal audit work was completed and responded to were limited as often delays may be caused by the auditees rather than the auditors. There may also be benefits in terms of impact by spending longer on negotiating feasible actions and having a firm commitment from the individual department to implement them. Progress on implementation of recommendations and their resultant impact is very important and helpful. SB confirmed that there were numerous good publications on this topic which she will highlight and ask SC to share. She also agreed to send SC a copy of the performance indicators at an Audit Committee for which she acts as the Chair.	**SC**
EXTERNAL AUDIT		
4.1	**Wales Audit Office Position Statement** GG reported on the current and planned work being undertaken by the Wales Audit Office. WAO monitor the Audit Assurance requirements for work to support opinions for Health Boards. A report will be presented at the July Audit Committee meeting on the NHS Hosted IT Systems. The Chair enquired as to how NWSSP pay the WAO for their work. NF confirmed that these are paid from the fee for services provided by the WAO to support the Velindre accounts. NF added that NWSSP has worked very well to develop a good working relationship with WAO over the past seven years, and that the arrangement works well, providing good value for money to the Welsh taxpayer. The Chair queried what implications Exhibit 3, relating to NHS related national studies recently published by the WAO, has for NWSSP and NF confirmed that he had taken the report to the Shared Services Partnership Committee for members to comment upon. In terms of Welsh Government's position, this is currently a review commissioned by Mark Drakeford, Cabinet Secretary, to look at Value Wales and National Procurement Services (NPS) in the future. NF advised that there have been previously been issues	**GG**

	with NPS, but that this would be fed into the review and the Public Accounts Committee.	
COUNTER FRAUD		
5.1	**Counter Fraud Progress Update** SJ represented the Counter Fraud Team in CG's absence and provided an update on the National Fraud Initiative. SJ noted that previously the creditor checks were completed by Velindre Finance Team, however it has been agreed that Accounts Payable in NWSSP would work in association with Velindre Finance to complete this, going forward. SJ advised that there are five ongoing cases of note at present, and gave details on each. The Chair queried whether case SSP18.01 could be dealt with through the internal disciplinary system. SJ confirmed that this was not possible as the individual no longer works for NWSSP.	
ITEMS FOR INFORMATION		
6.1	**Integrated Medium Term Plan 2018-2021 Summary** The report was received for information only and the Chair congratulated Marie-Claire Griffiths, Head of IMTP Development and Implementation, in the production of an excellent piece of work, in conjunction with Michael Thorpe of the Communications Team. The Committee endorsed the summary and it was described as being a very good read, which is easy to digest, helpful and relevant for staff. JH noted that the summary is an interesting way of engaging people and praised the bilingual pledge. AB noted that Lunch and Learn sessions and a corporate video have been introduced to support the IMTP launch and RD agreed to circulate the dates to Committee members.	**RD**
6.2	**Caldicott Principles Into Practice (C-PIP) Annual Report & Improvement Plan** The report was received for information only. While this exercise is a self-assessment it was noted that the current score was 96%, which was one of the highest scores achieved. Information mapping was a recommendation, however this will be picked up as part of the GDPR.	

6.3	**Forward Plan** The Plan was received for information only.	
DATE OF NEXT MEETING: Tuesday, 5 June 2018 from 14:00-16:00 NWSSP Boardroom HQ, Charnwood Court, Nantgarw		

Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Matters Arising

Actions arising from the meeting held on 6 February 2018			
4.1	CG	**Counter Fraud Progress Report** Annual Counter Fraud Report solely for NWSSP to be developed, in addition to that prepared for Velindre NHS Trust.	Completed Added to the Forward Plan for 24/07/2018
5.3	PS	**Corporate Risk Register** Review of NWSSP Risk Management Protocol to be brought to a future Committee meeting.	Completed Action Plan developed Agenda Item 7.1
7.3	PS	**Information Commissioner's Office (ICO) Training Audit 2017 Summary** Action Plan to be developed to address the recommendations, to be brought to a future Committee meeting.	Completed Action Plan developed Agenda Item 7.1
Actions arising from the meeting held on 24 April 2018			
0.1	RD	**Cyber Security Presentation** RD agreed to circulate links contained within the presentation.	Completed Links circulated by email on 27/04/2018
1.5	RD	**Matters Arising** RD agreed to publish the Committee papers on the NWSSP website, following the meeting.	Completed Papers now published
2.1	ALL	**Annual Governance Statement** Committee Members to feed back any comments on the draft document to Peter Stephenson by 8 May 2018.	Completed Annual Governance Statement updated
2.3	SC1	**Tracking of Audit Recommendations** Internal Audit Review of Audit Tracker to be presented at June Committee.	Completed Agenda Item 3.3
2.3	RD	**Tracking of Audit Recommendations** RD agreed to monitor recommendations not within the gift of implementation by NWSSP via the Audit Tracker.	Completed Built into process as of 05/2018.
2.3	RD	**Tracking of Audit Recommendations** Forward Plan to incorporate an annual review of all recommendations not yet implemented.	Completed Added to Forward Plan for 23/10/2018

2.4	RD	**Audit Committee Effectiveness Survey** Results of the Survey to be presented at June Committee	Completed Agenda Item 0.1
3.1	JQ	**Internal Audit Progress Report** Internal Audit Work Plan for 2018-19 to be presented at June Committee.	Completed Agenda Item 3.7
4.1	GG	**Wales Audit Office Position Statement** WAO Report on Nationally Hosted NHS IT Systems to be presented at July Committee.	Completed Added to the Forward Plan for 24/07/2018
6.1	RD	**Integrated Medium Term Plan 2018-2021 Summary** Dates for Lunch and Learn Sessions to be circulated to Committee Members.	Completed Links circulated by email on 27/04/2018

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	5th June 2018
AGENDA ITEM	2.1
PREPARED BY	Roxann Davies, Compliance Officer
PRESENTED BY	Andy Butler, Director of Finance and Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services

TITLE OF REPORT

Governance Matters

PURPOSE OF REPORT

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

1. DEPARTURES FROM STANDING ORDERS

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

2. CONTRACTS FOR NWSSP

The table overleaf summarises contracting activity undertaken during the period **9 April 2018 to 18 May 2018**.

A summary of activity for the period is set out in **Appendix A**.

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

3. NWSSP PROCUREMENT SERVICES ALL WALES CONTRACTING ACTIVITY

All Wales Contracting Activity in progress

During the period **27 March 2018 to 15 May 2018**, activity against **19** contracts has been completed. This includes **5** contracts at the briefing stage and **10** contracts at the ratification stage. In addition to this activity, extensions have been actioned against **4** contracts.

A summary of activity for the period is set out in **Appendix B**.

4. STORES WRITE OFFS

The value of stores, at **30 April 2018**, amounted to **£2,903,564**. For **April 2018**, a stock write off of **£130.00** has been actioned for out of date stock. This equates to **0.004%** of the total stock holding value in **April**.

Stock Type	Bridgend Stores £	Denbigh Stores £	Cwmbran Stores £
Stock Value	1,520,358	746,721	636,485
Out of Date Stock	130	0	0
Total	**0.01%**	**0%**	**0%**

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

A summary of activity for the period is set out in **Appendix C**.

5. GIFTS, HOSPITALITY & SPONSORSHIP

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

Gifts and/or Hospitality Declarations

There have been **3** declarations received relating to gifts and/or hospitality since the last Audit Committee meeting.

NWSSP Employee	Position	Type	Source	Description	Value	Authorised by	Accepted or Declined & Date
Andy Butler	Director of Finance and Corporate Services	Hospitality	Chair of HFMA Cymru	Performing Under Pressure Channelling stress for success	£25.00	N Frow	30.04.2018 Accepted
Neil Frow	Managing Director	Hospitality	Chair of HFMA Cymru	Performing Under Pressure Channelling stress for success	£25.00	M Foster	01.05.2018 Accepted
Neil Frow	Managing Director	Hospitality	ACCA	ACCA Health Panel	£20.00	A Butler	22.05.2018 Accepted

Sponsorship Declarations

There have been **11** declarations received relating to sponsorship since the last Audit Committee meeting.

NWSSP Employee	Position	Type	Source	Description	Value	Authorised by	Accepted or Declined & Date
John Prendergast	Senior Decontamination Engineer	Sponsorship	1. Wassenburg Ltd 2. Steris Ltd 3. Serve Medical Ltd 4. Serchem Ltd 5. Neocare 6. LTE 7. Getinge Ltd 8. Cantel Medical Ltd 9. Intercept Med Ltd 10. Isopharm Ltd 11. PFE Medical	Sponsorship to exhibit at All Wales Endoscope Decontamination Forum - to cover costs of venue hire and catering	£160.00 per sponsor 11 x received **Total = £1,760.00**	A Butler	23.04.2018 and 18.05.2018 Accepted

6. WELSH GOVERNMENT QUARTERLY UPDATE

On a quarterly basis, the NWSSP issues a letter to Dr Andrew Goodall at Welsh Government to confirm any Audit Reports which have achieved limited or no assurance. For Quarter 4 of 2017/2018, we submitted a nil return.

7. RECOMMENDATIONS

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

APPENDIX A - NWSSP CONTRACTS – Activity Undertaken (09/04/2018 -18/05/2018)

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
VEL	NWSSP-Supply Chain	NWSSP-STA-377	24/04/2018	Single Quotation Action	Annual Maintenance of Temperature Controlled Store at Picketston	1Cold Ltd	£8,767.00	Compatibility with existing service	Endorsed – Installer to provide first year maintenance	Formal Procurement to be planned

APPENDIX B - All Wales Contracting Activity In Progress (27/3/18 – 15/5/18)

Contract Title	Doc Type	Total Value	MR approval <£750K	WG approval >£500k	NF approval £750-£1M	Chair Approval £1M+
OJ31 Immunology Services (ABUHB)	briefing	£3,000,000	23/03/2018	10/05/2018	n/a	n/a
Trastuzumab	briefing	£21,463,322	27/03/2018	11/05/2018	n/a	n/a
Pathology Consumables	briefing	£6,273,468	26/04/2018	11/05/2018	n/a	n/a
Total facilities management	briefing	£2,738,193	14/05/2018	sent to WG 14/5	n/a	n/a
Orthotics Consumables	briefing	£4,745,837	14/05/2018	sent to WG 14/5	n/a	n/a
Outsourcing Ophthalmology Services for HDDA	extension	£1,500,000	09/04/2018	original approval applies 23/10/17	13/04/2018	13/04/2018
Design to Smile	extension	£1,387,700	17/04/2018	original approval applies 21/6/16	17/04/2018	20/04/2018
Home Parenteral Nutrition	extension	£14,568,912	30/04/2018	original approval applies 10/2/14	30/04/2018	01/05/2018
ABMU Outsourcing of surgical procedures	extension	£13,000,000	30/04/2018	original approval applies 26/1/16	01/05/2018	01/05/2018
Bobath therapy services (CVU)	ratification	£880,788	27/03/2018	11/04/2018	trust gov applies	trust gov applies
Survey of Ventilation (CVU)	ratification	£1,860,730	27/03/2018	29/03/2018	trust gov applies	trust gov applies
Generic Drugs Injections/Infusions 1	ratification	£11,664,092	27/03/2018	11/05/2018	Sent to NF 14/5	
NHS Building for Wales (SES)	ratification	£572,000,000	27/03/2018	11/04/2018	13/04/2018	13/04/2018
Laryngoscope Blades	ratification	£1,429,937	11/04/2018	27/04/2018	30/04/2018	01/05/2018
FIT	ratification	£900,680	16/04/2018	sent to WG 16/4		
Dental eReferral management system (NWIS)	ratification	£1,220,267	26/04/2018	04/05/2018	08/05/2018	08/05/2018
Haemostatic products	ratification	£3,148,094	30/04/2018	sent to WG 30/4		
Home Parenteral Nutrition	ratification	£17,616,784	03/05/2018	11/05/2018	Sent to NF 15/5	
HDUHB Primary Care Personal Dental Services	ratification	£2,637,446	03/05/2018	11/05/2018	Sent to NF 15/5	

APPENDIX C - Stores Write Offs (April 2018)

Bridgend Stores

Item Description	Value	Date
SELECT BAG ONE AX225G (NEUTRAL) 331 : 112634	129.60	04/04/2018
Total	**129.60**	

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	5 June 2018
AGENDA ITEM	2.2
REPORT PREPARED BY	Roxann Davies, Compliance Officer
PRESENTED BY	Peter Stephenson, Head of Finance and Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services

TITLE OF REPORT

Update on the Implementation of Audit Recommendations

PURPOSE OF REPORT

This report provides an update to the Audit Committee on the progress of tracking audit recommendations within NWSSP.

Please note that this report does not include figures and assurance ratings for the audit reports listed on the present Audit Committee agenda.

1. INTRODUCTION

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

2. CURRENT POSITION

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

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

There are **41** reports covered in this review; **14** reports have achieved **Substantial** assurance; **21** reports have achieved **Reasonable** assurance, **0** reports have been awarded **Limited** assurance or **No Assurance;** and **6** reports were generated with **Assurance Not Applicable**. The reports include **195** recommendations for action.

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

The following reports **Assurance Not Applicable** assurance ratings and on this basis, they are categorised as assurance not applicable:

- **3** Wales Audit Office Reports
- **2** Internal Audit Advisory Reports
- **1** SGS UK Ltd ISO14001 Audit Report

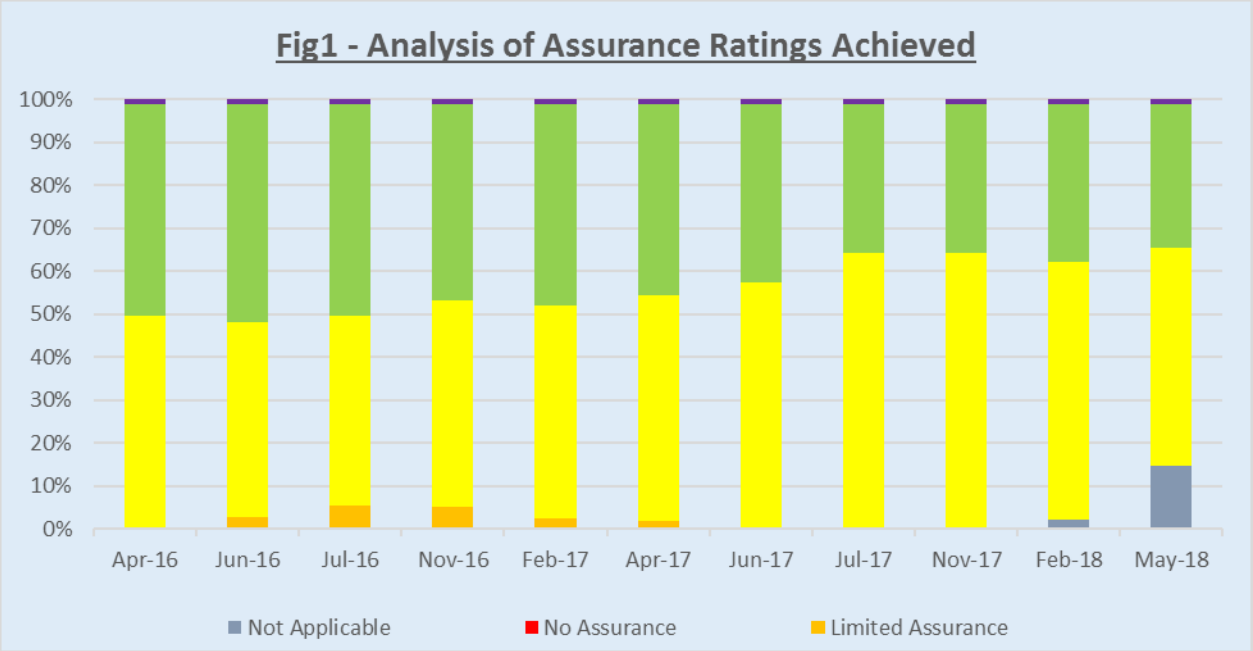
Table 1 - Summary of Audit Report Ratings

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

NWSSP Service	Assurance Not Applicable	No Assurance	Limited	Reasonable	Substantial	Total
Internal Audit Reports						
Corporate Services	0	0	0	2	5	**7**
Employment Services	0	0	0	3	3	**6**
Specialist Estates Services	0	0	0	2	2	**4**
Primary Care Services	0	0	0	0	2	**2**
Procurement Services	2	0	0	12	0	**14**
Workforce	0	0	0	1	2	**3**
Legal & Risk	0	0	0	1	0	**1**
Total	**2**	**0**	**0**	**21**	**14**	**37**
External Audit Reports						
Wales Audit Office	3	0	0	0	0	**3**
Other Audit Reports						
SGS UK Ltd ISO14001	1	0	0	0	0	**1**
GRAND TOTAL	**6**	**0**	**0**	**21**	**14**	**41**
Percentage	**15%**	**0%**	**0%**	**51%**	**34%**	**100%**

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

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



The above graph highlights an improvement over time and demonstrates that **100%** of NWSSP's audit reports are rated **Substantial** or **Reasonable** assurance, compared to **82%** in October 2012. In addition, **34%** of the reports are rated as 'substantial' compared with **30.7%** in October 2012.

Table 2 - Summary of Audit Recommendations

Recommendations		Implemented	Not Yet Due	Revised Deadline	Revised Deadline Not NWSSP	Overdue
Internal Audit	**150**	**143**	**4**	**1**	**2**	**0**
High	11	11	0	0	0	0
Medium	70	66	2	0	2	0
Low	62	59	2	1	0	0
Not Applicable	7	7	0	0	0	0
External Audit	**44**	**39**	**5**	**0**	**0**	**0**
High	8	8	0	0	0	0
Medium	35	30	5	0	0	0
Low	1	1	0	0	0	0
Not Applicable	0	0	0	0	0	0
Other Audit	**1**	**1**	**0**	**0**	**0**	**0**
High	0	0	0	0	0	0
Medium	0	0	0	0	0	0
Low	1	1	0	0	0	0
Not Applicable	0	0	0	0	0	0
TOTALS:	**195**	**183**	**9**	**1**	**2**	**0**

3. REVISED DEADLINE PROPOSAL FOR APPROVAL

A detailed breakdown of all audit recommendations is reviewed at each Senior Management Team meeting.

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

1. Procurement Services Accounts Payable 2017-18
   Audit Ref: NWSSP-1718-11 / Corp Gov Ref: PROC/17-18/3 Rec.4
   Requested extension from 31/05/2018 to **30/06/2018**

2. Employment Services Payroll Services 2015-16
   (Cardiff & Vale/Cwm Taf/PHW/Velindre)
   Corp Gov Ref: EMP/15-16/7 Rec.5
   Requested extension from 31/05/2018 to **01/09/2018**

3. Employment Services Payroll Services 2015-16
   (Cardiff & Vale/Cwm Taf/PHW/Velindre)
   Corp Gov Ref: EMP/15-16/7 Rec.4
   Requested extension from 31/05/2018 to **31/10/2018**

4. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the report findings and the progress made to date
- **APPROVE** the revised deadlines proposed.

SUMMARY OF LATEST AUDIT REVIEWS BY SERVICE AREA

Internal Audit Reference	Reference	Directorate	Health Board/Trust	Report Title	Year	Assurance Rating	Recommendations	Implemented	Not Yet Due	Revised Deadline	Overdue	Revised Deadline Not NWSSP Action
INTERNAL AUDIT REPORTS												
	CORP/13-14/1	Corporate Services	All Wales	Student Awards Services	2013-14	Substantial	2	2	0	0	0	0
	CORP/14-15/1	Corporate Services	NWSSP	Budgetary Control, Financial Reporitng & General Ledger	2014-15	Substantial	1	1	0	0	0	0
	CORP/15-16	Corporate Services	NWSSP	Information Goverance	2015-16	Reasonable	5	4	1	0	0	0
	CORP/16-17/1	Corporate Services	NWSSP	Risk Management	2016-17	Reasonable	4	4	0	0	0	0
	CORP/16-17/2	Corporate Services	NWSSP	Corporate Governance	2016-17	Substantial	7	7	0	0	0	0
NWSSP-1718-02	CORP/17-18/1	Corporate Services	NWSSP	Information Governance GDPR	2017-18	Substantial	2	2	0	0	0	0
NWSSP-1718-03	CORP/17-18/2	Corporate Services	NWSSP	Non-Medical Education Training Budget	2017-18	Substantial	3	1	2	0	0	0
						TOTAL	**24**	**21**	**3**	**0**	**0**	**0**
	EMP/14-15/1	Employment Services	All Wales	Recruitment: Qualifications & DBS Checks	2014-15	Substantial	2	2	0	0	0	0
	EMP/15-16/1	Employment Services	WAST	ESR CAATS	2015-16	Substantial	0	0	0	0	0	0
	EMP/15-16/2	Employment Services	BCU	ESR CAATS	2015-16	Substantial	1	1	0	0	0	0
	EMP/15-16/7	Employment Services	Cardiff & Vale/Cwm Taf/PHW/Velindre	Payroll Services	2015-16	Reasonable	9	7	0	0	0	2
	EMP/16-17/1	Employment Services	All Wales	Payroll Services	2016-17	Reasonable	8	8	0	0	0	0
	EMP/16-17/2	Employment Services	All Wales	TRAC System	2016-17	Reasonable	3	3	0	0	0	0
						TOTAL	**23**	**21**	**0**	**0**	**0**	**2**
	L&R/15-16/1	Legal & Risk	All Wales	Welsh Risk Pool Services	2015-16	Reasonable	2	2	0	0	0	0
						TOTAL	**2**	**2**	**0**	**0**	**0**	**0**
	PCS/14-15/2	Primary Care Services	All Wales	Post Payment Verification	2014-15	Substantial	3	3	0	0	0	0
NWSSP-1718-12	PCS/17-18/1	Primary Care Services	All Wales	Contractor Payments	2017-18	Substantial	1	0	1	0	0	0
						TOTAL	**4**	**3**	**1**	**0**	**0**	**0**
	PROC/14-15/1	Procurement Services	ABMU	Local Procurement Team	2014-15	Reasonable	4	4	0	0	0	0
	PROC/14-15/2	Procurement Services	Cardiff & Vale	Local Procurement Team	2014-15	Reasonable	4	4	0	0	0	0
NWSSP-1516-19	PROC/15-16/1	Procurement Services	All Wales	Bridgend Stores	2015-16	Reasonable	11	11	0	0	0	0
	PROC/15-16/2	Procurement Services	All Wales	Cwmbran Stores **Follow Up**	2015-16	Reasonable	4	4	0	0	0	0
	PROC/15-16/3	Procurement Services	Cwm Taf	Local Procurement Team	2015-16	Reasonable	4	4	0	0	0	0
	PROC/15-16/4	Procurement Services	BCU & WAST	Local Procurement Team	2015-16	Reasonable	2	2	0	0	0	0
NWSSP-1516-03	PROC/15-16/5	Procurement Services	All Wales	Central Sourcing	2015-16	Reasonable	7	7	0	0	0	0
NWSSP-1617-06	PROC/16-17/2	Procurement Services	All Wales	Health Courier Services **Follow Up**	2016-17	Reasonable	2	2	0	0	0	0
	PROC/16-17/3	Procurement Services	All Wales	Supplier Master File **Follow Up**	2016-17	Reasonable	2	2	0	0	0	0
	PROC/16-17/4	Procurement Services	Velindre/PHW	Local Procurement Team	2016-17	Reasonable	5	5	0	0	0	0
	PROC/16-17/5	Procurement Services	All Wales	Denbigh Stores	2016-17	Reasonable	7	7	0	0	0	0
NWSSP-1718-19	PROC/17-18/1	Procurement Services	ABMU	Carbon Reduction Commitment (CRC) Payment Review	2017-18	Advisory Report	5	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	5	0	1	0	0
						TOTAL	**65**	**64**	**0**	**1**	**0**	**0**
	SES/15-16/1	Specialist Estates Services	All Wales	Design4Life - BAM	2015-16	Reasonable	5	5	0	0	0	0
	SES/15-16/2	Specialist Estates Services	All Wales	Design4Life - Interserve	2015-16	Substantial	3	3	0	0	0	0
	SES/15-16/3	Specialist Estates Services	All Wales	Mechanical & Electrical Sub Contractors	2015-16	Substantial	11	11	0	0	0	0
	SES/15-16/4	Specialist Estates Services	All Wales	Design4Life - Open Book Audit: Laing O'Rourke	2015-16	Reasonable	4	4	0	0	0	0
						TOTAL	**23**	**23**	**0**	**0**	**0**	**0**
	WORK/15-16/1	Workforce	All Wales	WfIS Core Skills & Training Framework **Follow Up**	2015-16	Substantial	4	4	0	0	0	0
	WORK/16-17/1	Workforce	All Wales	WfIS ESR OH Bi-Directional Interface	2016-17	Reasonable	4	4	0	0	0	0
NWSSP-1718-17	WORK/17-18/1	Workforce	All Wales	WfIS ESR / Occupational Health Bi-Directional Interface (Immunisations)	2017-18	Substantial	1	1	0	0	0	0
						TOTAL	**9**	**9**	**0**	**0**	**0**	**0**
WALES AUDIT OFFICE EXTERNAL AUDIT REPORTS												
	WAO/15-16	All Services	All Wales	WAO Review of NWSSP	2015-16	Not Applicable	12	12	0	0	0	0
	WAO/16-17/1	All Services	All Wales	WAO Nationally Hosted NHS IT Systems Assurance Report	2016-17	Not Applicable	25	20	5	0	0	0
	WAO/16-17/2	All Services	All Wales	WAO Management Letter	2016-17	Not Applicable	7	7	0	0	0	0
						TOTAL	**44**	**39**	**5**	**0**	**0**	**0**
OTHER AUDIT REPORTS												
	ISO14001/17/18	Corporate Services	NWSSP	SGS UK Ltd Audit of ISO14001 Environmental Management System	2017-18	Not Applicable	1	1	0	0	0	0
						TOTAL	**1**	**1**	**0**	**0**	**0**	**0**
						TOTAL RECS	**195**	**183**	**9**	**1**	**0**	**2**

APPENDIX B - AUDIT RECOMMENDATIONS WITH REVISED DEADLINES FOR APPROVAL

ID	Rec No Reference NWSSP Service Customer of Service Report Title Report Year	Status	Issue Identified	Risk Rating	Recommendation	Responsibility for Action	Management Response	Original Deadline	Revised Deadline	Update On Progress Made
REVISED DEADLINE RECOMMENDATIONS FOR APPROVAL										
Procurement Services										
1	NWSSP-1718-11 4 PROC/17-18/3 Procurement Services All Wales Accounts Payable 2017-18	**Revised Deadline**	The process document does not clearly set out the step-by-step process for requesting, processing and checking additions/amendments to the supplier masterfile. Sample testing of 55 additions/amendments to the supplier masterfile confirmed that all could be verified to supporting documentation. However, five instances were identified where the New Supplier & Amendments Form had not been completed for a new supplier set-up, as required by the procedure. In addition, four of the five One-Off Payment Request Forms reviewed contained bank details but had not been authorised by an AP Manager, as required by the procedure. Non-compliant requests should be rejected by the Supplier Maintenance Team. The SMT Team Leader advised that they have been asked by some organisations to accept data loads on the basis that checking is undertaken by the Health Board prior to sending to AP. This arrangement is not reflected in the process document and poses an increased risk of fraud here as there is no purchase order, no invoice received by AP and no evidence to confirm payee bank details. Risk: Poor quality requests for additions/amendments to the supplier masterfile.	**Low**	The Supplier Maintenance Process should be revised to clearly set out the step-by-step process from the point of request by Accounts Payable/Procurement to the processing and checking of additions/amendments by the Supplier Maintenance Team. The document should clearly identify the circumstances in which each type of form should be used, and identify any exceptions to the rules. Where customer organisations request a dataload to be used as the supporting documentation for bank details, consider obtaining prior agreement from the organisations finance department as acknowledgement and acceptance of the associated risks.	Noel Williamson	Agreed – A review of the process and guidance will take place to address the comments above and would welcome input from Internal Audit in respect of the concerns being raised.	**31/05/2018**	**30/06/2018 Revised Deadline Submitted to Audit Committee For Approval:**	We have reviewed the How to Guide and we are satisfied that it does contain a clear step by step process included, including a completed example. The challenge that the Supplier Maintenance Team are confronted with is that forms are not completed correctly. The Supplier Maintenance Team will continue to work with its customer base to make the process as easy as can be. In order to fully understand the concerns raised in the Audit, a meeting will be arranged to go through the concerns and where we can enhance the process, we will take these on board. Given this we will defer the date by one month so a revised date is the 30th June, to allow for a meeting with Internal Audit
Employment Services										
2	5 EMP/15-16/7 Employment Services Cardiff & Vale/Cwm Taf/PHW/Velindre Payroll Services 2015-16	**Revised Deadline – Not NWSSP**	New appointments made via NHS Jobs should receive a pre-employment check by the NWSSP Recruitment Services Team prior to commencing employment with the Health Board/Trusts. There is a control within ESR system whereby Recruitment is required to select "offer-accept" following completion of an individuals' recruitment checks in order to allow Payroll to download the individual's record. However, the Payroll Manager advised that this control is not operational for C&VUHB/CTUHB/PHW/VNHST - a decision taken by the Health Boards/Trusts.	**Medium**	The "offer-accept" functionality should be operational for all Health Boards.	Lisa Williams, Service Improvement Development Manager, Kelly Skene, Regional Recruitment Services Manager	The functionality where Recruitment download appointees into ESR as offer conditional and change the status to offer accept following completion of all pre-employment checks is currently functional in two Health Boards. There are plans to roll this out across NHS Wales alongside the new enrolment form.	01/09/2015	**Revised Deadline Submitted to Audit Committee For Approval: 01/09/2018**	ESR Hire functionality continues to be piloted by HDdUHB (pilot extended to September). Consideration of this functionality will form part of this pilot. The preferred approach to utilising this function is expected to conclude

APPENDIX B - AUDIT RECOMMENDATIONS WITH REVISED DEADLINES FOR APPROVAL

3	4 EMP/15-16/7 Employment Services Cardiff & Vale/Cwm Taf/PHW/Velindre Payroll Services 2015-16	**Revised Deadline – Not**	Employment Services is in the process of implementing a new excel-based enrolment form following a pilot exercise within NWSSP. Whilst it is yet to be implemented within other organisations, the new process for the enrolment of new starters will provide additional controls to improve data quality and reduce the risk of ghost employees.	**Medium**	Implementation of the new enrolment form should be progressed.	Christine Williams Richards/Lisa	This is currently being rolled out throughout Health Boards and Trusts. Additional staff recruited to assist.	01/09/2015	**Revised Deadline Submitted to Audit Committee For Approval: 31/10/2018**	At WfIS PB in April 2018 the decision was made to implement the new enrolment form across outstanding HB/T with the exception of HDdaUHB. A timescale of 31 October 2018 has been identified to achieve this roll-out and is dependent upon HB/T uptake (facilitated by NWSSP) HDdaUHB will continue under ESR Hire pilot.

MEETING	NWSSP Audit Committee
DATE	5 June 2018
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 Management Protocol

PURPOSE OF REPORT

For the Audit Committee to approve the updated Risk Management Protocol.

1. INTRODUCTION

The Corporate Risk Management Protocol has been updated to reflect changes in the approach to risk management introduced over the last twelve months. In particular, the criteria for assessing risks has also been revised to be consistent with that operated by Velindre NHS Trust, and to provide a more relevant assessment of the type of risks likely to face NWSSP. Specific changes within the attached protocol have been highlighted to assist with review.

2. RECOMMENDATION

The Audit Committee is asked to

- **APPROVE** the revised Risk Protocol.

RISK MANAGEMENT PROTOCOL

RISK MANAGEMENT PROTOCOL

March 2018

STATEMENT OF INTENT

NWSSP is committed to ensuring that the management of risk throughout the organisation is consistent and effective.

NWSSP Statement

NWSSP is committed to achieving and maintaining the highest standards of managerial practices that maximise and progress service benefits.

NWSSP recognises that effective risk management is a key component of corporate governance and is critical to achieving the strategic objectives of the organisation.

NWSSP continues to embed the risk management process by ensuring staff recognise the principles that "risk management is everyone's business," and encourage them to report any hazards, risks, incidents and near misses within their working activities or environment.

NWSSP recognises the importance of continuing to promote a culture of honesty and openness when dealing with a breakdown/failure in a system or individual error/mistake. NWSSP is committed to investigating system failures and or individual errors to establish the underlying causes.

NWSSP will seek to ensure that risks and incidents are identified and managed in a positive and constructive manner, so that lessons learned are shared across the organisation.

NWSSP acknowledge that effective risk management allows managers and staff to respond to opportunities and to take appropriate risks on behalf of the organisation with greater confidence of a successful outcome.

Introduction

NWSSP seeks to integrate the risk management process by having a single clear systematic approach. Therefore risk management is not seen as a separate function but is an integral part of the day to day management activities of the organisation including financial, health and safety and environmental functions.

It is the aim of NWSSP to assess and control the risks which threaten or compromise its ability to fulfil its aims and objectives. Risk Management should be able to provide a suitable framework from within which staff can manage risks potentially facing the organisation in a consistent and

meaningful way. This protocol sets out a framework, which identifies the risk management arrangements for the organisation including the need to address the Healthcare Standards identified by NHS Wales Shared Services Partnership Committee (NWSSPC) for Shared Services.

Background

NWSSP Divisions through their staff are integral parts of Health Boards (HBs) and NHS Trusts and as such must abide by the Policies and Standards established by those as well as those of the NWSSPC. This protocol is intended to complement the HB's and NHS Trust's strategies by establishing a comparable framework around which NWSSP will manage risks potentially facing the organisation. This protocol should therefore not be looked at in isolation but should be looked at as a part of the overall protocols in place, and particularly the Velindre NHS Trust Risk Policy. It is the intention that this will provide a framework which enables NWSSP to define its risk management arrangements, taking into account the process of adherence to the standards set down by the Health Inspectorate Wales.

The overall objective of the Healthcare Standards is to support NHS bodies in Wales in developing an effective system of risk management and control. The standards will serve to support the process of continuous self-assessment introduced with controls assurance.

Purpose

The purpose of this protocol is to provide a clear systematic approach to the management of risk within NWSSP. The protocol will define the way in which NWSSP will continue to embed the risk management process across the whole organisation whilst taking note of the various requirements of external agencies and statutory bodies.

Aims

NWSSP has a clear commitment to operate high standards of governance and internal control and will aim to minimise and contain any costs or consequences that may arise in the event of an incident occurring. NWSSP is committed to the following Policy aims and objectives:

- A clear commitment to operate to the highest standards of governance and internal control through the adoption of Risk Management Policy and regular reporting of risk management issues to the NWSSPC;

- Provide evidence that NWSSP is making every effort to meet the objectives set within the protocol and will, in doing so, protect staff, the public and other stakeholders against risks of all kinds;

- To inform the NWSSPC about significant risks within the organisation for which they are responsible;

- Assist staff and the NWSSPC to identify risks, determine unacceptable levels of risk, and decide on where best to direct limited resources to eliminate or reduce those risks;

- Promote risk management awareness at all levels of the organisation;

- Develop, establish and implement an infrastructure and arrangements to ensure that managing risk becomes an integral part of the planning and management processes and general culture of the organisation;

- Ensure that NWSSP adopts best practice and achieves the highest standards of risk management;

- Manage risk in a positive but not punitive way as an opportunity to learn and improve systems in practice;

- Increase public confidence in the quality of service provided with the NHS; and

- Enable NWSSP to effectively meet its key objectives.

Objectives

NWSSP will:

- Ensure a safe environment for the delivery of health care and for staff to work in;

- Improve business performance by informing and improving decision making and planning;

- Continue to promote a single consistent approach to risk management across NWSSP;

- Ensure clear lines of accountability and responsibility for risk management exist;

- Ensure adequate risk reporting structures are in place across the whole organisation that provide assurance to the board;

- Develop and promote the risk management escalation process;

- Ensure effective processes are in place to achieve staff compliance with statutory, mandatory and professional standards;

- Encourage open and honest reporting of hazards, risks and incidents and near misses;

- Ensure that risks and incidents identified are managed in a positive and constructive manner, so lessons learned are shared;

- Promote a culture where innovations are encouraged; and

- Provide a sound basis for integrated risk management and internal control as components of good corporate governance.

Organisational Arrangements and Responsibilities

NWSSP is a large and complex organisation with some 1900 employees. The Managing Director, NWSSP is ultimately accountable for ensuring that risk is managed adequately, although there are levels of responsibility throughout the structure to ensure effective risk management. However, day-to-day implementation thereof is delegated to the Director of Finance and Corporate Services of NWSSP, who is assisted in this role by the Head of Finance and Business Development.

It is the responsibility of each of the Directors, Assistant Directors, and Heads of Service to ensure that risk is addressed at each of the locations relevant to their Directorates and that an effective feedback mechanism operates through NWSSP such that corporate and significant/critical risks are reported and discussed at NWSSP SMT meetings.

All employees individually and collectively have a responsibility for risk management with the identification of risks and the reporting of incidents and near misses being encouraged.

Staff should:

- Report risks, incidents and hazards using the appropriate reporting procedure;

- Be aware of their legal duty to take care of their own health and safety and the safety of others affected by their work activities;

- Attend statutory and mandatory training in line with NWSSP requirements;

- Act in accordance with the training and instruction provided by NWSSP; and

- Comply with the Velindre NHS Trust Risk Management strategy and NWSSP Protocol supporting health and safety policies and procedures.

Head of Finance and Business Development

The NWSSP Head of Finance and Business Development will provide advice and guidance on risk management related functions across NWSSP. The post holder will also support the development and implementation of a standard overarching risk management framework. This includes the coordination of risk assessments, risk registers, assurance maps and development and maintenance of the risk management system and its modules (Datix).

Host Bodies

Hazards and risks may be identified which are not within the ability of NWSSP to control or manage, such as building or facilities management issues which are instead the responsibility of a host organisation. The arrangements of NWSSP will be such that it is a requirement on its officers to bring such matters to the attention of the host body concerned at the earliest possible opportunity. Such action should always be the subject of a written report to the Director of Finance and Corporate Services of NWSSP.

Risk Management Framework

The organisational framework for Risk Management is controlled through the establishment of various Committees. The Committees are responsible for ensuring that risks that fall under their remit are reviewed and where significant risks are identified, these are appropriately escalated. See Annex 1 for the structure.

Risk Identification, Assessment & Management

NWSSP will embed processes to ensure that risk is identified, assessed and managed.

Identification of Risks

NWSSP will identify risks both by proactive and reactive methods. These will be managed proactively on an NWSSP Corporate Risk Register, supported by risk registers in each directorate which will be maintained by all nominated individuals assessing the risks which exist in their service area.

Corporately, all papers presented to the NWSSPC, Audit Committee and Senior Management Team meetings must contain a section on identified risks contained in the paper presented and how they will be managed. The Director of Finance and Corporate services will be responsible for reviewing the risks raised in papers and ensuring they are added where appropriate to the Corporate Risk Register.

Reactively, risks will become apparent from a number of sources including complaints, claims, losses, and clinical, internal and external audit. Adverse incidents are also an important information source. It is crucial that all incidents are reported and investigated through the Incident Reporting Procedure (Datix). Any trends identified will be recorded as risks along with the corresponding actions to mitigate them.

Risk Assessment Process

A formal risk assessment is required for all risk assessments that are held on the Datix system. See Annex 2.

The basic steps within the risk assessment process are:

- Identify the hazards;
- Assess who and what might be affected, and how;
- Evaluate the risks and decide whether existing precautions are adequate or should more be done;
- Record the findings;
- Monitor and review the risks and any resulting further actions; and
- Communicate and consult.

Risk Register

The Risk Register contains an overview of the identified risks, the controls already in place to manage the risks, and any actions that have been identified to further mitigate the risks. The format for the Risk Register has been agreed by the NWSSP SMT and the Audit Committee. All risk registers presented to any committee or sub group will follow this agreed format. It is important that this format is implemented at all levels to ensure consistency is achieved across NWSSP.

Risks are scored within the Register as follows:

- ***Inherent Risk Score*** – evaluation of the risk without consideration of any current or future controls or actions to mitigate it;

- ***Residual (or Current) Risk Score*** – evaluation of the risk as at today (i.e. taking into account current controls and mitigations, but **not** any further actions that are yet to be undertaken); and

- ***Target Risk Score*** – where the risk score should be once planned actions have been completed. (This should be a realistic rather than an aspirational assessment).

All risks identified will be assessed using the following matrices (in accordance with the Velindre NHS Trust Risk Policy) which take into account the likelihood of the risk occurring and the resulting severity.

Risk Quantification – MATRIX

Simple risk quantification is identified by multiplying the Impact X Likelihood = Risk Rating. This impact matrix below has been developed by the NPSA (National Patient Safety Agency) and is adopted by Velindre NHS Trust.

	LIKELIHOOD DESCRIPTION
5 Almost Certain	Likely to occur, on many occasions
4 Likely	Will probably occur, but is not a persistent issue
3 Possible	May occur occasionally
2 Unlikely	Not expected it to happen, but may do
1 Rare	Can't believe that this will ever happen

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Risk Rating Matrix = Impact x likelihood

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

Actions and Treatment Timetable

Risk Score	Risk Level	Action and Timescale
1-3	LOW	No action required providing adequate controls in place.
4-6	MODERATE	Action required to reduce/control risk within 12 month period
8-12	SIGNIFICANT	Action required to reduce/control risk within 6 month period
15-25	CRITICAL	Immediate action required by Senior Management

Management of Risk

Roles and Responsibilities

- **Senior Management Team (SMT) -** The SMT is accountable for the systems of internal control, based on an ongoing process designed to identify and prioritise the risks of the organisation, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. SMT review and update the NWSSP Corporate Risk Register at their monthly meetings which contains the corporate, significant and critical risks from across NWSSP including any escalated departmental risks. A SMT lead is assigned to each risk on the register.

- **The Audit Committee -** The Audit Committee provides the NWSSPC with a means of independent assurance that the systems in place for the management of risk are operating efficiently and effectively. The Committee will also provide an objective review of the corporate governance responsibilities, financial systems, financial information and compliance with law, guidance and codes of conduct. The Audit Committee reviews the Corporate Risk Register at each of its meetings.

- **Shared Services Partnership Committee -** The Shared Services Partnership Committee ensures that risk management arrangements are in place and both receives and provides assurance that appropriate and effective control systems are in place to identify and manage risks. The Shared Services Partnership Committee reviews the Corporate Risk Register at its quarterly meetings.

- **Sub/Working Groups -** A wide range of sub/working groups are in place across NWSSP to discuss their departmental/site risks and to ensure that any critical and significant risks are escalated to SMT along with risks which may become corporate. The aim of the working groups is to gather information and where appropriate share the lessons learned across the department.

- **NWSSP All Wales Health and Safety Meeting -** NWSSP All Wales Health and Safety meeting is chaired by the Director of

Finance and Corporate Services. Each Service Division will ensure an appropriate representative attends this committee to ensure that their risks and incidents are monitored and discussed and that the lessons learned can be shared across NWSSP. All significant risks regarding Health and Safety are reported to the Velindre NHS Trust Health and Safety Management Group.

Directorate Risks

Directors, Assistant Directors and Managers should ensure that all risks associated with their directorate are input into the Datix risk management system. Any red-rated risks should be referred to the NWSSP SMT for possible inclusion on the Corporate Risk Register. Directorate Management Teams monitor and review their Departmental risk register on a regular basis. Review of Directorate key risks is also a standing agenda item for the Quarterly Reviews undertaken by the Managing Director and senior colleagues.

Risk Escalation

The NWSSP Senior Management Team, assisted by key senior officers, are responsible for ensuring that risk management policies are implemented within NWSSP and that both risk assessment and incident reporting operates appropriately within the various areas of responsibility and in a climate where staff are encouraged to report incidents without fear of blame.

The process of escalation is used where a risk is unmanageable or uncontrolled or where the risk is significant or critical (12 and above). The purpose of the escalation process is to ensure that all managers at all levels across NWSSP have the option to escalate a risk where they are not able to manage or control it within their area. These risks are discussed at SMT.

Training and Awareness

It is essential that all NWSSP staff receive basic risk management awareness as part of their statutory training. This training can be facilitated at induction or via ELearning and should include:

- principles of risk management;
- roles and responsibilities for management of risk within NWSSP;
- techniques for identification and evaluation of risk;
- how to report hazards, incidents and near misses;
- awareness that risk is everyone's business; and
- policies that cover risk management and assessment.

Directors and Managers ensure that all staff involved in the risk assessment process have sufficient knowledge, experience and understanding of risk and are provided with sufficient training to ensure competence is demonstrated.

Managers ensure that risk assessment training is included in local training programs.

Review Mechanism

The risk management process is continually evolving and it is therefore intended to review this Protocol on an annual basis in light of changes in guidance, best practice and legislation.

Annex 1

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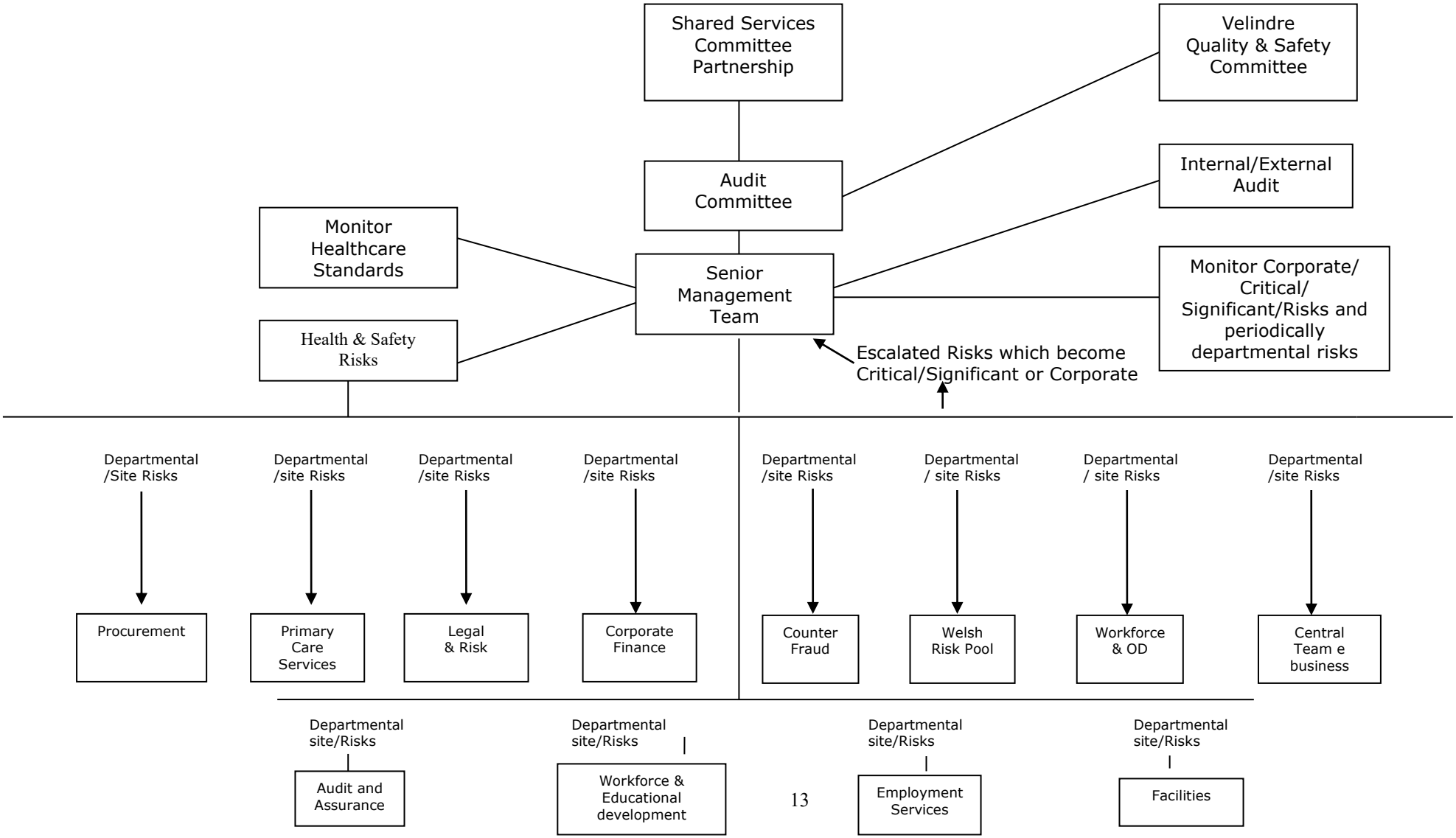
ASSURANCE FRAMEWORK



Annex 2

VELINDRE NHS TRUST	Service Area:	**DATIX - REF NO:**
	RISK ASSESSMENT	Department: Location/Site:
Title of Assessment:		**Date of Assessment:**

Tick the Type of Risk Assessment:

Business & Org		Operational		Clinical		Quality		Health & Safety	
Strategic		Financial		Legal		Project.		Environmental	

Describe the situation or the work activity or process being assessed.
Summarise the specific risks to NWSSP

Please give a full range of Hazards:
Include any Materials, Biological, Chemical, Environment, Ergonomic and Psychological etc.

Hazards identified:	**Impact Severity**	**Likelihood**	**Risk Rating**

Who is affected by the hazards and how many: Whole organisation, division, department, ward etc.
All, Many or One - staff, visitors, contractors or service users etc. may be harmed.

Evaluate Overall **Initial** – Risk : I x L= Risk Rating	**Impact**	**Likelihood**	**Rating**

List control measures in place: Are they acceptable Y/N

Evaluate **Current** – Risk with controls: I x L= Risk Rating	**Impact**	**Likelihood**	**Rating**

Further action required - additional control measures - to reduce risk

Actions Agreed by Manager: **Managers Name & Signature :**

Evaluate **Target** – Risk with actions completed: I x L= Risk Rating	**Impact**	**Likelihood**	**Rating**

Risk Assessment performed by:

Print Name/s	Signature/s	Date

Progress Report on further Actions: include review dates:

Annex 3

Risk Appetite

NO	Level accepted	Description of the potential affect
5	**High Risk**	Organisations accept potential risks that are likely to result in reputational damage, financial loss, major breakdown in services, information systems or integrity, significant incidents of regulatory and or legislative compliance, potential risk of injury to staff and service users.
4	**Medium/ major Risk**	Organisations is willing to accept risks that are likely to result in reputational damage, financial loss, major breakdown in services, information systems or integrity, significant incidents of regulatory and or legislative compliance, potential risk of injury to staff and service users.
3	**Moderate Risk**	Organisations is willing to accept risks in certain circumstances that are likely to result in reputational damage, financial loss, major breakdown in services, information systems or integrity, significant incidents of regulatory and or legislative compliance, potential risk of injury to staff and service users.
2	**Low Risk**	Organisation is not willing to accept, except in very exceptional circumstance agreed by the Board, risks that may result in reputational damage, financial loss, major breakdown in services, information systems or integrity, significant incidents of regulatory and or legislative compliance, potential risk of injury to staff and service users.
1	**Zero risk**	Organisation is not willing to accept risks, under any circumstances that will result in reputational damage, financial loss, major breakdown in services, information systems or integrity, significant incidents of regulatory and or legislative compliance, potential risk of injury to staff and service users.

Definitions **Annex 4**

Risk Management	The co-ordinated activities to direct and control the organisation with regard to risk.
Risk Management Process	A systematic application of risk management policies to the task of identifying, analysing, evaluating, controlling and the monitoring and review of risk across the Trust.
Risk Assessment (Pro-active)	A careful examination of the hazards in the workplace that may cause harm, to people the environment or the business and these include processes and tasks. The formal recording on a documented form.
Risk Assessment (Re-active)	A risk assessment that has been completed following an incident occurring, this may form part of the investigation process or may be a review of the original risk assessment in light of the incident and its severity.
Risk Appetite	The level of risk NWSSP is prepared to accept before action is deemed necessary to reduce it.
Risk Acceptance	The risk is managed to a level defined as reasonably practicable and where to implementation of any further controls will outweigh any benefit.
Residual Risk	The risk remaining following treatment or control.
Risk Register	The risk register is a term for a detailed list of risk assessments, the format for the register itself has been agreed at the SMT.
Risk Inventory	A risk inventory or profile, has no agreed format it may be a shortened version of the risk register or a more detailed profile. A risk inventory is normally less formal that a register and is managed at department level.
Risk Structure	A formal management structure that outlines the basic reporting and communication links and committees and groups that provides assurance to NWSSP SMT that risk is being effectively managed across all Service Divisions.
Risk Matrix	This is a tool developed to quantify risk, by scoring the impact x the likelihood that the risk will probably be realised to establish a Risk Rating. This tool can be used by Managers to prioritise significant risks.
Risk Impact	Potential harm scored via a impact matrix rising from 1-5
Risk Likelihood	Potential for occurrence scored via a likelihood matrix from 1-5
Significant Risk	Risk that are scored 12 and above that require treatment and control within 6 month period.
Critical risk	Risk scored 15 and above requiring immediate Senior management control.

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	5 June 2018
AGENDA ITEM	2.4
REPORT AUTHOR	Peter Stephenson, Head of Finance and Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler – Director of Finance and Corporate Services
PRESENTED BY	Peter Stephenson, Head of Finance and Business Development

TITLE OF REPORT

Annual Governance Statement 2017/2018

PURPOSE OF REPORT

The Audit Committee are requested to **APPROVE** the Annual Governance Statement for 2017/2018.

NWSSP ANNUAL GOVERNANCE STATEMENT 2017/2018

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to receive, for assurance purposes, the Annual Governance Statement for the NHS Wales Shared Services Partnership (NWSSP). The Committee are requested to **APPROVE** the Annual Governance Statement 2017-2018.

The Draft Annual Governance Statement was brought to the last Audit Committee meeting. It was been subsequently updated and was taken to the Senior Management Team on 24 May 2018. The Annual Governance Statement for 2017-2018 is now presented to the Audit Committee in its final version, for **APPROVAL**.

2. RECOMMENDATION

The Committee is asked to:

- **APPROVE** the Annual Governance Statement 2017/2018.

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Annual Governance Statement 2017/2018

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

CONTENTS

1. SCOPE OF RESPONSIBILITY

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

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

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

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

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

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

Figure 1 –NWSSP's Governance Structure

Underpinned through the overarching Velindre NHS Trust legal and assurance framework

2. GOVERNANCE FRAMEWORK

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

2.1 Shared Services Partnership Committee

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

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

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

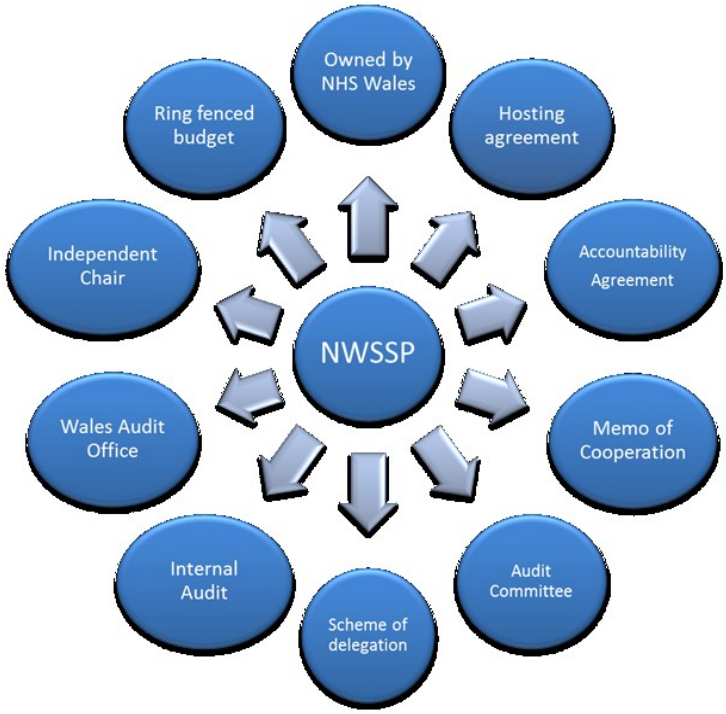
Health Boards and NHS Trusts in Wales have collaborated over the operational arrangements for the provision of shared services and have an agreed Memorandum of Co-operation to ensure that the arrangements operate effectively through collective decision making in accordance with the policy and strategy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

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

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

NWSSP's governance arrangements are summarised below.

Figure 2: Summary of Governance Arrangements



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

- Standing Orders;
- Hosting Agreement;
- Interface Agreement between the Chief Executive Velindre NHS Trust and Managing Director of 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 2018 is outlined in Figure 3 below. All meetings were quorate and attended by the Chair, and the attendance of the Committee is outlined in Figure 4.

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

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

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

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

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

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

✓ Denotes the nominated member was present

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

× Denotes Health Body not represented

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

The purpose of the Partnership Committee is set out below:

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

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

The Partnership Committee ensures that NWSSP consistently followed the principles of good governance applicable to NHS organisations, including the oversight and development of systems and processes for financial

control, organisational control, governance and risk management. The Partnership Committee assesses strategic and corporate risks through the Corporate Risk Register.

2.2 Partnership Committee Performance and Self Assessment

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

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

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

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

2.3 Velindre Audit Committee for NWSSP

The primary role of the Velindre NHS Trust Audit Committee for Shared Services (Audit Committee) has been to review and report upon the adequacy and effective operation of NWSSP's overall governance and internal control system. This includes risk management, operational and compliance controls, together with the related assurances that underpin the delivery of NWSSP's objectives. This role is set out clearly in the Audit Committee's terms of reference which were revised in 2017/2018 to ensure these key functions were embedded within the standing orders and governance arrangements.

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

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

The Committee attendees during 2017/2018 comprised of three Independent Members of Velindre NHS Trust supported by representatives

of both Internal and External Audit and Senior Officers of NWSSP and Velindre NHS Trust.

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

In Attendance	April 2017	June 2017	July 2017	Nov 2017	Feb 2018	Total Out of 5
Committee Members						
Martin Veale, Chair & Independent Member	✓	✓	✓	✓	✓	**5**
Ray Singh, Independent Member	✓		✓	✓		**3**
Professor Jane Hopkinson, Independent Member	✓	✓	✓	✓	✓	**5**
Wales Audit Office						
Audit Team Representative	✓✓	✓	✓		✓	**4**
NWSSP Audit Service						
Director of Audit & Assurance	✓	✓	✓	✓	✓	**5**
Head of Internal Audit	✓	✓	✓	✓	✓	**5**
Audit Manager	✓	✓	✓	✓	✓	**5**
Counter Fraud Services						
Local Counter Fraud Specialist	✓	✓	✓	✓	✓	**5**
NWSSP						
Margaret Foster, Chair NWSSP	✓		✓	✓	✓	**4**
Neil Frow, Managing Director	✓	✓	✓		✓	**4**
Andy Butler, Director of Finance & Corporate Services	✓	✓	✓	✓	✓	**5**
Jacqui Maunder, Head of Corporate Services	✓	✓	✓	✓	✓	**5**
Roxann Davies, Compliance Officer	✓	✓	✓	✓	✓	**5**
NWSSP Secretariat	✓	✓		✓		**3**
Other Staff		✓✓	✓✓	✓	✓✓	**4**
Velindre NHS Trust						
Steve Ham, Chief Executive		✓				**1**
Mark Osland, Director of Finance	✓	✓	✓		✓	**4**

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

2.4 Reviewing Effectiveness of Audit Committee

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

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

The survey questionnaire comprises self-assessment questions intended to assist the Committee in assessing their effectiveness with a view to identifying potential areas for development going forward. The survey for 2017/18 is being undertaken during May 2018.

2.5 Sub Groups and Advisory Groups

The Partnership Committee is supported by four advisory groups:

- **Workforce Education and Development Services Advisory Group (WEDSAG)**
  - Advisory group to the Shared Services Partnership Committee; and
  - Reviews progress with Workforce Development and Education activity on behalf of NHS Wales.

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

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

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

2.6 Senior Management Team (SMT)

The Managing Director leads the SMT and reports to the Chair of the Partnership Committee on the overall performance of NWSSP. The Managing Director is the designated Accountable Officer for Shared Services and is accountable, through the leadership of the Senior Management Team, for:

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

The SMT are responsible for determining NWSSP policy, setting the strategic direction and aims to ensure that there is effective internal control, and ensuring high standards of governance and behaviour. In addition, the SMT is responsible for ensuring that NWSSP is responsive to the needs of Health Boards and Trusts.

The SMT comprises:

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

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

3. THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to the achievement of the policies, aims and objectives of NWSSP. Therefore, it can only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks, evaluate the likelihood of those risks being realised and the impact they would have, and to manage them efficiently, effectively and economically. The system of internal control has been in place in NWSSP for the year ending 31 March 2018.

3.1 External Audit

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

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

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

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

3.2 Internal Audit

The Audit Committee regularly reviewed and considered the work and findings of the internal audit team. The Director of Audit and Assurance and the relevant Heads of Internal Audit have attended each meeting to discuss their work and present their findings. The Audit Committee are satisfied with the liaison and coordination between the external and internal auditors.

Quarterly returns providing assurance on any audit areas assessed as having "no assurance" or "limited assurance" were issued to Welsh Government in accordance with the instruction received from Dr Andrew Goodall, Chief Executive NHS Wales/Director General in July 2016. During 2017/18 no internal audit reports were rated as limited or no assurance.

For both internal and external audit, the Audit Committee have ensured that management actions agreed in response to reported weaknesses were implemented in a timely manner. Any planned revisions to agreed timescales for implementation of action plans requires Audit Committee approval.

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

3.3 Counter Fraud Specialists

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

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

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

During 2017/18, four 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 within the Health Body for which a number of days are then allocated and included as part of a an agreed Counter Fraud Work-Plan which is signed off, by the Health Body's Finance Director, on an annual basis.

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

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

3.4 Integrated Governance

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

- The Quality Assurance and Improvement Plan arising from the 2015-16 year end self-assessment;
- Tracking of Audit Recommendations;
- Corporate Risk Register;

- Directorate Assurance Maps; and
- Governance Matters report on single tender actions, declarations of interest, gifts and hospitality received and declined.

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

3.5 Quality

During 2017/2018, the Partnership Committee has given attention to assuring the quality of services by including a section on "Quality, Safety and Patient Experience" as one of the core considerations on the committee report template when drafting reports for Partnership Committee meetings.

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

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

3.6 Looking Ahead

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

Looking forward to 2018-2019 the Audit Committee will continue to explore the financial, management, governance and quality issues that are an essential component of the success of NWSSP.

Specifically, the Audit Committee will:

- Continue to examine the governance and internal controls of NWSSP;
- Monitor closely risks faced by NWSSP and also by its major providers;
- Work closely with the "Chairs of Audit Committee group" on issues arising from financial governance matters affecting NHS Wales and the broader public sector community;
- Work closely with external and internal auditors on issues arising from both the current and future agenda for NWSSP;

- Ensure the Partnership Committee is kept aware of its work including both positive and adverse developments; and
- Request and review a number of "deep dives" into specific areas to ensure that it provides adequate assurance to both the Audit Committee and the Partnership Committee.

4. CAPACITY TO HANDLE RISK

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

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

Velindre NHS Trust has an approved strategy for risk management and NWSSP has a risk management protocol in line with our host's strategy providing a clear systematic approach to the management of risk within NWSSP.

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

The Corporate Risk Register is reviewed monthly by the SMT who ensure that key risks are aligned to delivery and are considered and scrutinised by the SMT as a whole. It is the responsibility of each Director and Head of Service to ensure that risk is addressed within each of the locations relevant to their Directorates. It is also important that an effective feedback mechanism operates across NWSSP so that frontline risks are escalated to the attention of Directors.

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

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

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

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

The NWSSP Risk Protocol has been updated accordingly and now includes a greater focus on the risk appetite of the organisation. The operationalisation of the risk appetite is through the target score applied to each risk, and this has led to a re-structuring of the Corporate Risk Register into two sections as follows:

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

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

NWSSP's approach to risk management therefore ensures that:

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

An internal audit of the progress made with implementing the findings of the 2016/17 audit into risk management was finalised in May 2018 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.**

5. THE RISK AND CONTROL FRAMEWORK

NWSSP's commitment to the principle that risk is managed effectively means that we will continue to work to ensure that:

- There is compliance with legislative requirements where non-compliance would pose a serious risk;
- All sources and consequences of risk are identified and risks are assessed and either eliminated or minimised; information concerning risk is shared with staff across NWSSP and with Partner organisations through the Partnership Committee and the Audit Committee;
- Damage and injuries are minimised, and people health and wellbeing is optimised; and
- Lessons are learnt from compliments, incidents, and claims in order to share best practice and reduce the likelihood of reoccurrence.

5.1 Corporate Risk Framework

The detailed procedures for the management of corporate risk have been outlined above. As at 31 March 2018, there is one corporate risk categorised as having a "red" risk rating. This relates to issues surrounding the outsourcing of a number of primary care services in England which have an impact on NHS Wales. There are a number of options for NWSSP in managing this particular risk and these are being evaluated at present.

Generally to mitigate against potential risks concerning governance, NWSSP is proactive in reviewing its governance procedures and ensuring that risk management is embedded throughout its activities, including:

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

- The responsibilities of Directors are reviewed at annual Performance and Development Reviews (PADRs).

5.2 Policies and Procedures

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

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

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

5.3 Information Governance

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

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

NWSSP has an Information Governance Manager who has the objective of facilitating the effective use of controls and mechanisms to ensure that staff comply with Information Governance fundamental principles and procedures. This work includes awareness by delivery of an online core skills training framework eLearning module on Information Governance, classroom based training for identified "high risk" staff groups, developing and reviewing policies and protocols to safeguard information, and advising

on and investigating Information Governance breaches reported on the Datix incident reporting system.

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

NWSSP has an "Information Governance Steering Group" (IGSG) that comprises representatives from each directorate who undertake the role of "Information Asset Administrators" for NWSSP. This is to ensure that all information assets are accounted for as they are realised. This is an area that forms part of the recommendations of the General Data Protection Regulation (GDPR) that is due to be implemented by 25 May 2018 and which will be an increasing area of focus.

The IGSG discusses quarterly issues such as Data Protection Legislation, the Freedom of Information Act, Information Asset Ownership, Information Governance Breaches, Records Management, Training compliance, new guidance documentation and training materials, areas of concern and latest new information and law including the implementation of GDPR.

All members of the IGSG have the opportunity during a defined consultation period to review any work that requires comment before being approved by the NWSSP Senior Management Team. The Information Governance Manager provides information in relation to any areas that require input and determines the agenda for each meeting based on their own requirements and also from those members who have items for discussion. There is also an IT or "Informatics" section on the agenda for discussion of technological issues such as Cyber Security.

NWSSP has a suite of protocols and guidance documents used in training and awareness for all staff on the importance of confidentiality and to ensure that all areas are accounted for. These include email and password good practice guides, summarised protocols and general guidance for staff. There is also a documented Privacy Impact Assessment (or "Privacy by Design") process in place to ensure consideration of Information Governance principles during the early stages of new projects, processes or workstreams proposing to use identifiable information in some form. This poses questions on the Who, What, Why, Where, When and How of the project to get official Information Governance sign off and ensure that the work will not breach any confidentiality of patients, service users, clients or staff and that the integrity of the data is secure.

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

The Information Governance Manager attends various meetings including the Velindre NHS Trust IG and IM&T Committee and the NHS Wales

Information Governance Management Advisory Group (IGMAG) hosted by NHS Wales Informatics, attended by all NHS Wales Health Boards. This allows discussion of issues on an All Wales basis. The Information Governance Manager is also Chair of the Freedom of Information Community of Practice, and Chair and Author for the review of the "Your Information, Your Rights" public document in readiness for the new legislation on an All Wales basis. This document will inform patients of their rights and promotes openness and transparency within the NHS.

General Data Protection Regulations (GDPR)

Work has been ongoing during 2017/18 to prepare for the new General Data Protection Regulations (GDPR) which came into effect on 25 May 2018. The GDPR builds on and strengthens the previous Data Protection Act 1998. The key work undertaken in the year included:

- *Updates to Information Governance internal protocols and training materials;*
- *Development of Privacy Notices (fair processing notices) for staff and service users due to the enhancement of individuals' rights;*
- *Information mapping to include all data known, held and processed by the NWSSP*
- *Establishment of Information Asset Owners and Administrators;*
- *A thorough review of all internal activities, including specific areas such as Procurement and Recruitment Services;*
- *Attendance at National and Local Task and Finish Groups;*
- *Appointment of a Data Protection Officer (currently the Head of Information Governance, NHS Wales Informatics Service (NWIS))*

Plans are in place to ensure that NWSSP is fully compliant with GDPR and progress is being monitored by the SIRO and the Senior Management Team.

5.4 Counter Fraud

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

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

5.5 Internal Audit

The NWSSP hosting agreement provides in Section 14 that the Partnership Committee will establish an effective internal audit as a key source of its internal assurance arrangements, in accordance with the Public Internal Auditing Standards.

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

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

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

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

5.6 Integrated Medium Term Plan (IMTP)

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

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

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

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

5.7 Health and Care Standards for NHS Wales

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

The Health and Care Standards Framework comprises seven main themes and sub criteria against which NHS bodies need to demonstrate compliance. A summary of the themes is outlined below:

The process for undertaking the annual self-assessments is:

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

Each theme is assessed and given an overall self-assessment rating of between 1 and 5. As a largely non-clinical service provider, not all of the sub-criteria are applicable.

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

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

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

The overall rating against the mandatory Governance, Leadership and accountability module and the seven themes within the Health and Care Standards reflects NWSSP's overall compliance against the standards and has been rated as a 3 as outlined below:

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

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

6. MANDATORY DISCLOSURES

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

6.1 Equality, Diversity and Human Rights

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

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

We work together with colleagues across NHS Wales to collaborate on events, facilitate workshops, deliver and undertake training sessions, issue communications and articles relating to equality, diversity and inclusion, together with the promotion of dignity and respect.

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

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

We have worked with the NHS Wales Centre for Equality & Human Rights (CEHR) to introduce our own process for undertaking Equality Integrated Impact Assessments (EQIIA), which we are integrating into our Project Management System software. The EQIIA will consider the needs of the protected characteristics identified under the Equality Act 2010 (including the Welsh specific duties), the Human Rights Act 1998, Well-being of Future Generations (Wales) Act 2015 incorporating Environmental Sustainability, Modern Slavery Act 2015 incorporating Ethical Employment in Supply Chains Code of Practice (2017), and Welsh Language, Information Governance and Health and Safety aspects.

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

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

Personal data in relation to equality and diversity is captured on the Electronic Staff Record (ESR) system and staff are responsible for updating their own personal records using the Electronic Staff Record Self-Service. This includes: Ethnic Origin; Nationality; Country of Birth; Religious Belief, Sexual Orientation and Welsh language competencies.

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

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

The "NHS Jobs" all Wales recruitment service, run by NWSSP adheres to all of the practices and principles in accordance with the Equality Act and quality checks the adverts and supporting information to ensure no discriminatory elements.

6.2 Welsh Language

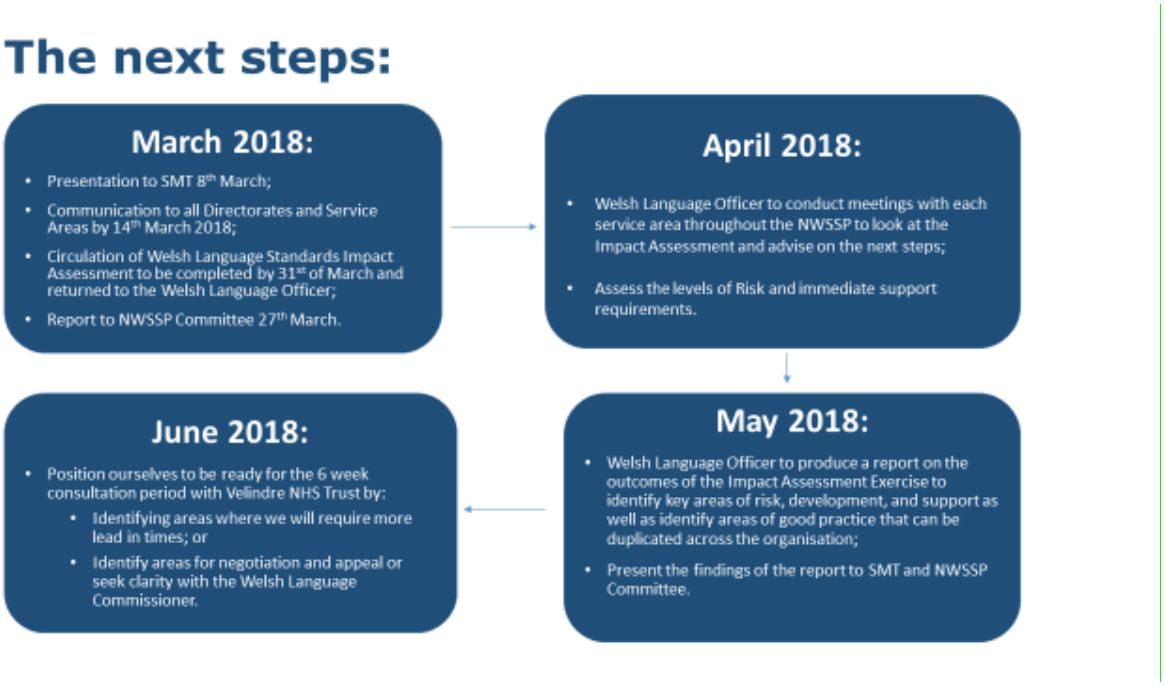
NWSSP is committed to ensuring that the Welsh and English languages are treated equally in the services we provide to the public and NHS partner organisations in Wales. This is in accordance with the current Velindre NHS Trust Welsh Language Scheme, Welsh Language Act 1993 and the Welsh Language Measure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

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

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

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

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



NWSSP has made significant progress in developing and growing its Welsh language services by successfully offering all staff the opportunity to learn Welsh at work. The NWSSP website is bilingual and we have invested in the development of a candidate interface on the TRAC recruitment system.

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

6.3 Handling Complaints and Concerns

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

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

During 2017-18, 14 complaints were received. **71%** of the complaints received were responded to within the 30 working day target, which is consistent with the performance for the prior year. Four responses were issued outside of the target, being responded to at 31, 34, 37 and 39 working days respectively. However, in all instances holding letters were

issued to the complainants detailing 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.

In the financial year 2017/2018, NWSSP responded to 65 requests for information:

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

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

6.5 Data Security

In 2017/2018, 38 information governance breaches were reported within NWSSP, these included issues with misdirection of email and records management.

All breaches are recorded in the Datix risk management software, and investigated in accordance with the Information Governance and Confidentiality Breach Reporting protocols. The protocols encourage staff to report those breaches that originate outside the organisation for recording purposes.

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

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

Members of the IGSG are required to report to the Steering Group meetings on any incidents in their areas to include lessons learned and any changes that have been made since an incident was reported.

There was one Information Governance breach reported in 2017/18 that was assessed as being of a category serious enough to report to the

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

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

6.6 ISO14001 – Sustainability and Carbon Reduction Delivery Plan

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

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

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

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

Carbon Footprint

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

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

6.7 Business Continuity Planning/Emergency Preparedness

NWSSP is proactive in reviewing the capability of the organisation to continue to deliver products or services at acceptable predefined levels following a disruptive incident. We recognise our contribution in supporting NHS Wales to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care, in accordance with requirement for NHS bodies to be classed as a Category 1 responders deemed as being at the core of the response to most emergencies under the Civil Contingencies Act (2004).

As a hosted organisation under Velindre NHS Trust we are required to take note of their Business Continuity Management Policy and ensure that NWSSP has effective strategies in place for:

- People – the loss of personnel due to sickness or pandemic;
- Premises – denial of access to normal places of work;
- Information Management and Technology and communications/ICT equipment issues; and
- Suppliers internal and external to the organisation.

NWSSP is committed to ensuring that it meets all legal and regulatory requirements and has processes in place to identify, assess, and implement applicable legislation and regulation requirements related to the continuity of operations and the interests of key stakeholders. At present there are local directorate plans in place for ensuring business continuity arrangements are effective for key services and buildings, and work is progressing in developing an overarching Business Continuity Plan which outlines our response to incidents and outbreaks, including the mobilisation of additional resource.

In addition, we complete the Caldicott Principles Into Practice (CPIP) annual self-assessment which assesses if organisations have current and tested business continuity plans in place for all of their critical infrastructure components and core information systems.

NWSSP are working towards implementing the Cyber Security Framework in order to address the specific needs of the service. This is an ongoing plan covering the areas of Identify, Protect, Detect, Respond and Recover. NWSSP have already started a number of work streams including Information Workflows and Governance, Awareness and Training, Procurement of Professional Incident Response Capability, Protective Technology through the SIEM Procurement Project and Business Continuity Planning workshops across the whole of the whole of Shared Services. NWSSP have also recently implemented a robust new virtualised infrastructure based on the tenets of the framework in order to provide a safe and secure environment for NWSSP business systems.

6.8 UK Corporate Governance Code

NWSSP operates within the scope of the Velindre NHS Trust governance arrangements. Velindre NHS Trust has undertaken an assessment against the main principles of the UK Corporate Governance Code as they relate to an NHS public sector organisation in Wales. This assessment was informed by the Trust's assessment against the "Governance, Leadership and Accountability" theme of the Health and Care Standards undertaken by the Board. The Trust is clear that it is complying with the main principles of the Code, is following the spirit of the Code to good effect and is conducting its business openly and in line with the Code. The Board recognises that not all reporting elements of the Code are outlined in this Governance Statement but are reported more fully in the Trust's wider Annual Report. NWSSP have also completed the self-assessment on the "Governance, Leadership and Accountability" theme of the Health and Care Standards with a positive maturity rating of 4.

6.9 NHS Pension Scheme

As an employer under Velindre NHS Trust and as the Payroll function for NHS Wales, within NWSSP's remit there are robust control measures in place to ensure that all employer obligations contained within the Scheme regulations for staff entitled to membership of the NHS Pension Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

7. MANAGING DIRECTOR'S OVERALL REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the Directors and Heads of Service within NWSSP who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

As Accountable Officer I have overall responsibility for risk management and report to the NHS Wales Shared Services Partnership Committee regarding the effectiveness of risk management across NWSSP. My advice to the Partnership Committee is informed by reports on internal controls received from all its committees and in particular the Audit Committee.

Each of the Committees have considered a range of reports relating to their areas of business during the last year, which have included a comprehensive range of internal audit and external audit reports and reports on professional standards from other regulatory bodies. The Committees have also considered and advised on areas for local and national strategic developments and a potential expansion of the services provided by NWSSP. Each Committee develops an annual report of its business and the areas that it has covered during the last year and these are reported in public to the Velindre NHS Trust and the local Health Boards.

Internal Audit Opinion

Internal audit provide me and the Partnership Committee through the Audit Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with Public Sector Internal Audit Standards by the Audit and Assurance function within NWSSP.

The scope of this work is agreed with the Audit Committee and is focussed on significant risk areas and local improvement priorities. The overall opinion of the Head of Internal Audit on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The Head of Internal Audit opinion for 2017/2018 was that the Partnership Committee can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively:

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

In reaching this overarching opinion the Head of Internal Audit has identified that the assurance domains relevant to NWSSP have all been assessed as providing reasonable assurance.

Internal Audit review of Corporate Governance

Internal Audit undertook a review of Corporate Governance in 2017/2018 to assess the control environment including review of this Annual Governance Statement and of the progress made in implementing the findings from the 2016/17 review of Risk Management. 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 associated with Corporate Governance was **Substantial Assurance**. This report was taken into account when completing the theme on the Governance, Leadership and Accountability Health and Care Standards self-assessment for 2017/2018.

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.

A separate review of the process for tracking Audit Recommendations (both internal and external audit) was undertaken by the Internal Auditors who 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 the Audit Recommendation Tracker was **Substantial Assurance**.

Financial Control

NWSSP was established by Welsh Government to provide a range of support services to the NHS in Wales. As Managing Director and Accountable Officer I retain overall accountability in relation to the financial management of NWSSP and report to the Chair of the Partnership Committee.

NWSSP Financial Control Overview

There are four key elements to the Financial Control environment for NWSSP as follows:

- **Governance Procedures** – As a hosted organisation NWSSP operates under the Governance Framework of Velindre NHS Trust. These procedures include the Standing Orders for the regulation of

their proceedings and business. The statutory requirements have been translated into day-to-day operating practice, and, together with the Scheme of Reservation and Delegation of Powers and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust. These arrangements are supported by detailed financial operating procedures covering the whole of Velindre and also local procedures specific to NWSSP.

- **Budgets and Plan Objectives** – Clarity is provided to operational functions through approved objectives and annual budgets. Performance is measured against these during the year.

- **Service Level Agreements (SLAs) –** NWSSP has SLAs in place with all customer organisations and with certain key suppliers. This ensures clarity of expectations in terms of service delivery, mutual obligations and an understanding of the key performance indicators. The SLAs are reviewed annually to ensure that they remain current and take account of service developments.

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

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

CONCLUSION

This Governance Statement indicates that NWSSP has continued to make progress and mature as an organisation during 2017/2018 and that we are further developing and embedding good governance and appropriate controls throughout the organisation. No significant control weaknesses have been identified during the year. NWSSP has received positive feedback from Internal Audit on the assurance framework and this, in conjunction with other sources of assurance, leads me to conclude that it has a robust system of control.

Looking forward – for the period 2018-19:

I confirm that I am aware of my on-going responsibilities and accountability to you, to ensure compliance in all areas as outlined in the above statements continues to be discharged for the financial year 2018-2019.

Signed by:

Managing Director – NHS Wales Shared Services Partnership

Date: 2018

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

NHS Wales Shared Services Partnership

HEAD OF INTERNAL AUDIT OPINION & ANNUAL REPORT 2017/18

May 2017

NHS Wales Shared Services Partnership

Audit and Assurance Services

Assurance Rating

Reasonable Assurance

CONTENTS

Report status: FINAL
Final report issued: 29th May 2018
Author: Head of Internal Audit
Executive Clearance: Neil Frow, Managing Director
Audit Committee: 5th June 2018

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 2017/18. 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 also taken into account, where appropriate, the number and significance of any audits that have been deferred during the course of the year (see also Sections 2.4.1 and 4.6).

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 2017/18.

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.

- Of the four Primary Care Services all Wales audits – General Medical Services, General Pharmaceutical Services (including Prescribing) and General Ophthalmic Services were given substantial audit assurance ratings, whilst General Dental Services was given a reasonable rating.
- Under the Procurement Services directorate, the all Wales audit of the Accounts Payable function was given a reasonable audit assurance rating. Further reviews were undertaken in response to requests by management; WAO Review – RKC Associates: Lessons Learned by NWSSP and ABMUHB CRC Payment Review. These were not given an assurance rating as they were investigations into specific matters raised by the WAO and ABMUHB respectively.
- The all Wales audit of Payroll Services, under the Employment Services directorate, was given a reasonable assurance rating.

NWSSP SPECIFIC AUDITS

- Audits of corporate governance areas, Audit Recommendation Tracker, Information Governance (GDPR) and Corporate Governance including Risk Management Follow-up received a substantial assurance rating. The audit of Performance Management received a reasonable assurance rating.
- Two reviews of specific services were undertaken. Non-Medical Health Education Budget received a substantial assurance rating. Surgical Materials Testing Laboratory (SMTL) received a reasonable assurance rating.
- The audit of WfIS ESR OH Bi Directional Interface (Immunisations) received a substantial assurance rating.

- Within Capital & Estates, proactive on-going support was provided for management in respect of the renewal of NHS Building for Wales Frameworks, ensuring timely feedback was provided at both the pre-qualification and invitation to tender stage of each respective appointment. Positive management action was noted to address matters identified.

- A small number of audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: concluded with an assurance note to management and reporting to Audit Committee or deferred until the 2018/19 audit year. Where changes were made to the audit plan then the reasons were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

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 2017/18 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 2017/18.

Our conformance statement for 2017/18 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2017/18 which will be reported formally in the Summer of 2018;
- 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 2017/18 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 2018/19 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 2017/18. The key performance indicators are summarised in **Appendix B**.

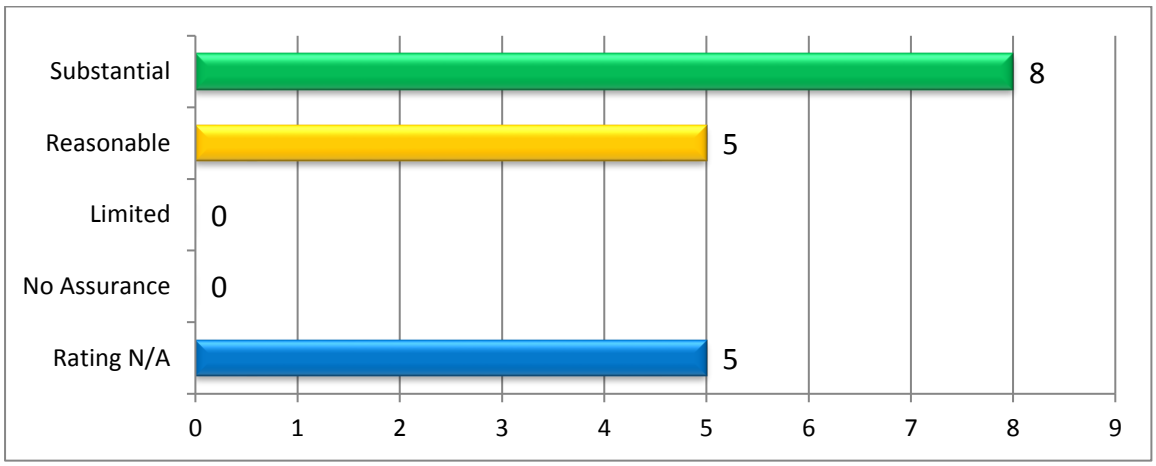
4. RISK BASED AUDIT ASSIGNMENTS

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 **18** 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 (Business Continuity) which was deferred to 2018/19 in agreement with management, as it was recognised that there was action required to address issues / risks already known to management and an audit review at that time would not add additional value. There was one further audit (GP Trainee Project) 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) (Final)	To evaluate and determine the adequacy of the systems and controls in place for the management of payments made to Pharmacists.

Review Title	Objective
General Medical Services (Final)	To evaluate and determine the adequacy of the systems and controls in place for the management of GMS payments.
General Ophthalmic Services (Final)	To evaluate and determine the adequacy of the systems and controls in place for the management of GOS payments.
Audit Recommendation Tracker (Final)	To evaluate and determine the adequacy of the arrangements in place for recording and monitoring implementation of audit recommendations.
Information Governance: GDPR (Final)	To evaluate and determine the adequacy of the arrangements in place for ensuring compliance with the Global Data Protection Regulations (GDPR).
Non-Medical Health Education Budget (Final)	To determine the adequacy and effectiveness of the arrangements in place for the management of the Non-Medical Health Education Budget.
WfIS ESR OH Bi Directional Interface (Immunisations) (Final)	To evaluate and determine the adequacy of the process for developing the interface between the Occupational Health (OH) and ESR systems.
Corporate Governance including Risk Management follow-up (Final)	To evaluate and determine the adequacy of the arrangements in place for ensuring effective corporate governance within NWSSP.

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
General Dental Services (Final)	To evaluate and determine the adequacy of the systems and controls in place for the management of GDS payments.
Employment Services – Payroll (all Wales report) (Final)	To evaluate and determine the adequacy of the systems and controls in place for the management of Payroll.
Accounts Payable (all Wales report) (Final)	To evaluate and determine the adequacy of the systems and controls in place for the management of the accounts payable function.
Performance Management and Reporting (Final)	To evaluate and determine the adequacy of the systems and controls in place over the performance management framework.
Surgical Materials Testing Laboratory (SMTL) (Final)	To review the arrangements in place for risk management and income arising from commercial testing contracts.

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
WAO Review – RKC Associates: Lessons Learned by NWSSP	To provide assurance to NWSSP that lessons had been learned in relation to the points made in the WAO report.
ABMUHB CRC Payment Review	To review the circumstances surrounding an issue in relation to a payment made by NWSSP Accounts Payable, on behalf of ABMUHB, to the Department of Business, Energy and Industrial Strategy in respect of carbon reduction commitment allowances.
Primary Medical Care Advisory Team	To review the arrangements in place for risk management and governance within this team. An initial review of risk was undertaken and we concluded that there are few measurable outcomes from the work of the small team which is currently under review by management. We therefore provided an assurance note to this effect to management.
Exeter System – Advisory Review	To monitor the implications of the withdrawal of the Exeter System on payments to primary care contractors. We kept this under review throughout 2017/18 and reported to the Audit Committee in February 2018 that we had concluded this activity for the year and we would perform specific work in 2018/19 as the options for replacement of the system were progressed.
Renewal of the NHS Building for Wales Frameworks	This was proactive on-going support for management, ensuring timely feedback was provided at both the pre-qualification and invitation to tender stage of each respective framework appointment. The review concluded in February 2018.

Additionally, the following audit was deferred for the reason outlined below. The deferral does not impact upon the Head of Internal Audit Opinion.

Review Title	Reason
Business Continuity	Work is being undertaken by NWSSP to develop business continuity arrangements. It was therefore agreed that this review should be undertaken in quarter 3 of 2018/19 in order to allow for this development work to be undertaken.

5. ACKNOWLEDGEMENT

In closing, I would like to acknowledge the time and co-operation given by directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2017/18 plan.

James Quance

Head of Internal Audit

Audit and Assurance Services

NHS Wales Shared Services Partnership

May 2018

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 2017/18	G	June 2017	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2017/18	G	100%	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	75%	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.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

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.

Office details: Audit and Assurance Services
1st Floor
Cwmbran House
Mamhilad Park Estate
Pontypool
NP4 0XS

Contact details: (01495) 300841

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
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Corporate Services

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Substantial Assurance


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Review reference:	NWSSP-1718-12
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Fieldwork commencement:	18th April 2018
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Final report issued:	21st May 2018
Auditors:	James Quance, Head of Internal Audit Sophie Corbett, Audit Manager Donna Morgan, Principal Auditor
Executive sign off:	Andy Butler, Director of Finance & Corporate Services
Distribution:	Neil Frow, Managing Director Andy Butler, Director of Finance & Corporate Services Peter Stephenson, Head of Finance & Business Improvement Roxann Davies, Compliance Officer

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 audit tracker process for monitoring and recording progress in implementing audit recommendations within NHS Wales Shared Services Partnership (NWSSP) was completed in line with the 2017/18 Internal Audit Plan.

The relevant lead for the assignment is Andrew Butler – Director of Finance & Corporate Services.

Recommendations arising from internal and external audit reports are recorded on an audit tracker database, which is used to monitor and record progress in implementing agreed actions. Responsible officers are required to provide monthly progress updates against each recommendation until it is reported as implemented. A summary extract of the audit tracker database is reported to each Audit Committee meeting and the monthly Senior Management Team (SMT) meetings.

1.2 Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the arrangements in place for recording and monitoring implementation of audit recommendations.

The specific objectives reviewed were as follows:

- appropriate arrangements are in place to ensure that the audit tracker is a complete and accurate record of recommendations arising from internal and external audit reports;
- responsible officers provide regular progress updates;
- recommendations are only recorded as implemented once the agreed action has been completed and the risk addressed;
- recommendations outside the control of the responsible officer, or requiring input or action by a third party are escalated where appropriate;
- there is a robust process for agreeing revised deadlines for implementation; and
- information reported to Audit Committee is accurate.

1.3 Associated Risks

The risks considered in the review were as follows:

i. identified risks and/or weaknesses are not addressed;
ii. recommendations inappropriately recorded as implemented resulting in false assurance that risks or weaknesses have been addressed; and
iii. inaccurate information reported to Audit Committee.

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 management of the audit tracker 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	The Audit Tracker is complete and accurate			✓	
2	Responsible officers provide regular progress updates				✓
3	Recommendations are recorded as implemented once the agreed action has been completed			✓	

Assurance Summary					
4	Escalation of recommendations outside of the control of NWSSP			✓	
5	Revising recommendation deadlines				✓
6	Reporting progress to the Audit Committee				✓

** 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 is classified as a weakness in the system control/design for management of the audit tracker. This is identified in the management action plan as (D).

2.4 Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control for management of the audit tracker. This is identified in the management action plan 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**	**2**	**0**	**2**

3 AUDIT FINDINGS

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

Objective 1: Appropriate arrangements are in place to ensure that the Audit Tracker is a complete and accurate record of recommendations arising from internal and external audit reports

It was evident that the Audit Tracker is regularly monitored and updated by the Compliance Officer, with a full audit trail of iterations maintained.

There were 222 recommendations recorded on the Audit Tracker as at April 2018:

	High	Medium	Low	Un-rated	Total	%
Implemented	22	112	70	4	**208**	94%
Not Yet Due		7	1		**8**	3.5%
Revised Deadline		3	1	1	**5**	2%
Outstanding	1				**1**	0.5%
Total	**23**	**122**	**72**	**5**	**222**	
%	10.5%	55%	32.5%	2%		

For a sample of 10 audit reports, we confirmed that all recommendations (47) had been completely and accurately recorded in the audit tracker.

However, subsequent testing undertaken on a sample of different recommendations (reported under objective 3 below) identified the following minor issues in relation to maintenance of the Audit Tracker:

- Management actions from the recent *WAO Review: RKC Associates Lessons Learned* review (report NWSSP-1718-01 refers) have not been recorded on the audit tracker. The responsible officer has, however, provided a progress update to the Audit Committee.
- Eight recommendations arising from the Health Courier Services Follow Up audit in 2016/17 (report NWSSP-1617-06 refers) were incorrectly recorded against the original Health Courier Services audit undertaken in 2015/16 (report NWSSP-1516-21 refers).

  Consequently, the audit tracker reference of two recommendations arising from the follow-up review is not in line with the references in the report.

- The audit tracker references for recommendations arising from the Bridgend Stores audit (report NWSSP-1516-19 refers) were not in line with the referencing in the report.

  This was due to multi-part recommendations being split and recorded separately in the audit tracker. This approach has not been applied consistently, and results in a discrepancy in the number of recommendations recorded in the audit tracker and report.

Please refer to **Recommendation 2 at Appendix A** for further details.

Objective 2: Responsible officers provide regular progress updates

Updates are requested by the Compliance Officer on an ad hoc (usually monthly) basis in line with SMT and Audit Committee meetings, until the recommendation is considered implemented.

No Issues Identified

Objective 3: Recommendations are only recorded as implemented once the agreed action has been completed and the risk addressed

Of the 222 recommendations recorded on the tracker, 40 recommendations have been followed up as part of the 2017/18 transactional audits.

We sampled 19 of the remaining 182 recommendations recorded as implemented in order to verify the recommendation status recorded on the audit tracker.

We were unable to obtain sufficient evidence to support the 'implemented' status for one medium priority recommendation in the Procurement Services Central Sourcing audit (report NWSSP-1516-03 refers). Please refer to **Recommendation 1 at Appendix A** for further details.

Objective 4: Recommendations outside the control of the responsible officer, or requiring input or action by a third party are escalated where appropriate

There are three recommendations on the audit tracker which are outside of the direct control of NWSSP. The process for dealing with these recommendations was discussed at the April 2018 Senior Management Team meeting.

The Head of Finance & Business Development and Director of Audit & Assurance have been tasked with establishing the procedure for the escalation of recommendations requiring action by a third party (e.g. Health Boards/Trusts), ensuring that they are formally reported to the organisation(s) concerned.

We were advised that work in this respect is ongoing, with a proposal to be drafted for the Senior Management Team meeting on the 24th May 2018.

Reported for Management Information

Objective 5: There is a robust process for agreeing revised deadlines for implementation

Minutes of the February 2018 Audit Committee meeting record that:

'A detailed breakdown of all audit recommendations was reviewed by the Senior Management Team during September and October 2017. There were a number of recommendations identified where it was not possible to complete the recommendations within the original deadline, as set out in the management response. These recommendations were reviewed by the Director of Finance and Corporate Services and a revised deadline was subsequently agreed. Going forward, it was agreed that proposals to revise original deadlines will be approved by the Audit Committee.'

It was evident that this process was in effect, as three requests to revise recommendation deadlines at the February 2018 Audit Committee were subsequently approved at the April 2018 meeting.

No Issues Identified

Objective 6: Reporting Progress

A summary of recommendations by report title, recommendation priority and status is regularly reported to Senior Management Team and Audit Committee.

We verified that the information reported to the Audit Committee in February and April 2018 was an accurate reflection of the audit tracker at those points in time.

No Issues Identified

Finding 1 – Recommendation Status *(O)*	**Risk**
We were unable to obtain sufficient evidence to support the 'implemented' status for one medium priority recommendation in the Procurement Services Central Sourcing audit (report NWSSP-1516-03 refers). Evidence of written agreement between the Director of Procurement Services and the Head of Sourcing (Non-Medical) confirming the formal delegation of contract award sign-offs for low value maintenance contracts was requested. We were provided with an email from the Director of Procurement Services' Personal Assistant stating that the arrangement was for the Head of Sourcing (Non-Medical) to sign off any low value maintenance contracts on behalf of the Director of Procurement Services. However, we were not provided with any evidence that this arrangement has been formally agreed and documented.	Potential non-compliance with Standing Orders and Standing Financial Instructions. Inaccurate information reported to Audit Committee.
Recommendation 1	**Priority level**
The agreement between the Head of Sourcing (Non-Medical) and the Director of Procurement Services should be drafted and formally signed; outlining the limits within which the Head of Sourcing (Non-Medical) can approve maintenance contracts.	**Medium**
The Audit Tracker should be reviewed and amended to reflect that this recommendation has not been actioned.	
Management Response 1	**Responsible Officer/ Deadline**

Agreed. The Director of Procurement Services has been notified of this issue and the Audit Tracker has been updated to re-open this action.	Compliance Officer Complete

Finding 2 – Accuracy & Completeness of the Audit Tracker *(O)*	**Risk**
Sample testing identified the following minor issues in relation to maintenance of the Audit Tracker: • Management actions from the recent *WAO Review: RKC Associates Lessons Learned* review (report NWSSP-1718-01 refers) have not been recorded on the audit tracker. The responsible officer has, however, provided a progress update to the Audit Committee. • Eight recommendations arising from the Health Courier Services Follow Up audit in 2016/17 (report NWSSP-1617-06 refers) were incorrectly recorded against the original Health Courier Services audit undertaken in 2015/16 (report NWSSP-1516-21 refers). Consequently, the audit tracker reference of two recommendations arising from the follow-up review is not in line with the references in the report. • The audit tracker references for recommendations arising from the Bridgend Stores audit (report NWSSP-1516-19 refers) were not in line with the referencing in the report. This was due to multi-part recommendations being split and recorded separately in the audit tracker. This approach has not been applied consistently, and results in a discrepancy in the number of recommendations recorded in the audit tracker and report.	Recommendations omitted from or inaccurately recorded in the audit tracker. Inaccurate information reported to Audit Committee.

Recommendation 2	Priority level
Management actions arising from the recent WAO Review: RKC Associates – Lessons Learned by NWSSP review should be added to the audit tracker. The Audit Tracker should be reviewed and amended to ensure consistency in approach, to ensure that the correct audit title has been reported, and to ensure that recommendations can be easily traced back to the original reports.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Agreed. The Audit Tracker has been amended in accordance with the above findings.	Head of Finance & Business Development / Compliance Officer Complete

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Confidentiality

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Audit

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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
Donna Morgan (Principal Auditor) – 01792 860597

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
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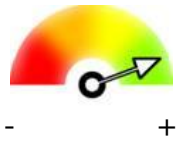

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Final report issued:	24th May 2018
Auditors:	James Quance, Head of Internal Audit Sophie Corbett, Audit Manager
Executive sign off:	Andy Butler, Director of Finance & Corporate Services
Distribution:	Neil Frow, Managing Director Andy Butler, Director of Finance & Corporate Services Peter Stephenson, Head of Finance & Business Development Roxann Davies, Compliance Officer
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.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee. Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the 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. EXECUTIVE SUMMARY

1.1 Introduction and Background

A review of the corporate governance arrangements within NHS Wales Shared Services Partnership (NWSSP) was completed in line with the 2017/18 Internal Audit Plan.

For 2017/18 the audit has focused on:

- preparation of the Annual Governance Statement; and
- action taken following the 2016/17 audit of Risk Management.

The Annual Governance Statement is a mandatory requirement by Welsh Government and is a key feature in the organisation's annual report and accounts. It demonstrates the management and control of resources, and assesses compliance and effectiveness of the organisation's governance arrangements.

1.2 Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the arrangements in place for ensuring effective corporate governance within NWSSP.

The specific objectives reviewed were:

- the Annual Governance Statement has been prepared in accordance with the NHS 2017-18 Manual for Accounts guidance issued by Welsh Government;
- the Annual Governance Statement is consistent with Internal Audit's knowledge of issues identified from the internal audit programme; and
- actions arising from the 2016/17 Risk Management audit (report NWSSP-1617-14 refers) have been implemented.

1.3 Associated Risks

The risks considered in the review were as follows:

i. the Annual Governance Statement does not comply with the requirements set out within the NHS 2017-18 Manual for Accounts;

ii. assurances reports within the Annual Governance Statement are not consistent with Internal Audit's knowledge of the organisation; and

iii. issues identified during the 2016/17 Risk Management audit have not been addressed.

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 corporate governance 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	The AGS has been prepared in accordance with the HS 2017-18 Manual for Accounts				✓
2	The AGS is consistent with IA's knowledge of issues identified from the IA programme				✓
3	Actions arising from the 2016/17 Risk Management audit have been				✓

Assurance Summary					
	implemented				

** 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 is classified as a weakness in the system control/design for corporate governance. This is identified in the management action plan as (D).

2.4 Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control for corporate governance. This is identified in the management action plan 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**	**0**	**2**	**2**

3 SUMMARY OF AUDIT FINDINGS

3.1 Annual Governance Statement

Review of the draft Annual Governance Statement presented to the Audit Committee in April 2018 confirmed that the statement has been prepared in accordance with the NHS 2017-18 Manual for Accounts guidance issued by Welsh Government and is consistent with our knowledge of issues identified from the internal audit programme.

No Issues Identified

3.2 Risk Management Follow-Up

The 2016/17 Risk Management audit identified three medium and one low priority recommendations – see Appendix B for details.

Significant progress has been made in transforming NWSSPs approach to risk management, including:

- Appointment of the Head of Finance & Business Development with responsibility for risk management.
- Risk management workshops held in April and June 2017 covering the principles of risk management, feedback from the internal audit review, assurance mapping and corporate risk register refresh.
- A revised approach to risk management has been adopted which involves embedding risk management in the quarterly review meetings, instead of Directorates submitting a copy of their register on a monthly basis for the purpose of Senior Management Team updates.
- The corporate risk register template has been updated following feedback received from the risk management workshops. It separately identifies 'risks for action' and 'risks for monitoring'; and now highlights inherent risk, existing controls and current risk. The source of each risk (i.e. escalated directorate risk, strategic objective) is also identified.
- We were informed that the Head of Finance & Business Development has met with each Directorate to talk through the revised risk management approach, transform risk registers to the new NWSSP format and undertake an assurance mapping exercise.
- Assurance maps are now in place for all Directorates. They were reported to the Audit Committee in November 2017 and will be reviewed/updated annually.

Overall, we are able to report that the recommendations arising from the previous audit have been implemented. However, the following exceptions were identified:

Original Finding 2

We identified instances where individuals responsible for implementing actions to mitigate the risks and target dates for implementation have not been identified.

See Finding 1 at Appendix A

Original Finding 3

Health Courier Services is part of the Procurement Services directorate yet it has its own risk register due to the nature of the service.

We noted that this register is not consistent with the revised NWSSP format. It includes the initial and current risk ratings, and actions agreed at the last risk assessment. However, it does not explicitly identify the inherent risk, existing controls or trend since the last review.

See Finding 2 at Appendix A

The following opportunities for improvement were also identified:

- It may be beneficial for the Head of Finance & Business Improvement to participate in the quarterly review meetings now that risk management is incorporated within this process.
- We identified two escalated directorate risks rated yellow and included as 'risks for monitoring' on the corporate risk register. We queried whether these should have been de-escalated to the directorate risk registers and the Head of Finance & Business Development advised that SMT have decided to keep these risks on the corporate register due to their volatility and potential impact on the organisation as a whole. In these circumstances the risks should be re-classified as corporate risks, rather than 'escalated from directorates'.

Finding 1: Responsibility for Implementation of Actions to Mitigate Risk *(D)*	Risk
We identified instances where individuals responsible for implementing actions to mitiga the risks and target dates for implementation have not been identified.	The lack of clear names and dates for achievement of agreed actions results in a lack of accountability over the management of individual risks, and might mean that the risks are not managed as well as they should be.
Recommendation 1	**Priority level**
Mitigation plans for risks should contain the name of the lead person undertaking the action and a date by which it is realistic for the action to be completed.	**Low**
Management Response 1	**Responsible Officer/ Deadline**
Accepted. Progress has been made in terms of applying names and dates for specific actions on the Corporate Risk Register but this approach needs to be embedded throughout the organisation. The Head of Finance and Business Development will work both at a corporate level and with directorates to ensure that this approach is embedded.	Head of Finance and Business Development. 30 September 2018

Finding 2: Directorate Risk Register Format *(O)*	Risk
Health Courier Services is part of the Procurement Services directorate yet it has its own risk register due to the nature of the service. We noted that this register is not consistent with the revised NWSSP format. It includes the initial and current risk	Risk information is inconsistent and not comparable, potentially

ratings, and actions agreed at the last risk assessment. However, it does not explicitly identify the inherent risk, existing controls or trend since the last review.	impacting on the organisations ability to effectively manage risks.
Recommendation 2	**Priority level**
The Health Courier Services risk register should be revised to ensure it is consistent with the NWSSP revised format	**Low**
Management Response 2	**Responsible Officer/ Deadline**
Accepted. All Directorates have adopted the revised Risk Register format but there are additional risk registers at sub-directorate level. The Head of Finance and Business Development will work with these services to update their risk registers into the revised format.	Head of Finance and Business Development. 30 September 2018

Summary of findings and recommendations arising from the previous internal audit of Risk Management (report NWSSP-1617-14 refers)

Finding 1 - Central Risk Function (D)	**Risk**
The central risk function within Corporate Services is primarily an administrative one, rather than fulfilling a risk manager role which would challenge, advise and guide directorates over the management of their key risks. Presently the challenge, advice and guidance is provided by the Director Finance and Corporate Services and this may reinforce a perception amongst directorates that risk management is a process they need to comply with, rather than being a value-adding activity.	Directorates may not sufficiently engage with the process, leading to poor identification and/or management of risks.
Recommendation 1	**Priority level**
NWSSP is a large organisation with approximately 1900 staff and a cost/benefit analysis should be undertaken to assess whether there is a benefit in reviewing the function, and Finance & Corporate services taking a more proactive role in advising, supporting and challenging directorate and corporate management over their key risks.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
Since its inception in 2011, NWSSP has evolved and grown as an organisation. Given the breadth of NWSSP's services in 2017 the time and capacity required to manage risk effectively has grown. We will undertake a review of the role of risk management within Finance & Corporate Services	Andy Butler, Director of Finance & Corporate Services August 2017
Follow-Up Status	**Further Action Required**
Implemented	None

Finding 2 - Review of Corporate Risk Register (Design)	Risk
The Corporate Risk Register should be a combination of the top-down risks (i.e. those risks that directly impact the strategic objectives of NWSSP and which need to be corporately owned) and bottom-up risks (i.e. risks that have been escalated from Directorates due to the impact that they may have on the whole organisation and/or they are unable to be managed without corporate support). This process is largely in place within NWSSP with horizon-scanning days being undertaken to identify the strategic risks, and any red-rated directorate risks being escalated to the Corporate Risk Register. However, there seems to be no process in place to consider when escalated risks have been mitigated to a level at which they can be de-escalated back to the Directorate level, and as a consequence the Corporate Risk Register often contains more risks than necessary. The nature of the risks on the Corporate Risk Register tends towards longer term mitigation plans. There is therefore very little clarity on who needs to do what and by when, which reduces opportunity for clear accountability over mitigation plans. Instead, there is a long and on-going narrative on progress with the risk and associated actions.	The current approach to the corporate risk register results in risks potentially being held for too long at this level, which might divert attention from those risks that the Corporate SMT should really be focusing on. The lack of clear names and dates for achievement of agreed actions results in a lack of accountability over the management of individual risks, and might mean that the risks are not managed as well as they should be.
Recommendation 2	**Priority level**
Risks that have been escalated to the Corporate Risk Register should only remain at this level for as long as is necessary. Mitigation plans for risks should ideally contain the name of the lead person undertaking the action and a date by which it is realistic for the action to be completed. The Corporate SMT should therefore focus on whether actions have been achieved within the required timescales and to understand the reason if this is not the case.	**Medium**

Management Response 2	Responsible Officer/ Deadline
Agreed - A risk management workshop will be held with Senior management to review our approach and to refresh our Corporate Risk Register. The revised risk register will be more action focused and be more specific in terms of mitigation plans.	Andy Butler, Director of Finance & Corporate Services June 2017
Follow-Up Status	**Further Action Required**
Partially Implemented	See Finding 1 at Appendix A

Finding 3 - Directorate Risk Management (Design)	Risk
For directorate risk registers to be effective they need to be owned by the Director/Directorate Management Team but with the opportunity for the Corporate Services Team to obtain assurance on risk management within each directorate. Each directorate has its own risk register and these are reviewed to a varying extent by the respective directorate SMT. The assurance at the corporate level can come from two sources: • Through the quarterly review process of each directorate undertaken by the Managing Director, the Director Finance and Corporate Services, and the Director of Workforce and Organisational Development; and	The current approach underpinning the corporate SMT meetings is inefficient and potentially dilutes the ownership over, and engagement with, the directorate risks. It may also dilute the effectiveness of the corporate SMT meeting through the inclusion of material that need not be a priority at that level. A lack of clear names and dates for achievement of agreed actions

• Through the Central Risk Team asking for a copy of each directorate's risk register to include in the papers for the monthly Corporate SMT meeting. The quarterly review process, which includes consideration of financial information and key performance metrics, is a very useful opportunity to gain assurance on key directorate risks and any risks identified at this stage are reported to the Corporate Services Team. The calling for copies of directorate risk registers for the Corporate SMT, which receives a mixed response in terms of compliance, reinforces a perception of a central administration process and risks choking the Corporate SMT agenda with too many papers, such that it may be difficult to focus on the key corporate issues and risks. As with the Corporate Risk Register, there is a lack of accountability over the mitigation plans for risks as very few have specific actions with an action owner and date for completion listed. We also noted that: • Although an agreed template to use for directorate risk registers has been provided, there were some differences in the risk register format between directorates (e.g. some included objectives, others noted the status of the risk and some included a risk assessment); • A number of directorates had not added any new risks in over two years; • Although a detailed desktop briefing had been provided there was occasional confusion as to the meaning of the target score in assessing risks; and • Very few risks were described in terms of cause, event and consequence which is a recognised means of ensuring that risks are fully understandable.	results in a lack of accountability over the management of individual risks, and might mean that the risks are not managed as well as they should be. The failure to complete risk registers fully, consistently and accurately detracts from the capability to ensure that the risks are effectively managed.

Recommendation 3	Priority level
Directorate risk registers should be completed in a consistent format and be owned and regularly reviewed by the Directorate SMT meetings, but with corporate assurance being gained through the quarterly review process as described above. Mitigation plans for risks should ideally contain the name of the lead person undertaking the action and a date by which it is realistic for the action to be completed. The various Directorates SMT meetings should therefore focus on whether actions have been achieved within the required timescales and to understand the reason if this is not the case. Directorates should be reminded of the need to consider whether any new risks should be added to their risk registers, and of the difference between the target score and the current score. Directorates should also be encouraged to describe risks in terms of cause (why something might happen), event (what could happen) and consequence (why do we care).	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
Agreed - The existing process for monitoring and capturing risks has worked well since NWSSP's inception in 2011, however we recognise that the process for managing risks effectively needs to be strengthened at directorate level. As a consequence: 1) the detailed desktop guidance will be reviewed and refreshed 2) The risk management workshop for senior managers will incorporate the matters highlighted above.	Andy Butler, Director of Finance & Corporate Services June 2017

Follow-Up Status	Further Action Required
Partially Implemented	See Finding 2 at Appendix A

Finding 4 - Business-as-usual risks (Operational)	Risk
Very few of the risks on the directorate risk registers are business-as-usual or operational risks. Instead they tend to relate to changes to processes and/or external factors. While there may be no need and/or desire to populate the risk registers with significant numbers of additional risks, there is a need to have clarity on where the assurances are gained over the key operational risks.	The current approach for directorate risk registers does not focus on key operational risks and there is a danger that these risks may not be managed as effectively as they could be.
Recommendation 4	**Priority level**
Each directorate needs to be clear on how its key operational risks are being managed (e.g. through regular monitoring and/or performance metric reporting). NWSSP should consider documenting an assurance map for the key operational risks in each directorate to understand how these risks are being controlled and assured.	**Low**
Management Response 4	**Responsible Officer/ Deadline**
Agreed: • We will run a risk workshop for senior managers and incorporate a session on assurance mapping • We will undertake a pilot assurance mapping exercise within Employment services	Andy Butler, Director of Finance & Corporate Services June 2017

and assess the benefits of rolling out the exercise to other directorates	
Follow-Up Status	**Further Action Required**
Implemented	None

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

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Audit

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

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

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

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

Responsibilities

Responsibilities of management and internal auditors:

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

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

Contact Details

James Quance (Head of Internal Audit) – 01495 300841
Sophie Corbett (Audit Manager) – 01792 860596

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

Employment Services

Payroll Services

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Reasonable Assurance

Previous review rating: Reasonable Assurance

CONTENTS

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Executive sign off:	Paul Thomas, Director of Employment Services
Distribution:	Neil Frow, Managing Director Andy Butler, Director of Finance & Corporate Services Paul Thomas, Director of Employment Services Lisa Williams, Assistant Director of Employment Services
Auditors:	James Quance, Head of Internal Audit Sophie Corbett, Audit Manager Emma Rees, Principal Auditor Ossama Lotfy, Principal Auditor

Dinithi Balasuriya, Internal Auditor
Arthur Burke, Internal Auditor

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

The Payroll Services function is split across five teams at four sites:

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

1.2 Scope and Objectives

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

The objectives reviewed were:

- starters, leavers and changes are accurately and promptly processed;
- payments to staff are timely and accurate;
- only employees of the organisation are paid; and
- overpayments are recovered.

A separate follow-up audit will be undertaken in early 2018/19 to assess progress in implementing agreed management actions from the previous internal audit (report NWSSP-1617-07 refers).

1.3 Associated Risks

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

i. payments are incorrect or not processed in a timely manner; and
ii. overpayments are not recovered resulting in financial loss to the Health Board/Trust.

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 Payroll Services is **Reasonable** Assurance.

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

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

2.2 Assurance Summary Table

Assurance Summary					
1	Prompt & Accurate Processing of Starters, Leavers & Changes			✓	
2	Timely & Accurate Payments to Staff			✓	
3	Only Employees of the Organisation are Paid				✓
4	Recovery of Overpayments				✓

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

2.3 Design of System / Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the system/control design for Payroll Services. These are identified in Appendix A as *(D).*

2.4 Operation of System / Controls

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

2.5 Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Two further findings were identified which are outside of the direct control of NWSSP Payroll Services and cannot be achieved without the agreement and cooperation of customer organisations. These are identified on page 12 of the report and have been reported to management to take forward with customer organisations.

3 SUMMARY OF AUDIT FINDINGS

The following examples of good practice were identified:

- Payroll Checking Processes

  The payroll teams at Companies House undertake payroll checking processes electronically. A macro-enabled spreadsheet developed by the Interim Deputy Payroll Manager identifies the key amendments requiring checking (including starters, leavers, amendments to contracted hours or salary) from the ESR permanent amendment reports.

  Payroll clerks record their initials against each entry as confirmation of checking and the Payroll Manager informed us that the track changes function in Excel maintains an audit trail to enable verification.

  The spreadsheet includes a check to ensure all entries in the report have been initialled as reviewed, which facilities senior review.

- Electronic Document Storage

  The payroll teams serving BCUHB, WAST and more recently ABMUHB use the Zylab system for electronic document storage which enables easier access to payroll documentation as and when required.

We identified four **Medium Priority** findings:

1. Missing Documentation

   There was no supporting documentation available for five of the starters/changes/staff payments reviewed.

   See Finding 1 at Appendix A

2. Verification of Staff Payments

   One instance was identified where an ABUHB consultant has been paid an additional payment for intensity band 2 instead of band 1 since September 2012 due to a Payroll error. The difference between the two bands for 2017/18 is £2,257. Therefore, the overpayment could potentially be in excess of £12k. The banding error was corrected at the time of audit and we were informed that the issue would be investigated with the individuals' line manager, with action taken to recover any overpayment if necessary.

   See Finding 2 at Appendix A

Evidence was received in support of all 10 payments sampled for CVUHB. However, we have unresolved queries in relation to five of the 10 reviewed.

Reported for Management Information

3. Checking Reports

The Payroll Team at HDUHB does not produce reports of starters, leavers and permanent amendments to ensure all have appropriate supporting documentation.

Payroll Teams at ABMUHB, BCUHB & WAST do not review reports of permanent amendments, although we understand that BCUHB & WAST are working towards implementing the same electronic review process currently in place in Companies House.

See Finding 3 at Appendix A

4. Exception Reports

There is variation in arrangements for payroll exception reporting across the five Payroll Teams:

Pre-Payroll Exception Reports

We were informed that the ABUHB & HDUHB Payroll Teams produce pre-payroll exception reports but they are not retained.

Reports had not been produced for one of the five months sampled for CTUHB & PHW.

Payroll Exception Report

The Payroll Exception report compares current period pay to the previous period. There is variation across the Payroll Teams in the report parameters and requirement for senior review – details are provided at Appendix A.

Sample testing identified a small number of instances where reports had not been produced, not all entries had been reviewed and inconsistencies in the dates of senior review – details are provided at Appendix A.

Payroll Message Report

This report summarises all payroll messages relating to individuals included on the current pay run. Many of these are for information purposes only (e.g. highlighting when an individual receives a pay increment) however some require investigation by Payroll (e.g. where an employee has no bank details assigned or is not assigned to a pay scale).

We were informed by the ABUHB & HDUHB Payroll Teams that payroll message reports are produced but not saved.

Reports had not been produced for PtHB but all three sampled had no evidence of review.

Reports had only been produced for three of the five months sampled for CVUHB, and for the two reports that had been produced one had no evidence of review and the other had only some entries evidenced as reviewed.

See Finding 4 at Appendix A

We identified four **Low Priority** findings**:**

1. Starters, Leavers & Changes – Format & Sign-Off of Forms

   There is variation in the format of enrolment, termination and changes forms in use for starters, leavers and changes as they are owned by the individual customer organisations. Examples of the differences include:

   - use of the new e-Appointment form – only two organisations are fully utilising this form for enrolments.
   - requirement for a physical signature – the majority of the ABMUHB enrolment and change forms reviewed had been completed electronically so the employee "signatures" were typed rather than signed. Line Manager "signatures" are also typed. However, the forms are submitted from the managers email address. We note that some areas of ABMUHB are now using the new e-Appointment form.
   - requirement for payroll to sign as input and checked – the enrolment forms used by HDUHB & some used by CVUHB do not require the signature of the Payroll Officers processing and checking. Payroll Officers for CVUHB sign a checklist instead.

Sample testing of starters, leavers and changes identified:

- four enrolment/change forms which had not been signed by the employee;
- two enrolment forms which had not been signed by the line manager;
- 21 enrolment/changes/termination forms which had not been signed as input by the Payroll Officer; and
- 12 enrolment/termination forms which had not been signed as checked by a Payroll Officer.

See Finding 5 at Appendix A

The new e-Appointment form is used by PHW & Velindre. Instead of a physical signature, it records the NADEX/Cymru ID of the user completing each section. However, it is rare for a new employee to be allocated a Cymru ID in time for enrolment therefore in the majority of starters reviewed the employee sections and sign-off had been completed using either a third party or the manager's Cymru ID.

The risk here is no greater than the anonymity of a physical signature as there is an audit trail to confirm who completed the form. Nevertheless, management should be aware that this control is not operating as intended.

Reported for Management Information

2. Required Information for Changes to Bank Details

In requesting a change of bank details, employees should confirm their existing details in order to verify the authenticity of the request.

We identified nine instances where current bank details had not been provided by the employee. In eight cases this information was not required by the form, and in one case the change had been processed on receipt of an email request from the employee's NHS email address.

See Finding 5 at Appendix A

3. Accuracy of Processing

One of the 20 new starters reviewed for ABUHB had a discrepancy in the hire date recorded on ESR and the enrolment form. An underpayment may have occurred as a result.

A discrepancy was identified with an increase in contractual hours for an individual employed by PtHB. According to ESR, the individual's

contractual hours prior to change was 30. However, the change form completed by the manager stated 22 hours. There is a risk that an overpayment may have occurred in the period prior to the change being processed.

Accuracy of First/Last Pay for Starters & Leavers

For one of the 20 new starters reviewed for ABUHB we were unable to locate a payslip for the first pay, and subsequent payslips did not include arrears pay. We were informed that the individual had been paid on the supplementary run. However, we were not provided with any evidence of this.

Evidence of incremental credit is required where a new employee does not start at the bottom of the pay scale. Two of the 20 starters reviewed for ABUHB had no evidence of incremental credit.

See Finding 6 at Appendix A

4. Authorised Signatory Lists

There is variation in the requirements for checking signatories against authorised signatory lists. This is primarily due to the majority of customer organisations not maintaining such a list.

In PtHB, all enrolment forms are sent to Payroll via the Health Board's Workforce Department which is responsible for ensuring that forms have been appropriately completed and authorised. In ABUHB, the Payroll Team is responsible for checking signatures against an authorised signatory list.

For two of the 20 new starters and two of the 20 changes reviewed for ABUHB, the signatures on the payroll forms could not be verified to the authorised signatory list. In three cases the signatures were illegible and in one case the authorising individual was not included on the list at the time of audit. We acknowledge that the list is a live document.

Reported for Management Information

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

1. New e-Appointment Form

   The 2015/16 internal audit reported that Employment Services have developed an excel-based new appointment form which is pre-populated via the recruitment process with the employee and post details from ESR, then sent to the recruiting manager to complete electronically.

   Data validation controls are built in to the form and it automatically records the NADEX details of the user as evidence of manager and employee sign-off. This relies on the Health Board/Trust allocating the new starter a Cymru ID in time for enrolment. Each section of the form is locked-down on completion so the data cannot be changed. Bank details are provided by the employee and are not visible to the manager.

   The form provides additional controls to improve data quality and reduce the risk of ghost employees. Following a pilot exercise within NWSSP the form has now been rolled out across VNHST, PHW and more recently ABMUHB.

   Implementation of the new appointment form needs to be progressed with the other Health Boards/Trust.

2. Timeliness of Submission of Enrolment and Termination Forms

   During testing we identified a number of instances where enrolment and termination forms had not been submitted to Payroll in a timely manner.

   In some cases this had resulted in late pay for new starters, or overpayment to individuals who had left the organisation. All overpayments identified had been recorded and dealt with via the overpayment registers. This creates unnecessary additional work for the Payroll Team within NWSSP and also the Finance Team and line managers within the customer organisations.

Finding 1: Missing Documentation *(O)*	**Risk**
There was no supporting documentation available for the following: • enrolment form for one new starter within ABMUHB; • increase in contractual hours for one individual within CVUHB; • change of bank details for one individual within CVUHB; • one increase in hours for CTUHB had been processed on receipt of an email request from a line manager. Payroll actioned the change and requested that a form be submitted. However, there is no evidence that it was received; and • one overtime payment for ABUHB.	Inappropriate or erroneous payments, resulting in financial loss to the customer organisation
Recommendation 1	**Priority level**
Payroll documentation must be retained and available on request in support of transactions processed within ESR.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
Enrolment form for the new starter within ABMUHB has now been located. Change form for the increase in contractual hours for the individual within CVUHB has now been located. Staff will be reminded of transactional saving process. The transition to e-forms will also deliver electronic submission and storage of all transactional instructions including overtime payments outside of e-rostering systems.	Beverley Cokeley, Payroll Manager (ABMUHB) / Complete Christine Richards, Payroll Manager (CVUHB) / Complete Janet Carsley, Payroll Manager (ABUHB) / 30th September 2018

NWSSP Employment Services will support the roll-out of e-forms, over a 6 month period, to all outstanding organisations covering enrolment, change, termination. This model will provide appropriate auditable workflows, authorisation and ensure retention of key payroll impacting instructions are available for transactional instructions outside of ESR Self Service. This timescale will be dependent upon HB/T commitment.	Employment Services Enablement and Payroll Service Managers / 30th September 2018

Finding 2: Verification of Staff Payments *(O)*	**Risk**
One instance was identified where an ABUHB consultant has been paid an additional payment for intensity band 2 instead of band 1 since September 2012 due to a Payroll error. The difference between the two bands for 2017/18 is £2,257. Therefore, the overpayment could potentially be in excess of £12k. The banding error was corrected at the time of audit and we were informed that the issue would be investigated with the individuals' line manager, with action taken to recover any overpayment if necessary.	Inappropriate or erroneous payments, resulting in financial loss to the customer organisation
Recommendation 2	**Priority level**
Ensure necessary action is taken to recover any overpayment.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
The immediate investigation of the potential incorrect intensity payment resulted in the line manager (responsible for completing the form) confirming the hand-written note referred to payment at band 1 not band 2. In line with ABUHB Overpayment Policy an invoice was issued on the 17 April 2018 to recover the overpayment.	Janet Carsley, Payroll Manger (ABUHB) / Complete

NWSSP Employment Services will support the roll-out of e-forms, over a 6 month period, to all organisations covering change to circumstances including instructions to pay or adjust intensity payments. This will remove handwritten instructions from Health Boards replacing with data validation where applicable eliminating interpretation of hand written instructions. This timescale will be dependent upon HB/T commitment.	Employment Services Enablement and Payroll Service Managers / 30th September 2018

Finding 3: Payroll Checking Reports *(D)*	**Risk**
The Payroll Team at HDUHB does not produce reports of starters, leavers and permanent amendments to ensure all have appropriate supporting documentation. Payroll Teams at ABMUHB, BCUHB & WAST do not review reports of permanent amendments, although we understand that BCUHB & WAST are working towards implementing the same electronic review process currently in place in Companies House.	Fraudulent or inappropriate additions or amendments to the Payroll may not be identified, potentially resulting in financial loss to the customer organisation.
Recommendation 3	**Priority level**
The electronic checking processes used by the Payroll Teams at Companies House should be rolled out across all Payroll Teams.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
During fieldwork audit identified that new starters were not checked against the ESR Joiners/Leavers report in HDUHB. In November 2017 the roll-out of this report was implemented by the Payroll Manager. Audit recommendations has highlighted that this report is not evidenced and Deputy Payroll Manager has confirmed that an alternative starters report has been used during this time. The use of this alternative report would enable checking of a new starter	Beverley Cokeley, Payroll Manager (HDUHB) / Complete

however copies have not been retained as part of best practice evidence. Immediate action has been taken to implement the correct Joiners/Leavers report with checking and retention of report for future audit review. Both Weekly and Monthly pay run processes will be audited by Deputy Payroll Manager to embed the reporting process and best practice. Payroll Managers (HDUHB, ABMUHB, BCUHB & WAST) are exploring suitability of adopting CH checking process to understand how this will integrate with HB/Trust policy/processed. IBM payroll exception tool is not deemed suitable for current use. A review of this tool is taking place under ESR National Special Interest Group. The timescale for completing this is outside of NWSSP control and dependent upon IBM development and implementation. Upon release this will be picked up by the Deputy Payroll Managers group.	Beverley Cokeley, Payroll Manager (ABMUHB & HDUHB) and Neil Evans, Payroll Manager (BCUHB & WAST) / 31st July 2018 ESR IBM / Awaiting National Development by IBM – no timescale at point of reporting.

Finding 4: Payroll Exception Reports *(D + O)*	**Risk**
<u>Pre-Payroll Exception Reports</u> We were informed that the ABUHB & HDUHB Payroll Teams produce pre-payroll exception reports but they are not retained. Reports had not been produced for one of the five months sampled for CTUHB & PHW.	Erroneous payments are not identified or prevented resulting in under/overpayment and potential financial loss to the customer organisation.

Payroll Exception Reports There is variation across the Payroll Teams in the report parameters and requirement for senior review: • ABMUHB Payroll Team use +£75 for weekly paid and +£500 for monthly paid staff. This applies to both Agenda for Change (A4C) and Medical & Dental (M&D) staff. Reports are not subject to senior review. • HDUHB Payroll Team use +/-£75 for weekly paid and +/-£750 for monthly paid A4C and M&D staff. Reports are subject to senior review and signed as evidence of this. • ABUHB Payroll Team use +/-£500 for both A4C and M&D staff. Reports are subject to senior review. This is evidenced by initials typed into the spreadsheet. • PtHB Payroll Team use +/-£300 for both A4C and M&D staff. • CVUHB, CTUHB, PHW & VNHST Payroll Teams use +£75/-£300 for weekly paid and +£300/-£750 for monthly paid A4C staff; and +£500/-£750 for M&D staff. Reports are not subject to senior review. • BCUHB & WAST Payroll Team use +/- £750 for monthly and +/- £100 for weekly pay for both A4C and M&D staff. Reports are subject to senior review however this is not evidenced on the report. Sample testing of exception reporting identified the following: • an exception report had not been produced for HDUHB for one of the sampled months; • for two of the HDUHB reports sampled, not all entries had been initialled as evidence of review; • all five reports reviewed for CVUHB had entries with no evidence of review or	

unresolved queries; • two ABUHB and two PtHB reports had no evidence of senior review; and • for ABUHB we also identified inconsistencies in the dates for senior review. For example, the report for April 2017 was dated as checked on the 29th March 2017, and the report for August 2017 was dated as checked on 22nd December 2017. <u>Payroll Message Reports</u> We were informed by the ABUHB & HDUHB Payroll Teams that payroll message reports are produced but not saved. Reports had not been produced for PtHB but all three sampled had no evidence of review. Reports had only been produced for three of the five months sampled for CVUHB, and for the two reports that had been produced one had no evidence of review and the other had only some entries evidenced as reviewed.	
Recommendation 4	**Priority level**
A standardised process for producing and reviewing payroll exception reports should be agreed and applied across all Payroll Teams.	**Medium**
Payroll Teams must ensure that exceptions reports are produced, reviewed and retained for each pay run.	
Management Response 4	**Responsible Officer/ Deadline**
The payroll exception reports will be saved going on file in HDUHB going forward.	Beverley Cokeley, Payroll Manager (HDUHB) / 30th June 2018

The missing pre-payroll exception reports for CTUHB and PHW have now been located. Team members will be reminded of best practice process to mark reports on checking. The differences in exceptions for all payrolls across Wales was considered at the Deputy Payroll Managers meeting 17.5.18 an assessment is currently being undertaken to remove variation. A single level will be implemented across all payroll teams during Quarter 2.	Christine Richards, Payroll Manager (CTUHB & PHW) / Complete Janet Carsley, Payroll Manager ABUHB/ Complete Deputy Payroll Managers / 30th September 2018

Finding 5: Starters, Leavers & Changes – Format & Sign-Off of Forms *(D + O)*	**Risk**
There is variation in the format of enrolment, termination and changes forms in use across the ten customer organisations. Examples of the differences include: • use of the new e-Appointment form; • requirement for a physical signature; • requirement for payroll to sign as input and checked; and • requirement to provide current bank details as verification for bank amendment requests. Sample testing of starters, leavers and changes identified: • four enrolment/change forms which had not been signed by the employee; • two enrolment forms which had not been signed by the line manager; • 21 enrolment/changes/termination forms which had not been signed as input by	Inconsistent processes inhibiting standardisation and efficiency. Fraudulent requests for changes to bank details are processed resulting in financial loss.

the Payroll Officer; and • 12 enrolment/termination forms which had not been signed as checked by a Payroll Officer. We identified nine instances where current bank details had not been provided by the employee. In two cases this information was not required by the form, and in one case the change had been processed on receipt of an email request from the employee's NHS email address.	
Recommendation 5	**Priority level**
Continued effort should be made to achieve standardisation through the implementation of the e-Appointment form across customer organisations, and development of similar amendment and termination forms.	**Medium**
Forms which have not been appropriately signed as required by the form should be returned to the customer organisation for completion. Payroll Officers must sign (either physically or via a secure electronic method) as evidence of input and checking.	
Bank change requests should include confirmation of current bank details as verification of authenticity.	
Management Response 5	**Responsible Officer/ Deadline**
NWSSP Employment Services will support the roll-out of e-forms, over a 6 month period, to all outstanding organisations covering enrolment, change, termination. This model will provide appropriate auditable workflows for authorisation and payroll processing/checking ensure auditable retention of change instructions are available for transactional instructions outside of ESR Self Service.	Employment Services Enablement and Payroll Service Managers / 30th September 2018

The new e-Payroll Instruction Form will redirect staff and managers to ESR Self Service to eliminate paper/manual instructions for change of bank details. This timescale will be dependent upon HB/T commitment.	

Finding 6: Accuracy of Processing *(O)*	**Risk**
One of the 20 new starters reviewed for ABUHB had a discrepancy in the hire date recorded on ESR and the enrolment form. An underpayment may have occurred as a result. A discrepancy was identified with an increase in contractual hours for PtHB. According to ESR the individual's contractual hours prior to change was 30. However, the change form completed by the manager stated 22 hours. There is a risk that an overpayment may have occurred in the period prior to the change being processed. <u>Accuracy of First/Last Pay for Starters & Leavers</u> Evidence of incremental credit is required where a new employee does not start at the bottom of the pay scale. Two of the 20 starters reviewed for ABUHB had no evidence of incremental credit.	Inappropriate or erroneous payments, resulting in financial loss to the customer organisation
Recommendation 6	**Priority level**
The identified discrepancies should be investigated and any under/overpayments addressed.	**Medium**

Evidence of incremental credit must be retained with the new starter documentation.	
Management Response 6	**Responsible Officer/ Deadline**
A review of all discrepancies has commenced to establish whether further action is required in line with local policy. Incremental credit is applied based on local HB/Trust policy. Whilst there are differences in policy this instruction cannot be incorporated into the e-Appointment Form. Departmental audit process to be developed to establish data quality standard for all new appointments including evidence of incremental credit for those appointed outside of the IAT process.	Janet Carsley, Payroll Manager (ABUHB & PtHB) / 30th June 2018 Deputy Payroll Managers Group / 30th November 2018

Audit Assurance Ratings

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

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

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

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, 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.

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

Surgical Materials Testing Laboratory (SMTL)

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Reasonable Assurance


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Executive sign off:	Pete Phillips, Director of SMTL
Distribution:	Neil Frow, Managing Director Andy Butler, Director of Finance & Corporate Services Pete Phillips, Director of SMTL
Auditors:	James Quance, Head of Internal Audit Sophie Corbett, Audit Manager
Committee:	Velindre NHS Trust Audit Committee for NWSSP

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

1. EXECUTIVE SUMMARY

1.1 Introduction and Background

A review of the Surgical Materials Testing Laboratory (SMTL) within NHS Wales Shared Services Partnership (NWSSP) Procurement Services was completed in line with the 2017/18 Internal Audit Plan.

SMTL was established in the 1970s as the Mid Glamorgan Quality Control Laboratory, and changed its name to SMTL in 1989. The laboratory has been hosted by Abertawe Bro Morgannwg University Health Board (ABMUHB) and its predecessors until transfer to NWSSP in October 2016.

SMTL provides accredited medical device testing services to the NHS in Wales and on a commercial basis to the international medical device industry.

In September 2017, the laboratory attained reaccreditation from the United Kingdom Accreditation Service (UKAS) to undertake testing in accordance with the requirements of ISO17025:2005. SMTL have been UKAS accredited since 1995.

This audit reviewed the arrangements in place for risk management and income arising from commercial testing contracts.

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 risk management and the management of income arising from commercial testing contracts in order to provide assurance to Velindre NHS Trust Audit Committee for NWSSP that risks material to the achievement of system objectives are managed appropriately.

We have not reviewed medical device testing processes or outputs, as we understand that these have been reviewed as part of the recent ISO17025 accreditation.

The specific objectives reviewed were:

- risks are recorded and monitored, with escalation to the NWSSP Senior Management Team where appropriate;
- pricing methodology for commercial testing is robust and ensures contracts are financially viable; and
- income due from commercial contracts is identified, invoiced and

received.

1.3 Associated Risks

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

i. risks are not identified, monitored or addressed;
ii. commercial contracts are not financially viable resulting in overspend or deficit; and
iii. income due is not identified or received resulting in financial loss.

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 SMTL is **Reasonable** Assurance.

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

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

2.2 Assurance Summary Table

Assurance Summary					
1	Risk Management				✓
2	Pricing Methodology			✓	
3	Income from Commercial Contracts				✓

** 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 one issue that is classified as a weakness in the system/control design for SMTL. This is 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 SMTL. 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**	**1**	**2**	**3**

3 SUMMARY OF AUDIT FINDINGS

The following examples of good practice were identified:

- Prices for routine tests are set out within the SMTL pricing schedule, which was established several years ago prior to the transfer to NWSSP. The Director of SMTL advised that prices have been inflated annually in line with guidance from the ABMUHB Finance Team. For 2018/19 an uplift of 3% has been agreed between the Director of SMTL and NWSSP Finance Manager, in line with recent years.

- A costing template is used to determine the price that should be charged for non-routine tests. The template compares the costs derived using two methodologies - fixed hourly rate (£143 for 2017/18) and actual costs based on staff resource, equipment consumables, overheads, an additional basic and a contingency allowance.

- The risk register is consistent with the NWSSP template and also includes an assessment of the mitigated risk once identified action has been completed. This highlights whether the identified action will be sufficient to mitigate the risk to the target level, or further action required.

- Guidance in respect of qualitative measures of consequence and likelihood is used to determine appropriate risk scores.

We identified one **Medium Priority** finding:

1. Compliance with Pricing Schedule / Use of the Costing Template

   A sample of 20 commercial testing 'projects' was reviewed to establish whether prices charged are in line with the pricing schedule or supported by a costing template. The following issues were identified:

   - In two cases the test undertaken was not included on the pricing schedule and there was no evidence that a costing template had been used.
   - In three cases there was a discrepancy between the price charged and the pricing schedule. The variances ranged from -£80 to +£132. We were informed that prices on the schedule are adjusted to take account of the specific requirements of the customer, for example different sample sizes. Calculations evidencing how the price had been derived were not documented.

   See Finding 1 at Appendix A

We identified two **Low Priority** findings:

1. Pricing Reviews

   The pricing schedule was established several years ago prior to the transfer from ABMUHB to NWSSP. Prices within the schedule are based on the costing template and have been inflated by 3% annually in line with guidance from the ABMUHB and now the NWSSP finance teams.

   An exercise was undertaken in 2015, and is currently ongoing for 2018, to review the prices in the pricing schedule. Test methods are subject to a separate technical review on a two-year rolling basis and whilst this does not include a review of price, any changes to staff resource, equipment and consumables usage would be identified.

   It would be more efficient and effective to align pricing reviews with the two-year rolling review of test methods.

   See Finding 2 at Appendix A

2. Target Risk Scores & Dates

   There are four "current" risks on the SMTL risk register. Three of these risks do not have a target date for achievement of the target risk rating.

   Two risks also had no further progress update between February – May 2018. When queried with the Director of SMTL it was evident that action is ongoing although this had not been documented on the risk register.

   See Finding 3 at Appendix A

Finding 1: Compliance with Pricing Schedule / Use of the Costing Template *(O)*	**Risk**
A sample of 20 commercial testing 'projects' was reviewed to establish whether prices charged are in line with the pricing schedule or supported by a costing template. The following issues were identified: • In two cases the test undertaken was not included on the pricing schedule and there was no evidence that a costing template had been used. • In three cases there was a discrepancy between the price charged and the pricing schedule. The variances ranged from -£80 to +£132. We were informed that prices on the schedule are adjusted to take account of the specific requirements of the customer, for example different sample sizes. Calculations evidencing how the price had been derived were not documented.	Risk of incorrect prices being charged, potentially resulting in financial loss to the organisation.
Recommendation 1	**Priority level**
The costing template should be used to determine the price for any test not included on the pricing schedule.	**Medium**
Any deviation from the pricing schedule should be clearly documented with supporting calculations on the project file.	
Management Response 1	**Responsible Officer/ Deadline**
Any costing which does not follow, or is not based on the pricing schedule will utilise the costing template. Variations to pricing which are not clarified in the RFW will be noted in the project's RT ticket along with an explanation of how the cost has been calculated. Our review of the initial audit findings have not demonstrated any significant deviation from our pricing/costing policy, but we acknowledge that these calculations were not always documented in an auditable manner.	Director of SMTL 30th June 2018

Finding 2: Pricing Reviews *(D)*	Risk
The pricing schedule was established several years ago prior to the transfer from ABMUHB to NWSSP. Prices within the schedule are based on the costing template and have been inflated by 3% annually in line with guidance from the ABMUHB and now the NWSSP finance teams. An exercise was undertaken in 2015, and is currently ongoing for 2018, to review the prices in the pricing schedule. Test methods are subject to a separate technical review on a two-year rolling basis and whilst this does not include a review of price, any changes to staff resource, equipment and consumables usage would be identified. It would be more efficient and effective to align pricing reviews with the two-year rolling technical review of test methods.	Current arrangements for pricing reviews are not as efficient as they could be.
Recommendation 2	**Priority level**
Pricing reviews should be aligned with the two-year rolling technical reviews of test methods.	**Low**
Management Response 2	**Responsible Officer/ Deadline**
Agreed. Pricing reviews are undertaken regularly but there was no pre-determined interval in which they should take place. Costings will now be reviewed in conjunction with the technical reviews of test methods which are a standing agenda item at SMTL's monthly TG meetings. An additional item has also been included on the annual Quality System Review agenda to consider any significant changes in staff resource, equipment and consumables which may trigger a pricing review outside of the two-year cycle.	Departmental Managers 30th June 2018 Director of SMTL Complete

Finding 3: Risk Register *(O)*	**Risk**
There are four "current" risks on the SMTL risk register. Three of these risks do not have a target date for achievement of the target risk rating. Two risks also had no further progress update between February – May 2018. When queried with the Director of SMTL it was evident that action is ongoing although this had not been documented on the risk register.	Action required to reduce risk to an acceptable level is not completed in a timely manner.
Recommendation 3	**Priority level**
All risks should be allocated a target date for achievement of the target risk rating.	**Low**
The risk register should be regularly updated to document ongoing progress in implementing actions to mitigate risk.	
Management Response 3	**Responsible Officer/ Deadline**
Partially Accepted. Completion of actions in respect of the three risks is dependent on action/information from third parties and therefore to a certain extent the timescales for achieving the target risk rating are outside of the control of SMTL. Noting this, deadlines for review, rather than deadlines for achievement of the target rating, have now been assigned to each risk. In addition the status of any escalation is now recorded in the RR. The risk register has been updated to include further progress updates in respect of the two risks identified.	Director of SMTL Complete Director of SMTL Complete

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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*

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

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

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the 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

Performance Management

Final Internal Audit Report

2017/18

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Reasonable Assurance

Previous review rating: **N/a – first review**

CONTENTS

Review Reference:	NWSSP-1718-09
Report Status:	Final
Fieldwork completion:	22nd May 2018
Audit management sign-off:	22nd May 2018
Draft report issued:	22nd May 2018 / 25th May 2018
Debrief meeting:	24th May 2018
Management response received:	25th May 2018
Final report issued:	25th May 2018
Executive sign off:	Andy Butler, Director of Finance and Corporate Services
Distribution:	Neil Frow, Managing Director Andy Butler, Director of Finance & Corporate Services Peter Stephenson, Head of Finance & Business Improvement
Auditors:	James Quance, Head of Internal Audit Sophie Corbett, Audit Manager Emma Rees, Principal Auditor
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 performance management and reporting within NHS Wales Shared Services Partnership ('NWSSP') was completed in line with the 2017/18 Internal Audit Plan.

The relevant lead for the assignment was Andy Butler – Director of Finance and Corporate Services.

The audit sought to provide assurance to the Velindre NHS Audit Committee for NWSSP that risks material to the achievement of system objectives are 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 over the performance management framework.

The objectives reviewed were:

- the key performance indicators ('KPIs') are aligned to the divisions' service delivery plans ('SDPs') in the IMTP;
- where relevant, KPIs are calculated consistently between the divisions (for example, customer satisfaction scores);
- the KPIs provide timely information to allow the divisions to take prompt action to prevent poor performance;
- the KPIs are reported to management, the Health Boards / Trusts and Welsh Government on a timely basis; and
- the level of detail in the KPI reports is appropriate for the intended audience.

During the audit, the following additional objectives were added to the review:

- quarterly performance reports contain adequate detail to monitor progress against delivery of the IMTP; and
- quarterly performance reporting on the delivery of the IMTP is sufficiently timely to identify, and take action to divert, poor performance.

Limitations of scope

The review covered a high-level consideration of the performance management framework. It did not cover:

- the quality of the data behind the KPIs;
- the systems used by the divisions to compile the data for their KPIs; and
- alignment of the KPIs with the Service Level Agreements between NWSSP and the Health Boards / Trusts.

We considered the KPIs with regard to the 2018/19 elements of the IMTP only.

With regard to the quarterly KPI reports, we only considered the information in the reports to the Health Boards / Trusts and not the information discussed between the NWSSP divisions and their counter-parts within the Health Boards / Trusts.

In order to maintain independence and objectivity, we excluded the Audit & Assurance KPIs from the scope of this review.

1.3 Associated Risks

The risks considered in the review were as follows:

i. the KPIs do not support performance management of the IMTP;
ii. lack of consistency between the divisions' KPI calculations, leading to the inability to consolidate or compare the KPIs; and
iii. the KPIs are not sufficiently timely to allow prompt action to prevent poor performance.

We also considered the following additional risk during the course of the review:

iv. IMTP performance monitoring does not allow for prompt identification and action to address poor performance.

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 performance management is **Reasonable** Assurance.

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

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

2.2 Assurance Summary Table

Assurance Summary					
1	KPIs are aligned to the divisions' SDPs within the IMTP		✓		
2	Relevant KPIs are calculated consistently between the divisions		✓		
3	KPIs provide the divisions with timely information to address poor performance			✓	
4	KPIs are reported to management, the Health Boards / Trusts and Welsh Government on a timely basis			✓	

Assurance Summary					
5	KPI reports contain appropriate detail for the intended audience				✓
6	IMTP performance reports contain appropriate detail			✓	
7	IMTP performance reports are sufficiently timely			✓	

** 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 performance management. These are identified in Appendix A as (D).

2.4 Operation of System / Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control for performance management. This is 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	**1**	**2**	**0**	**3**

3 SUMMARY OF AUDIT FINDINGS

Performance Management Framework

NWSSP continues to develop and refine its IMTP and performance management arrangements. A performance management culture has been developed by the senior management team and there is a clear focus on ensuring that performance is monitored and scrutinised through a number of reporting and scrutiny mechanisms, including:

- the annual IMTP and SDP development and update process within the divisions and at a corporate level;
- monthly reports to the SMT on financial and KPI performance;
- monthly reports on individual divisional performance are provided to the SMT for information;
- financial and KPI performance reporting to the Shared Services Committee;
- quarterly divisional performance reviews including updates on delivery of the SDPs, financial and KPI performance and workforce data;
- regular reporting and performance monitoring meetings with customer organisations; and
- links between the IMTP and corporate goals and the PADR process.

Our review focused specifically on the KPIs within the IMTP and the quarterly divisional performance reviews. However, the wider performance management framework was taken into account as we formulated our findings.

Good Practice

Within the scope of our review, we identified the following examples of good practice:

- the KPI reports to management, the Health Boards / Trusts and Welsh Government are all RAG rated. This allows for clear identification of how well the organisation is performing in each area and, in particular, areas of concern where further attention is needed;
- the level of detail in KPI reports to management, the Health Boards / Trusts and Welsh Government is appropriate for each audience;
- when used, the RAG rating report (developed by the Performance Manager) provides a clear indication of progress on delivering the IMTP, making it easy to identify if a project is on track or not (although this template is not always used by the divisions – see finding 2); and

- whilst improvements could be made to the reports used in the quarterly performance meeting (finding 2), we understand that the content of the meetings themselves provides a robust challenge on delivery of the divisional SDPs.

Findings

Whilst we have identified a number of areas for improvement within the performance management systems with regard to KPIs, it is important to understand that this is not necessarily indicative of poor operational performance within the organisation.

We identified one **High Priority** finding concerning KPIs. NWSSP uses KPIs to measure performance and drive progress against key targets. The IMTP contains high-level KPIs to monitor overall NWSSP performance. Each of the divisions then has their own divisional KPIs included within their SDPs.

We found that:

- the high-level KPIs intended to monitor overall organisational performance focus almost entirely on the performance of individual divisions. There is also no clear link between the high-level KPIs and the divisional KPIs;
- there is no clear link between the divisional KPIs and the content of their SDPs;
- the divisional KPIs are nearly always quantitative, with few qualitative KPIs in use;
- many of the divisional KPIs are not critical to the divisions' performance;
- divisional KPIs did not provide a balanced view of performance against their SDPs;
- many of the divisional KPIs rely on manual data collection and calculations.

We understand that management is now working with CEB Gartner to develop and refine the KPIs, including designing a corporate scorecard. We further understand that the Director of Finance & Corporate Services intends to meet with the divisional directors over the coming months to assist them with creating effective KPIs. We concur with this approach and recommend the detailed points in Appendix A Finding 1 and the KPI best practice guidance in Appendix B is taken into account during this process.

See Finding 1 at Appendix A

We identified two **Medium Priority** findings:

Monitoring Delivery of the IMTP

The divisions are not consistently using the RAG rating report template (developed by the Performance Manager) for their quarterly updates of performance against the IMTP. Where it is not in use, the level of detail in the performance reports is not sufficient to identify if a project is on track or not. We recommend that the divisions use the RAG rating report template within their quarterly performance reviews.

See Finding 2 at Appendix A

KPI Targets

The KPIs are RAG rated, with green indicating a target has been met, amber indicating a near miss and red indicating a target has been missed by a large margin. Our review of the KPI reports to the Senior Management Team throughout 2017/18 highlighted that many of the high-level KPIs were green and performance was well in excess of the target. This may be indicative of targets that are not sufficiently challenging.

In addition to this, our high-level review of the divisional KPIs within the 2018/19 SDPs identified that seven of the divisions only have KPI targets for the current year and do not show how they intend to improve performance over the three years of the IMTP.

See Finding 3 at Appendix A

Finding 1: Key performance indicators (D)	Risk
In facilitating achievement of the IMTP goals and priorities, NWSSP uses KPIs to measure performance and drive progress against key targets. The IMTP contains high-level KPIs to monitor overall NWSSP performance. Each of the divisions then has their own divisional KPIs included within their SDPs. Successful performance and expertise at an individual divisional level is critical. However, it is also necessary to create a balanced and integrated focus across the entire organisation. Whilst the 2018/19 IMTP does identify a number of high-level KPIs intended to monitor overall performance, these KPIs focus almost entirely on the performance of individual divisions and did not include goals common to the organisation, for example customer satisfaction. Our review of these high-level KPIs highlighted that there is no clear link between them and the divisional KPIs. We identified that ten of the 30 high-level KPIs are not included in the relevant SDPs. Of the 20 high-level KPIs that were included, 13 had a different target to the corresponding divisional KPI. We also found that the high-level KPIs only covered five of the 11 divisions (Health Courier Services, Surgical Materials Testing Laboratory, Specialist Estates Services, Digital Workforce Solutions, Central Team eBusiness Solutions and GP Specialty Registrar Lead Employer are not covered by the high-level KPIs). In addition to this, there is no clear link between the divisional KPIs and the content of their SDPs (i.e., the 'key priorities', 'what we will deliver' and 'key milestones' sections). We further noted that: • the divisional KPIs are nearly always quantitative (i.e., 'process KPIs'), with few qualitative KPIs (i.e., 'output KPIs') included; • most divisions have a large number of KPIs, many of which are not necessarily critical to performance – for example, five divisions (Central Team eBusiness Services, Digital Workforce Solutions, Employment Services, Primary Care Services and Procurement) had between 10-22 KPIs; and	The KPIs do not provide a balanced view of performance against the IMTP. The KPIs may not be effective in identifying poor performance on a timely basis. The high-level KPIs do not promote a balanced and integrated focus across the organisation. This could lead to divisions working with a silo focus within their functional area rather than working together for the good of the organisation.

• the divisional KPIs tend to focus on specific aspects of a service and do not provide a balanced overview of performance, for example the Health Courier Services and Employment Services KPIs. Whilst we did not perform detailed testing on the calculation of the divisional KPIs, we understand from discussions with staff that many of the KPIs are manually calculated and are time consuming to process. In these cases, it is difficult to produce timely information to identify poor performance.	
Recommendation 1	**Priority level**
We understand that management is now working with CEB Gartner to develop and refine the KPIs. We further understand that the Finance & Corporate Services team intends to meet with the divisional directors over the coming months to assist them with creating effective KPIs. We concur with this approach and recommend the below points and the KPI best practice guidance in Appendix B is taken into account during this process. With regard to developing and refining the KPIs, management should: • identify Key Areas of Focus (see Appendix B) important to the entire organisation, establish KPIs to monitor these areas and ensure these KPIs are reflected within the divisional KPIs; • ensure that there are clear links between the high-level KPIs, the divisional KPIs and the SDPs – this should be made explicit in the IMTP document; • ensure there is a balanced mix of input, process and output KPIs (see Appendix B); • ensure that the KPIs within the IMTP provide a balanced view of the IMTP/SDP contents and are critical to NWSSP and divisional performance; and • work towards ensuring that manual data collection and calculation of the KPIs is reduced to a minimum.	**High**
Management Response 1	**Responsible Officer/ Deadline**

Accepted. The risk of being unable to effectively demonstrate the value that NWSSP brings has been included in the Corporate Risk Register over the last few months and actions have been identified to reduce the risk that align to those recommended above. Responsibilities for implementing these actions and in embedding a more effective performance framework are to be reassigned to give more pace to their achievement. As noted above we are already working with CEB Gartner in this area and they are presenting to the SMT in June.	Director of Finance and Corporate Services. 1. 30 June 2018 – to agree approach, based on advice from Gartner and assign responsibilities. 2. 31 December 2018 – to embed a revised Performance Framework across NWSSP.

Finding 2: Monitoring Delivery of the IMTP (O)	**Risk**
The divisions provide updates against their SDPs on a quarterly basis. The Performance Manager has developed a report template to provide these updates in a clear and concise manner, clearly demonstrating whether delivery is on track through RAG rating along with a narrative description of progress made. However, our review of a sample of quarterly reports identified that the divisions are not consistently using this template. Where the template was not being used, there was no RAG rating and the narrative provided did not identify whether a project was on track or not.	IMTP performance update reports are not sufficiently clear to enable tracking of progress against the IMTP. Poor or delayed performance may not be promptly identified or addressed.
Recommendation 2	**Priority level**
The divisions should use the template RAG rating report to provide their quarterly updates on delivery against the IMTP.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**

Accepted. Progress has been made in formalising the quarterly review process but we will ensure that all Divisions are completing the template reports to provide their quarterly IMTP updates.	Director of Finance and Corporate Services. 30 September 2018

Finding 3: KPI Targets (D)	**Risk**
The KPIs are RAG rated, with green indicating a target has been met, amber indicating a near miss and red indicating a target has been missed by a large margin. Our review of the KPI reports to the Senior Management Team throughout 2017/18 highlighted that many of the high-level KPIs were green and performance was well in excess of the target. This may be indicative of targets that are not sufficiently challenging. In addition to this, our high-level review of the divisional KPIs within the 2018/19 SDPs identified that seven of the divisions only have KPI targets for the current year and do not show how they intend to improve performance over the three years of the IMTP.	KPI targets may not be sufficient to drive improvement.
Recommendation 3	**Priority level**
Management should review the KPI targets in place and ensure they are sufficiently challenging to drive continuous improvement throughout the organisation. This should include setting out targets showing how the division intends to improve performance over the period of the IMTP.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
Accepted – this will be considered as part of the overall process of revising and improving the performance framework.	Director of Finance and Corporate Services. 31 December 2018

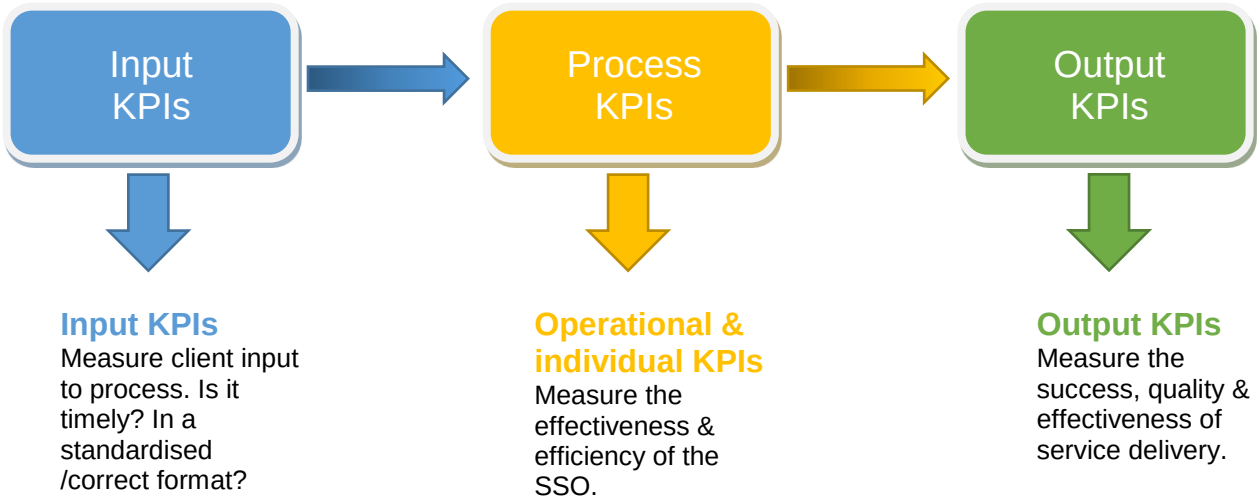
KPI Best Practice for Shared Services Organisations

KPIs are one of the most important parts of a performance management framework for Shared Services Organisations ('SSOs'). Well-defined KPIs will engage clients, drive continuous improvement and encourage desired behaviours within the organisation.

SSOs need to identify what is important to themselves and their clients, linking the KPIs to their strategic goals and cascading them down to operational targets.

Types of KPIs

There are three types of KPIs relevant to SSOs – Input, Process and Output:



All types are required to enable identification of system weaknesses – if any one type is missing, an SSO may take incorrect action to address poor performance because they do not understand where the weakness lies.

KPIs should be critical measures to reflect performance, not a long list of numbers and data that risk being lost amongst each other, although further detail should be available if greater levels of analysis are required.

Key Focus Areas

Identifying Key Focus Areas ('KFAs') that are common across the organisation is an integral part of the KPI process. Successful performance and expertise at an individual divisional level is critical. However, it is also necessary to create a balanced and integrated focus across the entire organisation.

Examples of KFAs include:

- financial performance, including achievement of budget and cost savings;
- customer satisfaction, covering aspects such as timeliness, accuracy, responsiveness, teamwork, professionalism;
- innovation, for example the number of quality improvements initiated, measuring success using milestones met; and
- employee development / engagement / satisfaction, considering staff surveys, education or qualification status, staff turnover, job changes.

Having identified its KFAs, SSOs should then define KPIs to monitor performance and drive improvement in these areas. Definition of these KPIs should include how they are calculated, to ensure consistency across the organisation. This will allow for internal comparison and benchmarking. Furthermore, performance can be consolidated to give an overview for the whole organisation.

Targets for KFAs should be set in such a way that achievement in one area is not at the detriment to another, for example, achievement of cost savings should not come at the cost of customer satisfaction.

Targets and benchmarking

KPI targets should include current and future operations, with links to external benchmarking where possible.

The use of exception indicators (for example, RAG rating) is important in identifying issues and driving improvement.

KPIs and targets should be refreshed as the targets are achieved or if the KPIs become less relevant.

Achieve buy-in

Client buy-in to the KPIs, particularly the input KPIs, is crucial to the success of an SSO. Clients need to work in partnership with their SSO in order for the SSO to fulfil its maximum potential. SSOs should therefore endeavour to negotiate and agree their KPIs with their clients.

Use of technology

Manual data collection and calculation of KPIs should be kept to a minimum to reduce the risk of error within the KPIs and ensure that KPIs are produced efficiently, effectively and on a timely basis.

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*
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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.

GIG CYMRU NHS WALES
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NHS Wales Shared Services Partnership

Internal Audit Operational Plan 2018/19

May 2018

DRAFT

Audit and Assurance Services

Contents

1. Introduction

The Managing Director is required to certify in the Annual Governance Statement for NWSSP that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Managing Director and the Shared Services Partnership Committee (SSPC), through the Audit Committee, with an independent and objective opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by management to improve risk management, control and governance within their operational areas.

The Public Sector Internal Audit Standards (PSIAS) require the Head of Internal Audit to develop and maintain an internal audit strategy designed to meet the main purpose of the internal audit activity. This strategy must advocate a systematic and prioritised review, outlining the resources required to meet the assurance needs of the Accountable Officer (Managing Director), Board (SSPC) and Audit Committee.

Accordingly this report sets out the risk based operational plan for the period April 2018 to March 2019, for NWSSP a hosted body of Velindre NHS Trust. Internal audit activity will be provided by NHS Wales Audit & Assurance Services, a division of the NHS Wales Shared Services Partnership.

2. Developing the Operational Audit Plan

2.1 Link to Auditing Standards

The operational plan for 2018/19 has been developed in accordance with the PSIAS 2010 – Planning - to enable the Head of Internal Audit to meet the following key audit planning objectives:

- provision to the Managing Director of an overall annual opinion on the organisation's risk management, control and governance, which

may in turn support the preparation of the Annual Governance Statement;

- audit of the organisation's risk management, internal control and governance arrangements through periodic risk based plans which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing line management with recommendations arising from audit work;
- quantification of the audit resources required to deliver the planned audit strategy;
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- provision of both assurance and advice by internal audit.

2.2 Risk Based Audit Planning Approach

The risk based planning approach recognises the need for prioritisation of audit cover to provide assurance to management of risk and the plan addresses these fundamental planning issues by considering the:

- organisation's risk assessment and maturity;
- coverage of the audit universe;
- coverage of previous years' activities; and
- audit resources required to provide a balanced and comprehensive view.

Whilst some areas of risk, control and governance require annual review, the risk based planning approach recognises that it is not possible to audit every area of an organisation's activities every year and therefore provides a rational basis for the prioritised allocation of audit resources.

2.3 Link to the System of Assurance

The risk based planning approach integrates with the organisation's system of assurance, thus we have considered the following:

- a review of the vision, values and forward priorities as outlined in the Annual Plan and 3 year Integrated Medium Term Plan;

- an assessment of the organisation's developing governance and assurance arrangements and the contents of the Risk Register;
- risks identified in papers to the Shared Services Partnership Committee and the Audit Committee;
- key strategic risks identified within the corporate risk register and assurance processes;
- results of the recent assurance mapping exercise undertaken by the Head of Finance & Business Development;
- discussions with Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of risk management, control and governance arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- other assurance processes including planned audit coverage of systems and processes now provided through NHS Wales Shared Services Partnership (NWSSP);
- work undertaken by other review bodies including Wales Audit Office (WAO) and NWSSP's Local Counter Fraud Service; and
- coverage necessary to provide reasonable assurance to the Managing Director in support of the Governance Statement.

2.4 Audit Planning Meetings

In developing the plan, the Head of Internal Audit has met with NWSSP Directors to discuss current areas of risk and related assurance needs. Meetings have been held with the following key personnel during the planning process:

- Managing Director;
- Director of Finance & Corporate Services;
- Director of Procurement Services;

- Director of Employment Services;
- Director of Primary Care Services
- Director of Legal and Risk Services;
- Director of Audit & Assurance;
- Head of Finance and Business Development; and
- Chair of Audit Committee.

3. Audit Risk Assessment

The prioritisation of each area in the audit universe is based on our assessment of audit risk in terms of inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal control). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, potential for fraud, and sensitivity.

4 Planned Audit Coverage

4.1 Operational Audit Plan

The Operational Audit Plan is set out in Appendix A and identifies the audit assignment, lead executive officer, outline scope, and proposed timing.

The operational plan has been divided into the following:

- assurance reviews for NWSSP where it processes transactions for individual Health Boards/Trusts; and
- assurance reviews for NWSSP alone.

This approach ensures that the major transactional systems which NWSSP operate and run on behalf of the Health Boards/Trusts are audited, plus those areas and systems affecting only NWSSP.

Required audit coverage in terms of capital audit and estates assurance will be delivered by our Specialist Services Unit (SSU) within NWSSP Audit & Assurance Services. Given the specialist nature of this work and the assurance link with the all-Wales capital programme we will need to agree with management the scope and coverage on specific schemes. The operational audit plan will then be updated accordingly to integrate this tailored coverage.

Further, our work on the major transactional systems will in part be delivered by our IM&T team to improve the breadth and efficiency of our audit coverage.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management and WAO requirements, where applicable.

The Audit Committee will be kept appraised of performance in delivery of the Operational Audit Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

4.3 Keeping the Audit Plan under Review

Our risk assessment and audit plan is limited to matters emerging from the planning processes indicated above. We continually review and update our risk assessment and take into account any emerging risks as the year progresses.

Regular liaison with the WAO, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource Needs Assessment

There is sufficient funding, capacity and capability to meet the audit resource needs.

The needs based operational audit plan indicates an aggregate resource requirement of 405 days to provide balanced assurance reports to the Managing Director as Accountable Officer in accordance with the NHS Wales Internal Audit Standards. Capital & Estates requirements will be separately agreed.

This assessment is based upon an estimate of the audit resource required to review the design and operation of controls in review area for the purpose of sizing the overall resource needs for the strategic audit plan. Provision has also been made in the strategic plan and needs assessment for other essential audit work including planning, management, reporting and follow-up.

The Public Sector Internal Audit Standards enable internal audit to provide consulting and advisory services to management where requested.

6. Internal Audit Charter

The Internal Audit Charter for Velindre NHS Trust defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service. This is appropriate because NWSSP is a hosted body of Velindre NHS Trust and is consistent with other hosted body arrangements in Wales.

7. Action required

The Audit Committee is asked to approve the operational audit plan for 2018/19.

James Quance
Head of Internal Audit (NWSSP)
Audit & Assurance Services
NHS Wales Shared Services Partnership

May 2018

2018/19 Operational Audit Plan

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
NATIONAL AUDITS					
Primary Care Services • General Medical Services (GMS) • Pharmacy Payments • General Ophthalmic Services (GOS) • General Dental Services (GDS)	Financial governance and management	To provide assurance that Primary Care Services is maintaining a robust system to facilitate timely and accurate payments to primary care contractors.	40	Director (Primary Care Services)	Q3
Employment Services – Payroll	Workforce management	To review the adequacy of the systems and controls in place for the management of Payroll Services in order to provide reasonable assurance that risks material to the achievement of system objectives are managed appropriately.	60	Director (Employment Services)	Q1 set up then continuous

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
		Use of computer assisted audit techniques (CAATs) for data analysis and sample selections where possible. Follow-up of action plan relating to previous audits. We will also monitor progress with key employment services initiatives, including ESR development, potential pay scale revision (CRR6), extending services, e-expenses and participate where appropriate in working groups.			
Purchase to Pay (P2P)	Financial governance and management	To review the adequacy of the systems and controls in place for key risk areas in the P2P process in order to provide reasonable assurance that risks material to the achievement of system objectives are managed appropriately. Catalogue management will be reviewed in detail.	50	Director (Procurement Services)	Q1 set up then continuous

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
		Audit focus will be informed by the outcomes of national procurement reviews. Use of computer assisted audit techniques (CAATs) for data analysis and sample selections where possible. Follow-up of action plan relating to previous audits.			
NWSSP SPECIFIC AUDITS					
Business Continuity Plans	CRR10 Corporate governance, risk and regulatory compliance	To review progress across NWSSP for delivering against Business Continuity Plans, especially for new functions brought into NWSSP. The review will also include a review of cyber security.	15	Director of Finance & Corporate Services	Q3
Risk Management and Assurance	Corporate governance, risk and regulatory compliance	To assess whether NWSSP is maintaining a robust system to manage risk and whether assurance mechanisms are operating effectively.	15	Director of Finance & Corporate Services	Q4

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
Cwmbran Stores	Financial governance and management	To evaluate and determine the adequacy of the systems and controls in place for the management of inventory, in order to provide assurance that risks material to the achievement of system objectives are managed appropriately.	15	Director (Procurement Services)	Q3
BACS Bureau	Financial governance and management	To review the systems and controls in place within the newly established BACS Bureau Team for the processing of BACS payments.	10	Director of Finance & Corporate Services	Q1
General Ophthalmic Services (GOS)	Financial governance and management	To assess whether NWSSP has implemented the actions resulting from a loss analysis exercise undertaken by NHS Protect.	15	Director of Primary Care Services	Q3
Patient Medical Records	Operational service and	To review the systems and controls in place for the retention and management of patient medical records and to assess	15	Director of Primary Care Services	Q4

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
	functional management	whether anticipated benefits are being realised.			
Welsh Language Standards	CRR 12 Corporate governance, risk and regulatory compliance	To assess whether NWSSP is complying with the Standards that come into force at the end of June 2018.	15	Director of Finance & Corporate Services	Q3
Information Governance & General Data Protection Regulation (GDPR)	Information governance and security	To ensure compliance with information governance requirements within services following the introduction of GDPR from May 2018.	20	Director of Finance & Corporate Services	Q3
Health Courier Services	Operational service and functional management	To review whether this service is complying with regulatory requirements and whether key controls are operating effectively.	15	Director (Procurement Services)	Q1

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
Welsh Infected Blood Support Scheme	Operational service and functional management	To review this new service via a directorate audit to provide a baseline and additional review of governance and management arrangements.	15	Director of Finance & Corporate Services	Q2
Annual Leave Management	Workforce management	To review the management of annual leave in directorates in order to ensure that entitlement is taken in accordance with policy.	15	Director of Workforce & OD	Q2
IT Systems	CRR10 Information governance and security	Review of the controls in place for managing the system (to be determined), including access control over application and underlying databases, data security and integrity mechanisms, ongoing management and maintenance, resilience and continuity.	15	Director of Finance & Corporate Services	Q4
ADVISORY REVIEWS AND RISK AREAS TO BE MONITORED					
Recruitment and Retention	CRR2	Advisory review to identify whether directorates are proactively addressing known recruitment and retention issues,	20	Director of Workforce & OD	Q2

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
	Workforce management	utilising best practice and exploring new approaches.			
Primary Care Payments System	CRR1 Financial governance and management	Support to the development and implementation of a solution to replace the Exeter system.	20	Director of Primary Care Services	TBC
Service Change	CRR1, CRR4, CRR5	To review the preparations, including identification and management of risk, in respect of known service changes such as transfer of staff from ABM UHB to Cwm Taf UHB and the creation of HEIW.	TBC	Director of Finance & Corporate Services	TBC
Capital & Estates	Capital & Estates	To be determined between SES and SSU.	TBC	Director (Specialist Estate Services)	TBC

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
AUDIT MANAGEMENT & REPORTING					
Audit planning reporting and management, national systems development	-	An allocation of time is required for the management of the service to the NHS Wales Shared Services Partnership: • planning liaison and management – incorporating preparation and attendance at Audit Committee; completion of risk assessment and planning; liaison with key contacts such as WAO and organisation of the audit reviews; • reporting and meetings – key reports will be provided to support this, including preparation of the annual plan and progress reports to the Audit Committee; and • review of the Annual Governance Statement and annual opinion and reporting.	35	-	Continuous

Office details: Audit and Assurance Services
1st Floor
Cwmbran House
Mamhilad Park Estate
Pontypool
NP4 0XS

Contact details: 01495 300841

MEETING	Velindre NHS Trust Audit Committee for NHS Shared Services Partnership
DATE	5th June 2018
AGENDA ITEM	4.1
PREPARED BY	Gillian Gillett, Financial Audit Manager, Wales Audit Office
PRESENTED BY	Gillian Gillett, Financial Audit Manager, Wales Audit Office
TITLE OF REPORT	Wales Audit Office Progress Report

TITLE OF REPORT

Wales Audit Office Progress Report

PURPOSE OF REPORT

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

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

Date issued: June 2018

Document reference: APS062018

Contents

Progress update

About this document

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

Assurance arrangements

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

Exhibit 1: assurance arrangements

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

Audit update

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

Exhibit 2: audit work update

Area of work	Scope	Planned timetable	Current status
Audit assurance requirements			
Audit assurance work	Assurances over NWSSP service areas required by the local audit teams of individual health bodies.	January – April 2018	Complete
Reporting to NWSSP			
Nationally Hosted NHS IT systems	Summary of work and any matters arising that need to be considered by the NWSSP management	June 2018	Report planned for July
Manangement letter	Summary of work and any matters arising that need to be considered by NWSSP management. This report will also include any issues relating to NWSSP identified by other Welsh health auditors.	June 2018	Report planned for July

NHS-related national studies

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

5 Exhibit 3 provides information on the NHS-related or relevant national studies recently published. 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
Reflecting on Year One: How have public bodies responded to the Well-being of Future Generations (Wales) Act 2015?	The report provides an assessment of how public bodies in Wales have responded to the Well-being of Future Generations Act. It is designed to support organisations during this transition phase. The report recognises that all public bodies are on a learning path to deliver legislation that is bold, ambitious and aims to drive a long term cultural change in public services, resulting in better outcomes for the people of Wales. The report found that public bodies are able to give examples of how they have used the Act to make the changes needed for them to effectively apply the sustainable development principle. Public bodies now need to set out how they will continue developing their approach to the Act so that they can deliver on the ambition and maximise the opportunities it affords. **Published: 10 May 2018** http://www.audit.wales/publication/reflecting-year-one
Speak my language: Overcoming language and communication barriers in public services	This report looked at how public bodies, particularly local government and NHS bodies providing front-line services, provide interpretation and translation services for BSL and other languages to enable people facing these communication barriers to access services. We concluded that organisations varied in the degree to which they understood the needs of their communities and ensured their services were accessible to people needing interpretation and translation services. **Published: 26 April 2018** http://www.audit.wales/publication/speak-my-language-overcoming-language-and-communication-barriers-public-services
A picture of primary care in Wales	This report is a snapshot of the current state of primary care in Wales and brings together numerous sources of data on primary care.

Topic	Details
	It does not attempt to provide a detailed analysis of the strengths and weaknesses of primary care. We will use this report to inform audit work in each health board during 2018, which will look at the amount of progress health boards are making in implementing the national primary care plan. **Published: 24 April 2018** http://www.audit.wales/publication/picture-primary-care-wales

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

Topic	Details
Diagnostic radiology – all Wales summary of local work	Report anticipated to be published Summer 2018
GP out of hours – all Wales summary of local work	Report anticipated to be published Summer 2018

Good practice

6 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research. Our Good Practice Exchange team also facilitates a programme of shared learning events. Exhibit 5 provides information on events, further details can be found on the Good Practice Exchange section on the Wales Audit Office website.

Exhibit 5: Upcoming events from the Good Practice Exchange

Event	Details
Adverse Childhood Experiences: Small Steps, Big Change	Following on from our previous webinar, the next in this series on Adverse Childhood Experiences (ACEs) will move the conversation on to the skills needed for an interactional approach to ACEs. **12 June 2018, 12pm – 1:30pm (webinar)** http://www.audit.wales/events/adverse-childhood-experiences-small-steps-big-change

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

MEETING	NWSSP Senior Management Team
DATE	5 June 2018
AGENDA ITEM	5.1
PREPARED BY	Craig Greenstock, Counter Fraud Manager (NWSSP)
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

Draft Counter Fraud Plan 2018/19

PURPOSE OF REPORT

To provide the Audit Committee with an opportunity to comment on the content, scope and timing of the draft Counter Fraud Plan for 2018/19.

1. INTRODUCTION

Attached at **Appendix 1** is the draft Counter Fraud Plan as at May 2018.

2. RECOMMENDATION

The Committee is asked to:

- **APPROVE** the draft Counter Fraud Plan.

NHS WALES SHARED SERVICES PARTNERSHIP COUNTER FRAUD WORK PLAN 2018 - 19

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 2018-19. 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 2018-19 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 2018/19 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	NWSSP Audit Committee
DATE	5 June 2018
PREPARED BY	Peter Stephenson, Head of Finance and Business Development
PRESENTED BY	Andy Butler, Director of Finance and Corporate Services
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services

TITLE OF REPORT

NWSSP NO PO NO PAY Policy Executive Briefing

PURPOSE OF REPORT

To provide the Audit Committee with information on the process for and implications of the implementation of the No Purchase Order, no Pay Policy across the NHS in Wales.

1. INTRODUCTION

The purpose of this paper is to brief the Audit Committee of the proposal to implement a national No Purchase Order/No Payment Policy within NWSSP. The Audit Committee is asked to **APPROVE** the attached national No PO/No Pay policy for implementation in NWSSP and to note the national and local implementation plans.

2. BACKGROUND

P2P - the Procure to Pay process – encompasses the end to end process from sourcing goods and services through to delivery and receipt of goods and payment to the supplier. The P2P service is run by NWSSP.

The Finance community in Wales, via the Finance Academy Wales, has sponsored a number of improvement work streams which seek to improve the efficiency of processes in core financial systems of which the P2P process is one. A national P2P Group, sponsored by the Finance Academy Wales and consisting of senior finance and procurement professionals from across NHS Wales has proposed to implement a Non Purchase Order/ No Payment Policy in NHS Wales. A No PO/No Pay policy would be one where invoices arriving in the system without an order number would be returned to the supplier unpaid. The supplier will then be instructed to seek an order number from the relevant department and manager that was supplied before payment is made. The aim is to drive up compliance with the standard Oracle order management process. This kind of policy is not unusual in large organisations across the public and private sectors.

The all Wales Directors of Finance were presented with the proposal at their meeting held on 15th September 2017 and supported the proposal. The policy, which is attached as an Appendix, was approved by the NHS Wales Shared Services Partnership Committee in January 2018.

3. KEY ISSUES

3.1 Why Implement a NON PO/No Pay Policy

The implementation of a national policy of 'No Purchase Order/No Pay' is considered by the Finance Academy Wales P2P Group to be an essential and fundamental building block from which the efficiency and effectiveness of the P2P process can be developed. Having looked at existing processes and systems and the features of world class P2P systems the all-Wales P2P Group concluded that where our standard Oracle process is used (i.e. requisition, order, receive goods, match receipted order and invoice and pay invoice) the system is very efficient.

The P2P process becomes inefficient when:

- P2P processes bypass the normal Oracle – requisition; order; receipt; pay - order management processes.
- Where users do not comply with the order management system (i.e. fail to receipt; get an order number in advance of supply of goods etc.)

In practice this means that the following are typical examples of P2P process inefficiencies:

- Invoices arriving without order numbers
    - Accounts Payable staff spend time locating dept. and authoriser.
    - Costs are not accounted
    - Payments to suppliers are delayed.

- Suppliers put account 'on stop' when invoice payments are delayed whilst approvals are sought.
- Weak financial control

If NHS Wales achieves a world class P2P service where:

- Requisitions are approved in a timely manner by the correct person
- Orders are generated from an approved catalogue
- Goods are received and receipted in Oracle quickly
- Invoices are received centrally with a Purchase Order No. quoted

Then the invoices will be paid quickly, efficiently and the following organisational benefits will accrue:

- Better control environment – the right people authorising, in advance of expenditure being incurred.
- Catalogue compliance will be improved leading to less off catalogue purchasing and lead to revenue savings.
- More comprehensive procurement intelligence is captured through the system about what and where goods and services are purchased allowing for better sourcing decisions.
- Costs are more accurately accrued by the system reducing management accounting and Accounts Payable (AP) team workload.
- Public Sector Payment Policy compliance will improve because process times reduce.
- Early payment discounts can be maximised.
- Processing costs in NWSSP AP will reduce releasing resources for NHS Wales.

3.2 All Wales Oxygen Finance Early Payment Discount Contract

NWSSP have recently let a contract with Oxygen Finance to enable health organisations across Wales to benefit from early payment discounts where payments to suppliers are made early. The company seeks agreements with suppliers on behalf of NHS Wales and provides interfacing software to the Oracle Financial system so that cash discounts can be deducted from payments and the appropriate accounting undertaken when payments are made. Typically payments agreements are for terms of around 10 days from invoice date which requires very efficient approval processes. The benefits for NHS Wales are substantial and estimated to be £9M over a five-year period. Key to delivering benefits is an efficient payment process. The Non Po/No Pay policy is aimed at making the P2P and therefore payment process more efficient and so the policy implementation entirely supports this initiative and if successful should enable NHS Wales to secure real cash benefits.

3.3 National Implementation Plan

A national plan has been developed and agreed, the key components of which are as follows:

Implementation Date - Implementation of the plan will begin in June 2018, with suppliers and staff being communicated with when invoices arrive without an order. However for a 3 month period invoices will continue to be paid i.e. they will not be returned to suppliers if no order number is quoted. After this shadow running period of 3 months the policy will be implemented in full from 1 September 2018. The policy is being implemented across NHS Wales with the exception of Cardiff and Vale UHB where a number of local issues prevent implementation until later in the financial year.

Policy Agreement - National agreement to the policy has been secured through Directors of Finance and NHS Wales Shared Services Partnership Committee. However, agreement to the policy from this NWSSP is also required. The policy is attached in Appendix 1.

Communications - A detailed plan for the engagement of all users, managers and suppliers has been developed to support implementation in NWSSP. Communication with suppliers will be undertaken by NWSSP on behalf of all Health Boards and Trusts.

Training - Training resources will be distributed to all users to support them in knowing how to set up requisitions, orders and receipt goods and services within the Oracle system.

Exceptions to No PO/No Pay - Some categories of expenditure clearly would not lend itself to enforcing this policy for example local authority rates or utilities costs. These exceptions are detailed in the policy and those suppliers will be excluded from any communications relating to the policy implementation.

Escalation Protocols – Once the initial implementation phase has passed it is important to ensure that the new policy is complied with by users and suppliers alike. Therefore an escalation process forms part of the policy to ensure that non-compliance is eradicated.

Operational Procedures - Detailed operational procedures have been developed with the Procurement and Accounts Payable functions within NWSSP to ensure the policy framework is effectively operated at an operational level for example the process of returning invoices to suppliers and communicating noncompliance to users.

3.4 Local Implementation Plans

Each Health Board/Trust in NHS Wales has carried out an implementation readiness assessment in order to assess and mitigate key risks locally.

For NWSSP the main areas of risk are potentially, those that currently do not seek purchase order numbers on a prospective basis and this currently spans all Divisions to a degree.

A schedule has been supplied to respective divisional Directors with non-conforming items highlighted. It has been recommended to the Directors to ensure the purchasing arrangements not only conform to the policy but that other ways are purchasing are sought by involving the Procurement Team at purchase or negotiation stage dependant on value. In exceptional circumstances, Directors have been asked to ensure that written cases are made for these respective purchases to be formally classed as "exceptions" and accordingly added to the existing agreed list agreed with the Academy.

4. NEXT STEPS

Subject to approval of the policy and the local plan for implementation the policy will implemented in a shadow form from 1 June with full implementation from 1 September 2018.

5. RECOMMENDATION

The Audit Committee is asked to **APPROVE** the implementation of the National No PO/No Pay Policy in NWSSP.

NHS Wales Shared Services Partnership

NHS Wales No PO No Pay (No Purchase Order No Payment) Policy

To be adopted by Each Health Board and Trust in NHS Wales

Contents:

1 Introduction/Overview

The P2P - the Procure to Pay process – encompasses the end to end process from sourcing goods and services through to delivery and receipt of goods and payment to the supplier. A No PO/No Pay policy is where invoices arriving in the system without an order number are be returned to the supplier unpaid. The supplier will then be instructed to seek an order number from the relevant department and manager that was supplied before payment is made. The aim is to drive up compliance with the Standing Financial Instructions as well as the standard order management process.

2 Policy Statement

The implementation of a national policy of 'No Purchase Order/No Pay' is to be an essential and fundamental building block from which the efficiency and effectiveness of the P2P process can be developed.

3 Aims/Purpose

To ensure:

- That all goods and services are ordered appropriately and are supported by official Purchase Orders in line with LHB and Trust Standing Financial Instructions.
- Efficient processes are put in place so that goods are delivered when required.
- Control costs - in respect of
    - All non-pay expenditure incurred by the Health Board or Trust is valid and appropriately authorised in advance of the goods/services being received.
    - Minimising transactional costs associated with payment for goods.
    - Invoices to suppliers are paid within deadlines set by Welsh Government requirements.
    - Financial incentives for early payment offered by suppliers are maximised.

4 Objectives

This policy ensures that NHS Wales only pays for goods, services and works which have been properly ordered and authorised in accordance with the NHS Wales Procurement rules and Standing Financial Instructions **BEFORE**

receiving an invoice. It also ensures invoices received by the NHS Wales Accounts Payable teams can be processed efficiently to minimise delay to suppliers and contractors. Invoices received by the NHS Wales Accounts Payable Team without a valid PO number will severely delay payment to the suppliers. Successful adoption of this policy will lead to the following benefits:

- Better control environment – the right people authorising, in advance of expenditure being incurred.
- Catalogue compliance will be improved leading to less off catalogue purchasing and lead to revenue savings.
- More comprehensive procurement intelligence is captured through the system about what and where goods and services are purchased allowing for better sourcing decisions.
- Costs are more accurately accrued by the system reducing management accounting and Accounts Payable (AP) team workload.
- Public Sector Payment Policy compliance will improve because process times reduce.
- Early payment discounts can be maximised.
- Overall processing costs in NWSSP P2P will reduce releasing resources for NHS Wales.

5 Scope

This policy is relevant to the following groups of staff within NHS Wales-Health Boards, Trusts and NHS Wales Shared Services Partnership:

- ***Requistioners***
  Those staff that process requisitions for goods and services in departments and directorates within NHS Wales.

- ***Approvers/Budget Holders***
  Those staff that approve requisitions for goods and services in departments and directorates within NHS Wales.

- ***Staff that Receive Goods/Services***
  Those staff that indicate within the Oracle or other ordering systems that the goods/services ordered have been received.

- ***Procurement Staff***
  All staff in the Procurement department.

- ***Accounts Payable Staff***
  All staff involved in the invoice payment process.

- ***Finance Departments***
  All staff involved in financial management.

6 Roles and Responsibilities

6.1 All Staff with Responsibility for Ordering

It is the responsibility of all staff, designated under the local scheme of delegation, that order goods and services to ensure that a Purchase Order number is provided to a supplier in advance of the goods or services being supplied.

6.2 Requistioners

All staff that raise requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied.

6.3 Requisition Approvers/Budget Holders

All managers and budget holders designated to approve requisitions for goods and services must ensure a Purchase Order number is provided to a supplier in advance of the goods or services being supplied.

6.4 Staff That 'Receipt' Goods and Services

All staff that work in central stores, receipt and distribution points and local departments where goods are delivered or services are received must ensure that the Purchase Order is marked as 'received' as soon as possible within the Oracle system but no later than within 2 working days of the delivery of goods or provision of the service.

6.5 Procurement Staff

All staff working within NWSSP Procurement Services must ensure that this policy is adopted and adhered to by all staff and that local operational procedures for supporting the No PO/No Pay Policy are observed at all times.

6.6 Accounts Payable Staff

All staff that process the payment of invoices within NWSSP Accounts payable must ensure that no invoice is paid (unless it is identified as an exception in Appendix 1) if a Purchase Order number is not quoted on the invoice. All invoices received with no Purchase Order number must be recorded within the Oracle system and the supplier notified in accordance with the communications shown in Section 8.

6.7 Finance Staff

Senior Finance and procurement staff must lead the implementation of this policy within their respective organisation.
All Finance staff must be aware of this policy and promote it in relevant discussions with budget holders.

Finance staff must ensure there are processes in place to capture data on invoices received but unpaid that have no Purchase Order so that expenditure is accrued on the assumption that the invoice will eventually be paid.

7 Main Body

7.1 How does No PO/No Pay Work?

No PO/No Pay works by requiring all invoices submitted by suppliers and contractors to contain an official PO number. In all but agreed exceptional circumstances the PO number will be:

- Generated from NHS Wales Oracle Ordering system
- Generated from other local ordering systems e.g. pharmacy
- Given to the supplier or contractor BEFORE making any commitment to spend NHS Wales's monies.
- There are a number of categorises of expenditure that are excluded from the policy which are shown in Appendix 1.

Any invoice received by the Accounts Payable Team that does not quote a valid PO number will delay its processing and approval which could result in severe delays to supplier invoice payment unless covered by an exception shown in Appendix 1. Exceptions will be reviewed and amended from time to time and users notified of the amendments accordingly.

7.2 What constitutes a Valid PO?

All suppliers will be notified by NHS Wales Procurement Services as part of the implementation of the policy of the No PO/No Pay Policy that they must not, under any circumstances, accept any verbal or written order from NHS staff unless a valid PO number is given or there is an agreed exception as set out in Appendix 1.

Any invoice received that does not quote a valid PO number will be subject to a non-compliance escalation procedure as detailed below.

7.3 What is a Valid PO number?

Valid PO's are Purchase Orders from NHS Wales ordering systems which are the following:-

- Oracle Financial and Procurement System
  - Oracle is the standard financial system used by NHS LHB's / Trusts in Wales.
- Oracle via Basware
  - This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
- Oracle EBS via GHX
  - This is an electronic exchange linked to Oracle for the electronic transmission of purchase orders.
- The Pharmacy system used for generating pharmaceutical orders.

7.4 Submission of invoice

The Purchase Order will confirm which address invoices need to be submitted for payment. Some invoices will be submitted through the electronic exchanges or via the OCR process.

7.5 Public Sector Payment Policy

Provided a supplier has quoted a valid Purchase Order number which has been obtained in advance of supply, NHS Wales commits to paying invoices in line with the Public Sector Payment Policy i.e. within 30 days from receipt of a valid invoice [not the invoice date], or receipt of the goods or service, whichever is later.

7.6 Notification to Supplier of No PO on Invoice

If a supplier sends an Invoice with No PO and it does not sit within the agreed exception list then the first standard letter will be sent ***[see Appendix 2]*** explaining the No Po No Pay policy and what do next.

Subsequent failure to quote a valid PO will result in a second letter shown in **Appendix 2(a).**

7.7 Notification to NHS staff of No PO raised

If a member of NHS Wales's staff requests goods or services from a supplier that does not sit within the agreed exception list then the a standard letter (see **Appendix 3**) will be sent to the member of staff.

8 Non Compliance Policy

To ensure the implementation of the is policy is effective it is important that there is a clear policy of dealing with non-compliance, whether that is in relation to internal staff within NHS Wales or suppliers. The following escalation process will therefore apply:

Supplier

Level	Response	Action
Level 0	Communication to Suppliers of NHS Wales policy	NWSSP standard communication
Level 1	First reminders to non-compliant suppliers – Appendix 1	Appendix 2 letter – payment made
Level 2	Final reminders to non-compliant suppliers – Appendix 1a	Appendix 2a letter – payment NOT made until a valid purchase order number is quoted

NHS staff

Level	Response	Action
Level 0	Communication to NHS staff of NHS Wales policy	NWSSP and LHB / Trust communication
Level 1	First reminders to non-compliant NHS staff – Appendix 3	Appendix 3 letter
Level 2	Communication with individual / line manager	LHB / Trust to deem if a training need etc. Option is available to remove Oracle responsibility.

9 Training

Training resources aimed at the key staff affected by this policy have been developed and will be communicated to all relevant staff in advance of the implementation date.

10 Implementation

The No PO No Pay policy has already been adopted by some NHS LHB's in Wales but will be implemented as one standard policy from the 1st June 2018 with notifications to suppliers and staff then commencing. Invoice payments will not be withheld for a period of a further three months until 1st September 2018. It will apply to all orders for goods, services or works placed with NHS Wales subject to the agreed exceptions in Appendix 1. The policy is a national NHS Wales policy but responsibility for implementation will be for local Health Board's and Trusts following and agreed national implementation plan.

11 Audit

This policy will be subject to internal audit review from time to time.

12 Review

This policy will be reviewed every 3 years.

13 Appendices

Appendix 1	PO Exceptions List
Appendix 2	Letter to Supplier template
Appendix 2a	Letter to Supplier Template
Appendix 3	Letter to staff template

APPENDIX 1

Exceptions to the No PO/No Pay Policy

The following areas do not require a valid PO number. This list is currently under review. The Exceptions List currently covers:

- CHC/Nursing Home Payments
- Pharmacy
- NHS Organisations including NCA/IPC
- Nurse bank agency invoices
- Leased car repairs
- Primary Care Contracts including Out of Hours, Low Vision, Collaborative Fees, Blue Badges
- Orthotics
- Study Leave
- Business Rates
- Eye Tests
- Mobile Phone Charges
- Reimbursements to Patients including Patients travelling
- Telephone Call Charges
- Telephone Line Rental
- Utilities
- Work Permits
- Bunkered Fuel & Fuel Cards
- Purchase Card
- Taxis
- TV Licences

Technical list of Exceptions:-

- Payment of Salary deductions
- Tax, NI & Superannuation
- Petty cash
- Losses & Compensation including Redress

Appendix 2

Letter to Supplier template
ACCOUNTS PAYABLE DEPARTMENT

Dear Supplier **Date:** _____

YOUR INVOICE NO: _____

In accordance with our No PO No Pay Policy and as part of ongoing efforts to improve efficiency we are currently monitoring the level or purchasing taking place outside the organisations standard Purchase Order system processes.

We have recently received the above quoted invoice from yourselves and a valid purchase order number was not quoted. Please be advised that use of valid PO numbers is mandatory for this category of supplies.
On this occasion the invoice concerned will be passed for retrospective authorisation. We must however advise you that this process is discretionary and release of your payment may be delayed as a result. If you wish to secure prompt payment in future please do not accept orders for this category of supplies without first receiving a valid PO number which then must be quoted on your invoice.
If you wish to discuss this matter further, please contact:-

Name: _____

Tel No: _____

We are continuing to monitor the level of compliance with this policy, and reserve the right to return invoices, suspend payment or review your contract if instances of non-compliance with our payment policy continue to occur.
Many thanks for your help in resolving this matter

Yours faithfully

Appendix 2a

Letter to Supplier Template
ACCOUNTS PAYABLE DEPARTMENT

Dear Supplier **Date:** _____

YOUR INVOICE NO: _____

In accordance with our No PO No Pay Policy and as part of ongoing efforts to improve efficiency we are currently monitoring the level or purchasing taking place outside the organisations standard Purchase Order system processes.

We have recently received the above quoted invoice from yourselves and a valid purchase order number was not quoted. Please be advised that use of valid PO numbers is mandatory for this category of supplies.
You have previously received a letter outlining this policy and stating that any further invoices received without a PO will not be paid.

We therefore advise you that until a Purchase Order Number is quoted this invoice will not be paid.

If you wish to discuss this matter further, please contact:-

Name: _____

Tel No: _____

Yours faithfully

Appendix 3

Letter to staff template
ACCOUNTS PAYABLE DEPARTMENT
Dear Colleague **Date:** _____

No PO No Pay Policy

In accordance with the above Policy and as part of ongoing efforts to improve efficiency we are currently monitoring the level of purchasing taking place outside the Oracle PO system.
The following invoice has been received and a Purchase Order Number has not been quoted, but your name has been stated by the Supplier as the ordering point of contact:-

Name: _____

Department: _____

Supplier Name:
_____
_____

Invoice No: _____

Invoice Value: _____

Brief description of goods/services invoiced:
_____
_____
_____

Please be advised that in accordance with the above Policy, use of Oracle PO numbers is mandatory for this category of supplies.

If you did make this purchase through the Oracle system can you please contact me [details below], to advise the Supplier of the PO Number.

Name: _____

Tel No: _____

If you did not make this purchase through the Oracle system please ensure in future that orders of this type are only ordered through the Oracle system. Failure to use the Oracle system with an associated valid PO delays the invoice payment process and risks interrupting supplies and

is a contravention of the LHB's / Trusts Standing Financial Instructions. Non-compliance could result in further communication with yourself and your line manager and impact your ability to raise orders in future. Many thanks for your help in resolving this matter.

Yours faithfully

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	5th June 2018
AGENDA ITEM	6.2
REPORT PREPARED BY	Martin Riley, Head of Finance
PRESENTED BY	Andy Butler, Director of Finance and Corporate Services
RESPONSIBLE HEAD OF SERVICE	Anne-Louise Ferguson, Director of Legal and Risk Services

TITLE OF REPORT

Transfer of the management of redress from the Welsh Government to NWSSP

PURPOSE OF REPORT

To update the Committee on the transfer of Redress, the budget transfer and management arrangements in place to manage effectively.

INTRODUCTION

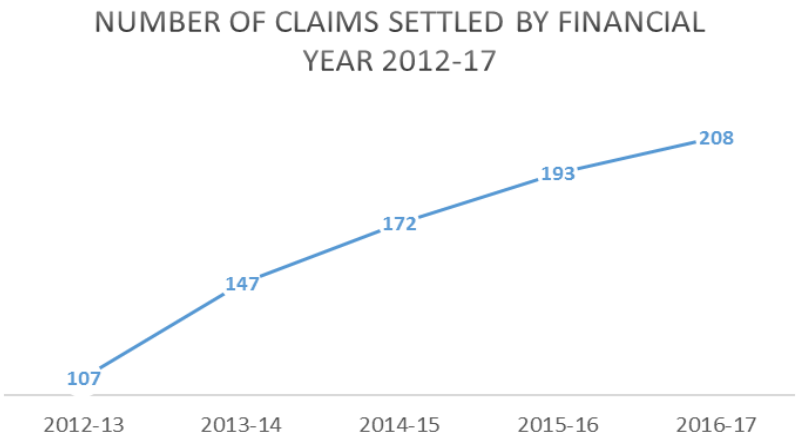
NWSSP Legal & Risk Services ("L&RS") has been providing training, guidance and support to each of the Welsh Health Bodies following the implementation of the Putting Things Right scheme (NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011). The redress system authorises Welsh Health Bodies to offer settlement on claims up to the value of £25k. The budget and management of this has sat within Welsh Government and up to March 2018 Welsh Health Bodies sought reimbursement of claims paid out from the Welsh Government.

The Welsh Government have transferred this function to the Welsh Risk Pool within NWSSP from April 2018. This report sets out the historical and current activity in relation to redress, the work that NWSSP would need to

undertake in relation to embedding robust systems, accountability, governance, processes and learning from events plus an analysis of the risks and benefits associated with the transfer of this function.

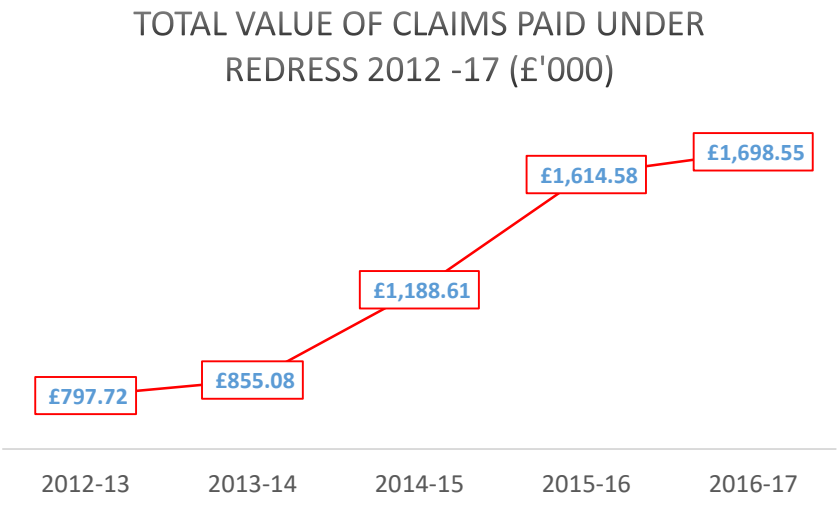
THE GROWTH OF REDRESS CASES

All figures shown below have been supplied by the Welsh Government and analysed within NWSSP. Redress commenced in 2012 and figures on the number of claims have been analysed to the end of the 2016/17 financial year. The graph below tracks the growth in the number of cases in this period.



The claims settled have almost doubled since 2012/13 from 107 to 208 in 2016/17. Growth has slowed significantly. No information about the number of claims has been available from the Welsh Government for 2017/18.

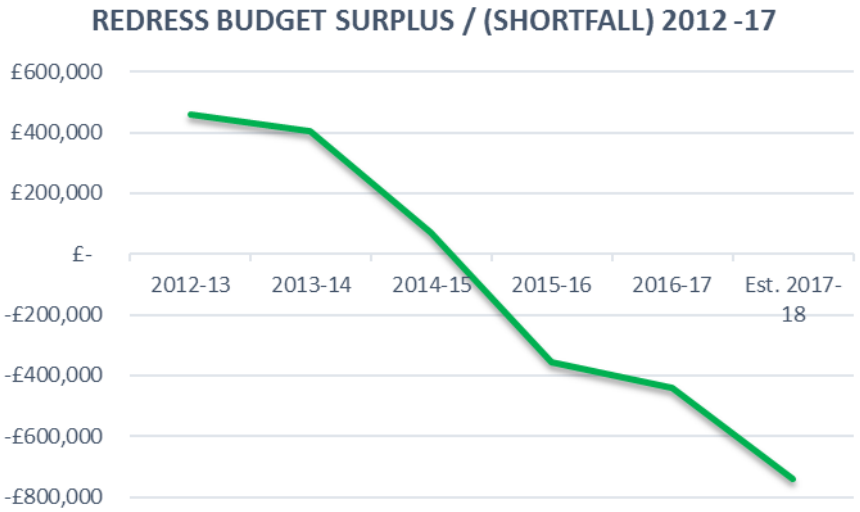
In terms of payments the graph below tracks the increase in payments over the same period.



The total value of claims has increased year-on-year but as the growth in the number of claims settled under redress has slowed, the growth in annual expenditure has also slowed. The reimbursement to Health Boards was £1.7m in 2016/17 and nearly £2m in 17/18.

The average damages paid over the 5 years are £6,162 and average costs per claim are £1,280.

The annual budget for redress within the Welsh Government has been confirmed as £1.259m. A surplus was recorded against this budget until 2015/16. Since then, due to the increasing use of redress, costs have been higher than budget leading to a deficit position which has been managed from other Welsh Government health budget variances. In 2016/17 this budget was overspent by £440k. In 2017/18 the overspend increased to approximately £0.75m.



ADDING VALUE TO REDRESS WITHIN NWSSP

The processes introduced will need to **add value** and **be similar in nature** to the procedures currently in place for all other claims within the remit of the WRPS Committee. By incorporating some of the principles and engagement set out below the financial benefits can be increased. However, there are other benefits that arise due to trend analysis, increasing governance in this area and learning lessons from events. These are detailed in more detail in the table below.

Duties	Link with:	Necessary because / Added value:
Health Board Trust liaison – mirror the process used for CN claims	HB / Trusts / WRPS & LARS staff	Core Business
Database management / report writing	LARS Information Officer	Informs: PtR Solicitors, Safety and Learning Advisors and Finance Team of activity

Performance / benchmarking	PtR solicitors re: trends, activity level	Claim profile monitoring, changing trends, behaviours, cost savings, impact
Marketing / raising awareness	PtR Solicitors – increasing activity levels, targeting support	Changing the balance between redress and cases <£25k damages entering litigation results in cost reduction for the NHS.
Supporting meetings	PtR solicitors re: raising awareness Safety & Learning Advisors	Understanding the business, presenting activity, figures, benchmarking
Preparation of report for WRPS Committee	The Head of Safety and Learning will need to review and sign-off	Provides additional information for WRPS Committee. Completes information re: claims in Wales. Informs decision-making. Provides WRPS Committee with the ability to reject reimbursement, defer reimbursement and seek additional assurances
Reimbursement of Claims	Authorising Officer Finance Team	Core business
Manage deferred reimbursements	Head of Safety and Learning and Safety & Learning Advisors, HBs &Trusts	Ensure the WRPS Committee recommendations are achieved on a timely basis and reported back to Committee accordingly
Increase accountability and ensure lessons are being learned	Head of Safety and Learning and Safety & Learning Advisors	Send requests and receive evidence from Trusts / HBS that the actions requested by the WRPS Committee are being delivered and met on a timely basis
Collate and share improvement strategies	WRPS Clinical Assessors / Safety & Learning Advisors	Claim profile monitoring, changing trends, behaviours, cost savings, impact
Building links between implementing lessons learned & reimbursement	Head of Safety and Learning and Safety & Learning Advisors	Compile quarterly lessons learned reports and disseminate good practice
Forecasting future activity	Finance Team	Inform the IMTP. Redress brings additional allocation and additional costs (not necessarily the same figure) to the WRPS £75m. It is vital this is tracked accurately as it will have an impact on the year-end outturn and potentially the Risk Sharing Agreement.

The table above identifies that to add the most value collaborative work between the WRPS, the Legal and Risk Solicitors and the NHS Service is necessary. Managerially the responsibility for the administration and learning lessons would sit within the WRPS team. There is little scope within the current structure to absorb any further new work. Therefore a contribution to running costs has been acquired to ensure that the governance arrangements, processes, communication and lessons learned can be delivered totalling £45k per annum.

TRANSFERRING TO NWSSP: FUNDING ARRANGEMENTS

The Welsh Government's baseline budget for Redress is £1.259m with no identified funding for running costs. Overspends against this budget have been managed in recent years through favourable variances on other centrally held budgets. As more claims are settled via redress, there is an expectation that the call against the pre-PIDR affected £75m allocation (or £76.3m with the inclusion of the redress) will reduce, thus resulting in cost savings to the NHS. In terms of running costs, the management of redress forms only a small part of staff roles within Welsh Government and therefore does not warrant a transfer of resources to manage.

However, it is important to note that whilst these are real savings to the NHS in Wales the cost in the short term (1 to 3 years) will increase. This is because claims settle far quicker under redress. The effect on having fewer claims in the system will benefit the NHS in the medium term as the profiling of cases currently in the system reduces and fewer new claims are transferred to LARS.

This will result in a cost pressure in 2018/19 against the baseline budget likely to exceed £740k (the difference between the 17/18 budget of £1.259m and the expected level of expenditure of £2m). Based on current forecast levels it is anticipated that the Risk Sharing Agreement for claims over £25k will not be invoked. However, if only £1.259m was transferred for Redress, this places a potential additional risk on the NHS.

Whilst it is recognised that current practices within the Welsh Government do not warrant a transfer of resources to cover the running of the scheme in NWSSP, this report has identified work that will need to be undertaken to add value, learn lessons and instil the same level of scrutiny, accountability and governance for redress as for the other claims managed by the WRPS.

Welsh Government have therefore agreed that the risks against the traditional WRPS budget of £75m and the Redress budget are managed separately in the short term. They will be managed as two schemes within NWSSP for the next three financial years, but with the expectation that the risks are managed in total by the NHS from 2021/22 onwards.

Under this arrangement, the level of funding transferred from Welsh Government to NWSSP under this option would be £1.3m.

Any overspend against the Redress budget, including running costs of the new arrangements, would be met by any underspend against the £75m WRPS allocation. If the £75 million WRPS allocation is fully utilised, the Welsh Government would fund the shortfall on the redress budget including running costs.

SUMMARY

The Committee are invited to;

- **NOTE** the added value and benefits of the transfer of this budget into NWSSP
- **NOTE** the funding arrangements as set out in the report

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	5th June 2018
AGENDA ITEM	7.1
PREPARED BY	Tim Knifton, Information Governance Manager
PRESENTED BY	Andy Butler, Director of Finance & Corporate Services

TITLE OF REPORT

Information Commissioner's Office Training Audit Action Plan

PURPOSE OF REPORT

To provide the Audit Committee with an Action Plan in relation to progress of the actions arising out of the Information Commissioner's Office (ICO) Audit on Information Governance training and awareness within the NWSSP, which was brought to Audit Committee in February 2018.

Summary of observations, actions and recommendations
2017 Audit

Area (2017 audit)	Observation/ Recommendation	Responsible directorate	Suggested actions required	Updates to actions	RAG Status and date
Training Needs Analysis	No organisation-wide training needs analysis in place for Information Governance.	Workforce/Training & Development	A method to address training needs for IG is required	Discussion required to consider options for running reports through Business Intelligence to provide the data	September 2018
Induction training	Unclear from the evidence provided whether unsupervised access to personal data is allowed prior to completion of the Corporate Induction day.	Workforce/Training & Development Corporate Services	Encouragement for new starters to complete their eLearning on appointment as soon as possible. Corporate Induction attendees are provided with the basic IG handouts on the day	WFOD are currently testing the enrolment of new starters at the applicant stage onto e-learning so they have the option of completing ahead of starting work	September 2018
Corporate Induction training	No evidence of Corporate Induction training activity reporting to the Senior Management Team (SMT).	Workforce/Training & Development	Regular reporting to the SMT to reflect new starters/uptake	Discussion required to consider options for running reports through Business Intelligence to provide the data	September 2018
Corporate Induction training	No evidence that there are procedures in place to follow up with staff who have not yet completed Corporate Induction training.	Workforce/Training & Development	A process is developed where new starters are made aware of Corporate Induction and the requirement to attend. There is an escalation process in place to capture those who have not yet attended.	WFOD currently run a Business Intelligence Quarterly report managers can be contacted for them to remind new starters who have not attended Corporate Induction	**Complete**

Area (2017 audit)	Observation/ Recommendation	Responsible directorate	Suggested actions required	Updates to actions	RAG Status and date
Mandatory training programme	The reports provided do not indicate if they are compliance against the national bi-annual target or the NWSSP annual target, or simply a running total of staff numbers completing training since the ESR records began.	Workforce/Training & Development	Financial year and quarterly activity reports are run to detail how many employees have completed the mandatory modules in those periods.	Discussion required to consider options for running reports through Business Intelligence to provide the data	September 2018
Mandatory training programme	Awareness of the pay progression policy and the need to complete mandatory training.	Workforce/Training & Development	Circulation of the pay progression policy.	Pay Progression policy awareness is delivered through PADR skills training and corporate induction	**Complete**
Barriers to training	Responsibility for training needs rests with line managers currently, which means that strategic implications of Information Governance may not be fully realised.	Workforce/Training & Development	Linked to Training Needs Analysis and requirements for Training & Development to decide on how to address this area.	Discussion required to consider options for running reports through Business Intelligence to provide the data	September 2018

Area (2017 audit)	Observation/ Recommendation	Responsible directorate	Suggested actions required	Updates to actions	RAG Status and date
General Data Protection Regulation	Consideration of the impact of GDPR on NWSSP's various business areas (in particular Procurement Services and areas around Workforce and Employment).	Corporate Services	Analysis of Information Asset Registers/Mapping exercises. Evaluation of areas that require or process Personal Data/Service users information. Evaluation of areas that require updating due to consent. Continual reminders to IGSG regarding consent providing opportunities to review	GDPR is currently a standing item on the /IG Steering Group agenda. There is a well-populated Information Asset Register that is being reviewed. Work has been completed with Recruitment, workforce, payroll and expenses. As well as Privacy Notices for staff. Changes have been made to Protocols and regular updates are undertaken.	Initially May 2018 but as this is an ongoing exercise of revision and review there is no considered completion date

Incomplete recommendations from the previous 2015 audit

Area (2015 audit)	Observation/Recommendation	Responsible directorate	Action required	Updates to actions	Status
Training Needs Analysis	Conduct a training needs analysis for IG in all directorates, which includes role specific training mandated for roles such as IAOs (if appointed) and SIRO. Ensure that anyone in NWSSP with responsibility for records management, archiving, disposal or administration receives training appropriate to that responsibility.	Workforce/Training & Development	Linked in with the 2017 audit. Training and Development to consider how best to facilitate a training needs analysis programme for identifying specific staff that handle information.	Information Asset Owners training has been delivered by the NWSSP Information Governance Manager	**Complete**
Corporate Induction	NWSSP should monitor completion of induction and follow up non-completion via regular compliance reports and dip sampling. Failure to complete local induction could also be raised as an issue at relevant directorate meetings and dealt with robustly. NWSSP should ensure that the proposed reintroduction of a formal corporate induction programme addresses these issues.	Workforce/Training & Development	This is linked to the 2017 audit. Training and Development to consider how best to facilitate this.	There is a Corporate Induction programme currently in place.	September 2018 More work is required to consider regular compliance reports and dip sampling

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	5th June 2018
AGENDA ITEM	7.2
REPORT AUTHOR	Roxann Davies, Compliance Officer
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
PRESENTED BY	Roxann Davies, Compliance Officer

TITLE OF REPORT

Audit Committee Forward Plan 2018-19

PURPOSE OF REPORT

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

Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Forward Plan 2018-19

Month	Standing Items	Audit Reports	Governance	Minutes/Chairs Reports/Annual Reports
Q2 2018/19 **24 July 2018**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**External Audit** -WAO Report on NWSSP 2017/18 **Internal Audit** -As outlined in the Internal Audit Operational Plan -Quality Assurance & Improvement Programme	Governance Matters Tracking of Audit Recommendations Corporate Risk Register	Minutes & Matters Arising Counter Fraud Work Plan Counter Fraud Self Review Tool Submission Counter Fraud Annual Report Audit Committee Annual Report Review of Audit Committee Terms of Reference
Q3 2018/19 **23 October 2018**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**External Audit** -Wales Audit Office – Proposed Audit Work 2018/19 **Internal Audit** -As outlined in the Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register Health and Care Standards Assurance Maps Annual Review of Audit Recommendations Not Yet Implemented	Minutes & Matters Arising Health & Care Standards Action Plan Review of Standing Orders Review of Raising Concerns (Whistleblowing) Policy Directorate Assurance Mapping Review

Q4 2018/19 **February 2019**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** -As outlined in the Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register	**Pre-meet between Audit Committee Chair, Independent Members, Internal and External Auditors and Local Counter Fraud** Minutes & Matters Arising Review of Standing Orders
Q1 2019/20 **April 2019**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** -As outlined in the Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register Annual Governance Statement Health & Care Standards Caldicott Principles Into Practice Annual Report	Minutes & Matters Arising Audit Committee Effectiveness Survey
Q1 2019/20 **June 2019**	External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** -As outlined in the Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register Annual Governance Statement Health and Care Standards Review of NWSSP Risk Management Protocol	Minutes & Matters Arising Head of Internal Audit Opinion and Annual Report Results of Audit Committee Effectiveness Survey